Contents

Information about reference material and sources of evidence which will be of assistance when reading Annex A

Annex A is an account of the evidence heard and received during Phase One of the Inquiry. It consists of 31 chapters. It is advisable to read this note before proceeding to read Annex A because it explains how you can gain access to (a) reference material: explanation of acronyms; details about individuals mentioned in the report and information about further reading, and (b) the sources of evidence and the footnotes in Annex A.

(a) Reference material

Explanation of acronyms: A list of acronyms commonly referred to in this Annex can be found at the end of the Final Report.

People: A list of the full names and titles of those individuals referred to in this Annex can be found at the end of the Final Report.

Further reading: A bibliography of published works which have informed the Panel's work can be found in Annex B.

(b) The sources of evidence and footnotes in Annex A

Annex A brings together evidence from a variety of sources, as indicated by the footnotes. There are five main sources:

The transcript	This is a verbatim transcript of the evidence given orally over 96 days of hearings held during 1999/2000. The transcript is always referred to as 'T' followed by the day of evidence and the page number of the transcript for that day. Thus 'T39 p. 37 Mr Hooper' refers to page 37 of the transcript for Day 39 of the hearings, the evidence of Mr Hooper.

Witness statements	The Inquiry received 577 statements from witnesses, 127 of whom also gave oral evidence to the Inquiry during Phase One. The statements are always referred to as ‘WIT’ followed by a string of reference numbers and the name of the person who provided the statement. Thus ‘WIT 0074 0021 Dr Baker’ refers to page 21 of the written statement of witness 74, Dr Ian Baker, Where individuals provided more than one statement the witness number remains the same, and the pages of each statement run on consecutively. The Inquiry also invited formal written comments on witness statements from those people who were referred to or who had an interest in a statement. References to such formal written comments also begin with the letters ‘WIT’.
Submissions	A number of the participants to the Inquiry prepared final submissions at the end of the oral hearings. Other individuals made unsolicited submissions to the Inquiry. These are referred to as ‘SUB’.
Documents	The Inquiry received 42,071 documents, amounting to 219,828 individual pages in total (900,000 when medical records are included) from several main sources.[1] These include, for example, minutes of meetings, reports and correspondence. The vast majority of these documents were from the period under review (1984 to 1995). A reference to a document always begins with the source from which the Inquiry acquired the document (which is not necessarily the same as the originator of the document). The main references to sources are UBHT (United Bristol Healthcare Trust); DOH (Department of Health) and HAA (Avon Health Authority).
Papers prepared or commissioned by the Inquiry	The Inquiry commissioned a considerable number of papers from experts, including statistical analyses. These papers always start with the letters ‘INQ’.

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[1] A full list of the meaning of all the acronyms used to identify various sources of documents is at the end of this note

Accessing the sources of evidence via the CDs and the Inquiry's website

The evidence files are available on the CDs and website in PDF format. These files can be viewed using Adobe Acrobat Reader software. This software is free and links to it and instructions are available on the CDs and the website.

Access to the sources is possible via the CDs and the Inquiry's website, www.bristol-inquiry.org.uk, which will continue in existence after the Inquiry has ended.

Access via the footnotes in Annex A

The footnotes in Annex A refer to a page or pages of one of the five main categories of evidence: transcript, witness statement, submission, document or Inquiry paper. Click on the footnote number in the text to go to the footnote. From there you can access the source document by clicking on the underlined text in the footnote. The document may open in your web browser window or it may open in a new window. If it opens in the browser window, use the browser 'back' button to return to the Annex.

Access via the other annexes

The CDs and the website both contain: Annex B – papers commissioned by or submitted to the Inquiry; Annex C – the Inquiry's Interim Report; and Annex D – the transcript of the oral hearings. A list of the main contents of the Annexes can be found at the end of the Final Report.

Access to witness statements

All witness statements and all formal written comments on those statements can only be viewed in full via the Inquiry's website, www.bristol-inquiry.org.uk. These are not available on the CDs.

It is not possible through any of the routes to view in full all of the documents submitted to the Inquiry. All relevant extracts are being made public through the footnotes in Annex A. The documents themselves cannot be made public in full because they contain information which is extraneous to the Inquiry's Terms of Reference and further, their publication could impinge on the privacy of individuals.

List of acronyms applied to documents referred to in footnotes

APA	Association of Paediatric Anaesthetists and the Royal College of Paediatrics and Child Health
BCS	British Cardiac Society
BMA	British Medical Association
BPCA	British Paediatric Cardiac Association
CCNR	Clinical Case Note Review
CEPOD	Confidential Enquiry into Peri-operative Deaths
DOH	Department of Health
ES	Dr Eric Silove
GMC	General Medical Council
HA A	Avon Health Authority
ICS	Intensive Care Society
INQ	Paper commissioned by the Inquiry
JDW	Mr James D Wisheart
JPD	Mr Janardan Prasad Dhasmana
JS	Mr Jaroslav Stark
MP	Member of Parliament
MR	Medical Records
PAR	Parents
PICS	Paediatric Intensive Care Society
RCN	Royal College of Nursing
RCP	Royal College of Pathologists
RCPCH	Royal College of Paediatricians and Child Health
RCSE	Royal College of Surgeons of England
REF	Letters from referring paediatricians
SCS	Society of Cardiothoracic Surgeons
SH	Mr Stewart Hunter
UBHT	United Bristol Healthcare NHS Trust
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting
WIT	Formal Written Witness Statements
WO	Welsh Office

Chapter 1 – The Background to and Conduct of the Public Inquiry

The Terms of Reference

1 On 18 June 1998 the Secretary of State for Health announced to Parliament the setting up of this Public Inquiry under Section 84 of the National Health Service Act 1977 (the 1977 Act) into events at the Bristol Royal Infirmary. The Terms of Reference of the Inquiry were:

> 'To inquire into the management of the care of children receiving complex cardiac surgical services at the Bristol Royal Infirmary between 1984 and 1995 and relevant related issues; to make findings as to the adequacy of the services provided; to establish what action was taken both within and outside the hospital to deal with concerns raised about the surgery and to identify any failure to take appropriate action promptly; to reach conclusions from these events and to make recommendations which could help to secure high quality care across the NHS.'

2 The Inquiry, therefore, was not required to consider only the actions of certain doctors, or to focus only on cardiac services provided under the supra regional service (SRS) for children under 1 year of age: it was required to look at the complete cardiac surgical service provided for children at Bristol during the period 1984–1995, and any relevant related issues.

3 Before, during and since the period of the Inquiry's Terms of Reference, Bristol has been served by a group of hospitals. Prior to 1 April 1991 this group comprised the United Bristol Hospitals (UBH),[1] and following the adoption of trust status, the United Bristol Healthcare (NHS) Trust (UBHT).[2] The term UBH/T is used hereafter to refer to the hospitals comprising the UBH and the UBHT, both before and after trust status.

4 The paediatric cardiac surgical service was provided at two hospitals in central Bristol: the Bristol Royal Infirmary (BRI) and the Bristol Royal Hospital for Sick Children (BRHSC)[3] and thus the Inquiry was concerned with events at both sites.

5 An examination of the paediatric cardiac surgical service demanded a focus beyond events in the operating theatre itself. Any parent would consider that the (Bristol) 'service' began with the referral of their child to the BRI or to the BRHSC, and did not conclude until discharge from in-patient care (and the conclusion of any necessary follow-up).

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[1] The Bristol Royal Infirmary, Bristol Royal Hospital for Sick Children, Bristol Eye Hospital, Bristol Maternity Hospital, Bristol General Hospital, University of Bristol Dental Hospital. Between 1960 and 1974 they were joined by: Bristol Homeopathic Hospital and Farleigh Hospital

[2] The Bristol Royal Infirmary, Bristol Royal Hospital for Sick Children, Bristol Eye Hospital, Bristol General Hospital, University of Bristol Dental Hospital, Barrow Hospital, Keynsham Hospital, St Michael's Hospital, Bristol Oncology Centre

[3] The BRHSC was formerly known as the Bristol Royal Children's Hospital (the BRCH). It was also referred to in evidence as the Bristol Children's Hospital (the BCH)

The powers of the Inquiry

6 The Inquiry was set up under the 1977 Act and had certain powers conferred on it by that Act.[4]

7 The Chairman had the power to summon any person to give evidence or to produce documents to the Inquiry.[5] The Chairman was also empowered to take evidence on oath or affirmation.[6]

8 The 1977 Act also provided for the Secretary of State to order the costs of parties to the Inquiry to be paid.[7]

The Inquiry Panel

9 The Chairman, Professor Ian Kennedy, and the other members of the Panel (Professor Sir Brian Jarman OBE, Mavis Maclean and Rebecca Howard) were independent of government, the Department of Health (DoH), the National Health Service (NHS), and any other body or organisation, in the conduct of the Inquiry.

10 Professor Kennedy is Professor of Health Law, Ethics and Policy at the School of Public Policy, University College, London.[8] Professor Jarman is Emeritus Professor at Imperial College School of Medicine at St Mary's Hospital, London, a member of the Standing Medical Advisory Committee to the Government, and was a GP Principal at Lisson Grove Health Centre in London NW8 until October 1998.[9] Rebecca Howard was the Executive Director of Nursing at the Manchester Children's Hospitals NHS Trust and a registered sick children's nurse. From September 2000 she has been the Director of Nursing at the Royal Liverpool Children's NHS Trust.[10] Mavis Maclean is Director of the Oxford Centre for Family Law and Policy, Oxford University.[11]

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[4] Section 84(1), 1977 Act. Anyone who, once summoned, refused to attend, or to produce documents to the Inquiry, would have been liable to a fine and/or imprisonment of up to six months, Section 84(4), 1977 Act

[5] Section 84(2)(a), 1977 Act

[6] Section 84(2)(b), 1977 Act

[7] See below at para 21

[8] Professor Kennedy holds degrees in law from universities in the UK and USA and is a Barrister and Honorary Bencher of the Inner Temple. Until December 1996, he had been Dean of the Law School at King's College London for ten years and was Director and then President of the Centre of Medical Law and Ethics which he founded in 1978. He has been a member of the Medicines Commission, the General Medical Council (GMC) and the Department of Health's Expert Advisory Group on AIDS. He chaired the Secretary of State for Health's Advisory Group on Xenotransplantation and the Minister of Agriculture's Advisory Group on Quarantine. He is Chairman of the Nuffield Council on Bioethics and serves on the Archbishop of Canterbury's Advisory Group on Medical Ethics and the International Forum on Transplant Ethics. The Reith Lecturer in 1980, Professor Kennedy has taught and lectured throughout the world. He is the author of texts on medical law and ethics, and was, until 1998, co-editor of the leading journal on medical law. He is a member of the editorial board of ten national and international journals

[9] Professor Jarman was previously Head of Division, Primary Care and Population Health Sciences, at Imperial College School of Medicine. He is a Fellow of the Royal College of Physicians, a Fellow of the Royal College of General Practitioners and a Fellow of the Faculty of Public Health Medicine

[10] Rebecca Howard has contributed to the development of national policy in the area of children's services, and has a special interest in paediatric intensive care

[11] Mavis Maclean qualified in sociology and law. She has researched and written about compensation for accident victims, and now works in family law and family policy, with a particular interest in the children of separated parents. She is the academic advisor to the research secretariat of the Lord Chancellor's Department and a former member of the Lord Chancellor's Legal Aid Advisory Committee

Secretary to the Inquiry and Secretariat

11 The role of the Inquiry's Secretariat was to support the Chairman and Panel in the planning and management of the Inquiry. This involved handling all non-legal aspects of the Inquiry's work. The Secretariat, for example, commissioned expert (including statistical) evidence and advice; organised the Clinical Case Note Review (CCNR); and planned and managed Phase Two of the Inquiry. The Inquiry's Secretary acted as secretary to meetings of the Panel.

12 The Secretariat was responsible for all practical and administrative arrangements. This included the project to find and commission an Inquiry office and hearing chamber; the organisation of IT support; the day-to-day management of the hearing chamber and matters concerning staffing, contractors and the Inquiry's finances. The Secretariat included a communications team responsible for liaising with the press and media and responding to their enquiries; producing regular newsletters for families; and for the management of the Inquiry's website. The Secretariat commissioned a video as a visual record of the Inquiry. It includes information about the Inquiry's procedure and the physical arrangements for the hearings. Copies will be available in due course and may be borrowed from the library of the Department of Health, HM Treasury Solicitor or the library of the Cabinet Office.

13 The Inquiry Secretary was Una O'Brien, a member of the Senior Civil Service; the Assistant Secretary was Zena Muth, also a civil servant. The size of the Secretariat varied depending on the stage of the Inquiry but, throughout the public stages of the Inquiry, it included between 15 and 20 members of staff.

The Solicitor to the Inquiry

14 The Chairman decided that, in view of the probable involvement of the DoH as a participant in the Inquiry, it would be inappropriate for departmental lawyers to act on behalf of the Inquiry. Consequently, HM Treasury Solicitor was approached to provide legal assistance. Peter Whitehurst and Charlotte Martin, both from the Treasury Solicitor's Department, were appointed to head the Inquiry Solicitor's team.

15 They, in turn, recruited a team of lawyers to support them in obtaining evidence and witness statements, calling witnesses to give oral evidence, instructing and assisting Counsel to the Inquiry, and in writing the accounts of the evidence heard by the Inquiry which form the basis of this Annex.

Counsel to the Inquiry

16 Brian Langstaff QC, Eleanor Grey and Alan Maclean were appointed as Counsel to the Inquiry. They did not represent any organisation or individual appearing before the Inquiry. It was not their role to prosecute or to prove any particular case.

17 As members of the independent Bar the role of Counsel was to provide independent impartial advice and assist the Panel by presenting and testing evidence, both oral and written.

The Preliminary Hearing and the call for evidence

18 A Preliminary Hearing took place, in public, in Bristol[12] on 27 October 1998. The purpose of this hearing was to explain the function and procedures of the Inquiry and to consider any applications for legal representation to be paid out of public funds.

19 By that time, a number of organisations had already started to respond to the Inquiry's requests for documents relevant to the Terms of Reference. In addition, the Chairman publicly called for all who had relevant documentary evidence to send it to the Inquiry. He stressed that, if necessary, the Inquiry would use its statutory powers to require the production of documents and the attendance of witnesses.

20 The Chairman emphasised that the Inquiry was neither a trial nor a disciplinary hearing: there were to be neither 'parties' nor 'sides'. The Inquiry would not adopt the process of a criminal or civil court, but rather, an inquisitorial as opposed to an adversarial approach, since this was most suited to the Inquiry's duties under the Terms of Reference. Thus, those who were involved in the Inquiry were referred to as 'participants' rather than 'parties'.

21 The 1977 Act provides power for the Secretary of State for Health to order the payment of participants' costs out of the public purse, on the recommendation of the Chairman.[13]

22 In keeping with established conventions, the Chairman indicated that he would not recommend that public bodies, commercial organisations, trade unions and other bodies with substantial funds should have their costs met from the public purse.

23 Applications for funding from the public purse were received from the Bristol Heart Children Action Group (the BHCAG), the Bristol Surgeons Support Group (the BSSG), Mr Jim and Mrs Bronwen Stewart,[14] the Royal College of Nursing (RCN) and the Medical Defence Union (MDU). There were also a number of incomplete applications from individuals.

24 Subsequently the Secretary of State accepted the Chairman's recommendations that the costs of the BHCAG and the BSSG be met out of public funds.

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[12] The Council House, College Green, Bristol

[13] Section 84(6) of the 1977 Act provides:
'Where the Secretary of State causes an inquiry to be held under this section he may make orders –
'(a) as to the costs of the parties at the inquiry, and
'(b) as to the parties by whom the costs are to be paid …'

[14] The parents of Ian Stewart, a patient who underwent open-heart surgery at the BRI

25 Where costs were to be met at public expense, they were paid at rates agreed by the HM Treasury Solicitor's Costs Department.[15] Prior approval of disbursements, including any expert's fee, above a minimal level, was also necessary. Bills of Costs were subject to scrutiny to ensure that it was proper to fund any work done out of public funds.

26 Additionally, a small number of witnesses were reimbursed for the expense of their attendance at the hearings.[16]

27 The Chairman emphasised to all participants that, unless there was a significant conflict of interest or other justification, the appearance of multiple teams of lawyers would be considered to be unnecessary. In the case of the BHCAG and the BSSG, in order to ensure that focused legal representation for parents and patients was available, it was agreed that one team of solicitors should represent each Group and instruct one team of barristers. This minimised costs, while achieving maximum efficiency.

Early contact with participants

28 During the early months of the Inquiry, in late 1998, the Secretary made contact with representatives of the Executive of the BHCAG and the BSSG. In addition to meeting members of the Executives, meetings were also held with local groups of parents and some individuals.

29 The Solicitor also held a number of meetings with the participants' legal representatives.

30 The purpose of these meetings was to understand concerns, to explain the Inquiry's functions and to consult on processes and procedures.

The Issues List

31 After considering the outcome of all the discussions with those involved and the documentation thus far obtained, the Inquiry identified the key issues to be investigated. A draft Issues List was prepared and sent out for consultation. Informed by this exercise, a final version was prepared and then issued in March 1999.[17]

32 The Issues List was intended to be a guide, identifying relevant issues in the system responsible for the management of care of children who received cardiac surgical services. It was designed to assist the process of examination and enquiry. It did not seek to pre-judge any issue before that process had taken place. It was not a statement of the methods that were to be used to examine each issue.

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[15] Based on local rates subject to level of case-holder

[16] A list of costs appears in the Appendices to the Final Report

[17] See Annex B

33 The length of the treatment of an issue in the List was not to be taken as an indication of its importance to the Inquiry nor did the List attempt to set out an order of priorities. Indeed, the weight given by the Inquiry to each issue varied, particularly as the evidence developed.

The Bristol office and the hearing chamber

34 The Chairman and Panel considered that it was appropriate that Phase One of the Inquiry should be held in Bristol. In early autumn 1998 the Secretariat, with assistance from the DoH's estate management branch, viewed several buildings. In selecting suitable premises consideration was given to the following:

- central location and accessibility by public transport; and
- sufficient space to provide office accommodation and a hearing chamber on one site.

35 The premises selected consisted of three floors at 2–10 Temple Way, Bristol. The accommodation provided two floors of office space and a floor for use as a hearing chamber, with accommodation for participants, members of the public and the media.

36 The office space required little alteration, other than the erection of partition walling and the installation of cabling to support the IT infrastructure.

Design of the hearing chamber

37 The hearing chamber required considerable work. In considering the requirements, much thought was given to those with a close interest in the Inquiry, particularly the families of children who had received paediatric cardiac surgical services at Bristol. The hearing chamber was specifically designed not to resemble a court and to ensure that members of the public who attended the hearings were able to follow proceedings closely.

38 The public seating was laid out in a semi-circular design with the Panel sitting on a slightly raised dais to the left of the witness. The witness sat at a table opposite the centre of the semi-circle, facing members of the public. Counsel to the Inquiry were placed to the witness's right. Legal representatives who attended the Inquiry sat behind the Inquiry's Counsel.

39 Voice-activated cameras were placed in the ceiling of the chamber and video screens were placed strategically throughout the room to assist the view of the public. In addition to the video screens, there were also document display screens that permitted all those in the chamber to view documents that were being discussed.

Public facilities

40 The Inquiry recognised that families whose children had been treated at the BRI and BRHSC would wish to attend the Inquiry and it was with this in mind that the following facilities were also provided:

- family room with soft furnishings, toys, a television and videos suitable for children of all ages;
- quiet room with soft furnishings where those attending the Inquiry could receive support from a trained counsellor;
- overflow room so that, if the hearing chamber was full, members of the public were able to follow the proceedings via a video link;
- waiting room with coffee machines, cold water dispenser, and refreshment machine;
- a number of meeting rooms, which could be pre-booked, so that witnesses coming to give evidence were able to meet their legal representatives, family, or professional colleagues in private; and
- smoking room.

The media

41 The Chairman and Panel were anxious to ensure that the Inquiry was as open as possible. They recognised the legitimate interest which the media had in reporting what took place. It was with this in mind that they sought to extend every assistance to the media to aid them in their role. Copies of the written statement made by a witness were made available to the media at the time that they were made public. The Inquiry also made available the day's transcript on the Internet each evening. There were also members of the Secretariat, in the communications team, whose role was to liaise with the media.

42 There was a dedicated seating area in the hearing chamber with a media room adjacent with facilities such as an ISDN line and dedicated fax machine.

43 However, given the sensitive nature of much of the evidence, it was decided not to allow any photography or broadcasting, either by radio or television, of the hearings.

Documentary evidence

44 The Inquiry received 42,071 documents,[18] a total of 219,828 pages, from over 30 sources. All documents provided were scanned into the Inquiry's database and each page given a unique identification number, denoting the source of the document, file and page number.[19]

45 One or more members of the Solicitor's team and/or Counsel initially read all documents. Duplicates and documents not falling within the Terms of Reference were removed. The remaining 'core bundle' of documents was then 'issue coded' by members of the Solicitor's team in preparation for the hearings. Issue coding involved recording on the database the issues (from the Issues List) to which each document was relevant. Thus, in preparation for the hearings it was possible to search the database for all documents addressing a particular issue.

46 Work on the 'core bundle' continued into 1999 as documents continued to be provided. The bundle was made available over that period to the Panel and to legal representatives of the participants by means of a series of CD-ROMs.[20]

47 Because it was considered essential that the confidentiality of patients be preserved, the Solicitor's team read all documents particularly with this in mind. Details of personal contact, references to individual patients, and references from which it was thought likely that a reader could identify a patient, were redacted, i.e. blocked out, on the scanned documents.[21]

Witness statements

48 The Inquiry's legal team identified those organisations or individuals from which it wished to receive written witness statements.

49 In relation to evidence from parents of children who had been treated at Bristol, the Inquiry was anxious to hear from parents who had experience of the paediatric cardiac surgical services ranging throughout the period 1984–1995, whether they had positive or negative comment to make.

50 Parents were sent questionnaires enquiring whether they wished to take part in the Inquiry. All those who indicated that they wished to take part were invited to make written statements. Generally, where families were members of the BHCAG or the BSSG, the Groups' Solicitors took their statements. The Inquiry's Solicitor's team and local firms of solicitors also took statements, when it was appropriate.

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[18] Excluding medical records and witness statements and comments

[19] Thus 'UBHT 2000 0001' would denote page 1 of a document scanned in file 2000 provided by the UBHT

[20] In the case of participants, CD-ROMs were provided on receipt of strict undertakings as to confidentiality

[21] Where the parents of a patient, or patients themselves who had attained majority, had given express signed consent to the Inquiry to the publication of personal information, redaction was limited in accordance with their consent

51 Likewise, witnesses who were employed, for example by the UBHT, Avon Health Authority (Avon HA) or the DoH, provided statements through solicitors acting for the respective organisation. A number of clinicians were individually represented and statements were provided through their solicitors, often instructed by the Medical Defence Union (MDU) or the Medical Protection Society (MPS). A small number of witnesses provided their statements directly to the Inquiry, with or without assistance from the Inquiry Solicitor's team.

52 Witness statements were received from 577 witnesses. The Inquiry's Solicitor and Counsel read each statement. If it contained comments that were considered to be critical of any other person or body in a material way, a copy of the statement was sent to the person or body criticised to allow them to respond. Every statement and every factual comment was subsequently published.[22]

53 All statements and comments published by the Inquiry were scanned into the Inquiry's database and allocated a unique number, commencing with the identification code 'WIT'.[23]

54 Where the Inquiry decided it was not necessary to call a witness to give oral evidence, that witness statement was published on the Inquiry's website.

55 Where witnesses were called to give oral evidence, their statement was made public at the time that they gave their oral evidence. These statements were also made available, confidentially, in advance of publication to participants who might be affected by the content, who then had the opportunity to advise Counsel to the Inquiry or comment in writing.

Other possible witnesses

56 The Inquiry sought to obtain evidence from clinicians who were members of the junior medical staff at the BRI or BRHSC during the period 1984–1995, in particular those whose rotations involved working in paediatrics, paediatric cardiology, cardiothoracic surgery and anaesthesia. It was hoped that their evidence would give an indication of their experiences at the time and whether any distinctions or comparisons could be made between the evidence of those who were there during different periods.

57 Several attempts were made to trace these former junior doctors. Evidence from those doctors who responded with pertinent comments is set out later in this Annex.

58 The initial search for former staff was assisted by lists of names of registrars and senior registrars provided by the UBHT. Unfortunately, the list did not give complete details of the names; in most cases it contained only a first initial and surname. The list

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[22] However, the Inquiry's Solicitors were authorised, if they considered that a statement or comment contained material (e.g. defamatory or scandalous matter) which could not reasonably assist the Inquiry in its task, to redact that material prior to publication

[23] Thus 'WIT 0200 0001' would denote page 1 of a statement produced by witness number 200

provided the Inquiry with approximately 378 individuals. These were compared against the current medical register and 188 individuals were found, to each of whom the Inquiry wrote. The Inquiry could not rely completely on having identified the correct individual, due to the duplication of common names and the lack of details of initials. When responses were received indicating that a doctor had been contacted in error, further letters were written in an attempt to contact the correct person.

59 A notice was placed in the *'British Medical Journal' ('BMJ')* on 29 May 1999 inviting anyone who had worked as a member of the junior medical staff at the BRI or BRHSC to contact the Inquiry. The notice stated that the Inquiry was particularly interested in the experiences of those whose rotations brought them into contact with the disciplines of paediatrics, paediatric cardiology, cardiothoracic surgery and anaesthesia. Five replies from clinicians were received. They were sent the Issues List and asked for comment, but no replies were forthcoming.

60 The Inquiry sent an alphabetical list of the names provided to the main medical organisations in the UK asking them, initially, to confirm whether any of the clinicians on the list were members of the organisation. The following were asked to assist in supplying contact details for the names on the lists:

- Royal College of Surgeons of England (RCSE)
- Royal College of Anaesthetists (RCA)
- Royal College of Physicians of London (RCP)
- Royal College of Child Health Practitioners (RCCHP)
- Society of Cardiothoracic Surgeons of Great Britain and Ireland (SCS)
- British Paediatric Cardiac Association (BPCA)
- Association of Anaesthetists of Great Britain & Ireland (AAGBI)
- Association of Paediatric Anaesthetists of Great Britain and Ireland (APAGBI)
- British Association of Paediatric Surgeons (BAPS)

61 These organisations were asked if they would be willing to forward letters to clinicians on behalf of the Inquiry, to avoid any problems arising from the confidentiality of the organisations' information. Those that responded, in fact, supplied the full names and addresses of their members, although the majority of these proved to be incorrect or out of date. (The names and addresses supplied were often those given to the organisation when a clinician first became a member and any subsequent move rendered the records held by the organisation inaccurate. There was again the recurring problem that the Inquiry had only a list with surname and first initial.

This produced a number of similar duplicate names.) The Royal College of Physicians of London and the Royal College of Surgeons of England supplied extensive lists of details of their members. Based on those lists, another letter was sent out on 12 August 1999 to approximately 140 clinicians.

62 A number of the organisations contacted by the Inquiry suggested the list of names should be sent to the GMC to check against more up-to-date records. The Inquiry wrote to the GMC to ask for its assistance in tracing former junior medical staff. The GMC responded to the effect that it could only provide contact details if the Inquiry was able to supply full names and the GMC registration number for each clinician. The Inquiry could not provide these details.

63 The assistance of a private company was also sought in tracing former junior doctors. The company, IMS Health, assured the Inquiry that it held databases on clinicians with information about where they trained, when they qualified and their specialties. The Inquiry was keen not to contact any clinicians by mistake a second time, especially if they had already indicated that they never worked in Bristol, and it was thought that this narrowing of the search would be more successful. Unfortunately, the Inquiry still received further negative responses from clinicians who had never worked in Bristol.

64 The Inquiry received a poor response to its letters, as regards both the numbers who replied and the accuracy in reaching the intended recipients. The reason for this stemmed from the original staff lists supplied by the UBHT. Not surprisingly, the form of those lists changed over the years and it made the task of identifying registrars and senior registrars difficult and time consuming, especially where only surnames were recorded. The majority of the responses were from clinicians indicating they had been written to in error (due to duplication of the names) or that they had never worked at the BRI/BRHSC at any time in their career. Of the responses from clinicians who worked at the BRI/BRHSC during the relevant period, the information provided was very limited, because of the time that had elapsed or the fact that the majority were junior at the time and did not feel they could add any useful insight into the paediatric cardiac surgical service at Bristol.

65 The Inquiry also contacted referring clinicians in the Bristol catchment area, and their letters in response are considered in Chapter 11 of this Annex.

The Expert Group

66 It was considered crucial for the Inquiry to hear expert advice on a variety of issues, including medical and nursing care. It was therefore decided that the Inquiry would appoint a group of experts of its own to provide this advice, rather than have to rely on experts commissioned by the various participants.[24] The approach was intended to move away from the adversarial model, in which experts tended to represent ‘parties’, and to ensure that the Inquiry had access to a wide range of impartial advice.

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[24] A list of the members of the Expert Group and a full account of the purpose of the Group is in Annex B

67 As expert advisors to the Inquiry, members of the Expert Group could, as with all other witnesses, only be called to give evidence by the Inquiry itself. They were asked to assist the Inquiry in a number of ways:

- by providing written opinions, which were subsequently published by the Inquiry;
- by providing background information and briefing to the legal team to assist them in preparing for the oral hearings; and
- by attending the hearings, either to give evidence themselves or to assist Inquiry Counsel when a witness was giving oral evidence.

68 In addition, the members of the Expert Group were asked to make themselves available to give occasional seminars to the BHCAG and BSSG, in order to assist them in understanding the issues and preparing their contributions to the Inquiry.

69 Other organisations with a direct interest in the Inquiry were also free to seek advice from the Expert Group. However, in keeping with the non-adversarial approach, all such requests were made via the Secretariat who arranged meetings and forwarded requests for information.

70 The experts included paediatric cardiac surgeons, paediatric cardiologists, anaesthetists, paediatric intensive care nurses, paediatric nurses, pathologists, statisticians, health service managers and accountants. Because so many members of the Expert Group were also in full-time practice, the Inquiry recognised the need to have a large enough pool of experts to call upon so as not to make unreasonable demands upon the time of a small group of people.

71 A large number of the clinical members of the Expert Group assisted with the Clinical Case Note Review (CCNR).[25]

The information technology systems

Background

72 It was evident from the beginning that one of the greatest challenges that the Inquiry would face would be to manage the large volume of information that it would receive. Initially, the Chairman and Secretariat visited other public inquiries then in progress to become familiar with the technology in use. [26]

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[25] See Annex B

[26] The *'Inquiry into the Matters Arising from the Death of Stephen Lawrence'*, and the *'BSE Inquiry'*

73 The DoH's IT systems were provided by ICL. Within the terms of the Department's contract with ICL it was possible to extend the service to include a bespoke IT system for the Inquiry. In October 1998 the Secretariat, with support from the Department's Information Services Division, drew up a specification of the IT requirements. However, a number of services that were required by the Inquiry could not be directly provided by ICL, namely, a document management system and a real-time transcription service, and an invitation to tender for these services was issued.

74 In November 1998 ICL appointed two partner organisations, Legal Technologies (a company which specialises in document management systems for large trials) and Smith Bernal (a company specialising in the provision of a real-time transcription service). Together these three organisations met the Inquiry's IT needs.

Office systems

75 The Inquiry required an IT system for use by the Inquiry Chairman, Panel, Legal Team and Secretariat which was independent of all other systems. This system was based around Microsoft Office and gave the Inquiry full confidential e-mail and Internet access. Additionally, Legal Technologies provided the database of scanned images of all documents received by the Inquiry. Prior to scanning the images, guidelines were drawn up so that information such as the name of the author of the document and the recipient were included in the database. The creation of this database allowed the Inquiry staff to carry out detailed searches of all the images scanned.

Hearing chamber

76 Extensive use was made of IT in the hearing chamber. In particular, use was made of the document database that allowed scanned images to be displayed on a number of computer screens instantaneously within and outside the chamber. This allowed the witness, the Chairman and Panel, members of the public and legal representatives simultaneously to see the document being discussed. These images were also displayed on screens in other rooms on the hearing chamber floor, namely the waiting room and the overflow room. They were also relayed to the Secretariat and the Solicitor's team on the floor below, who also had an e-mail link to Counsel to the Inquiry.

Transmission of proceedings to other locations

77 It was recognised that, given the large catchment area of the BRI/BRHSC, there would be many people living in the South West and South Wales who would wish to follow the proceedings, but would be unable to attend the Inquiry.

78 Therefore, the Inquiry contacted a number of Community Health Councils (CHC) within the South West and South Wales seeking their agreement to host a live video link from the hearing chamber to a room within the local CHC office. Three CHCs (Truro, Barnstaple and Cardiff) were able to assist and received a live video link of the proceedings.

79 Additionally, on a weekly basis, the Inquiry provided copies of the transcripts and witness statements to CHCs and public libraries in the South West and South Wales.

Commissioned work

80 The Inquiry commissioned work from external sources and from members of the Inquiry's Expert Group.

81 One particular, extensive piece of work was that of obtaining all the available clinical records relating to children receiving cardiac surgical services in Bristol between 1984 and 1995. This involved 1,827 cases falling within the Terms of Reference.[27] An expert coder, using a standardised set of codes, coded each of the clinical records,[28] so that an independent database could be established for the Inquiry. The results were then subject to analysis, and contributed to a statistical evaluation of the adequacy of the service at Bristol.

The Clinical Case Note Review (CCNR)

82 There was no template against which the adequacy of the service provided at Bristol could readily be measured. The Inquiry, therefore, had to make its own assessment from a variety of sources. These included a statistical review of the main data sources which might inform the Inquiry of comparative outcomes at Bristol, both relative to other units and to its own performance over time; evidence of individuals of their contemporaneous views; evidence given with hindsight (with its limitations); contemporaneous documentation; the inferences properly to be drawn from the documentary and oral evidence given to the Inquiry; and the knowledge base of clinicians at the relevant time.

83 Additionally, the Panel asked clinical experts to review a sample of the clinical case notes of children whose care fell within the Terms of Reference. The purpose of the CCNR was to provide the Panel with a qualitative perspective on what the notes revealed about the overall pattern of care, and to highlight areas where it appeared, from the notes, that services were adequate or less than adequate.[29]

84 Teams of clinicians drawn from the Expert Group undertook the exercise. The teams reviewed a weighted sample, initially, of the clinical case notes of 80 children; these included children who had died within 30 days of surgery and children who were alive at that time. The weighting of the sample was designed to reflect the principal

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[27] The Inquiry received 2,056 children's records, comprising 3,497 individual files (as children treated at the BRI and BRHSC had a separate set of notes from each hospital): a total of 673,963 pages of medical records

[28] The codes used were those routinely used by hospital administrative systems at the time: ICD9 for diagnosis and OPCS4 for procedure

[29] See Annex B for an explanation of the methodology employed in the CCNR

issues of concern to the Inquiry. Due consideration was given to any distortions caused by the process of weighting when the final conclusions were advanced.

85 The clinicians were grouped into six multidisciplinary review teams, and each team was asked to review a set of clinical case notes.

86 Each review team consisted of five members:

- paediatric cardiac surgeon;
- paediatric cardiologist;
- paediatric anaesthetist/intensivist;
- paediatric pathologist; and
- paediatric nurse or intensive care nurse.

87 The Inquiry's approach to the CCNR was deliberately qualitative and acknowledged that, for the years from 1984 to 1995, there were no clearly set down, nationally agreed standards for paediatric cardiac surgical services. Therefore, the members of each review team were asked, as far as possible, to apply their best clinical judgement drawing on their understanding and knowledge of received professional standards at the time at which the care was delivered. In determining the most appropriate method for the review, the Inquiry took the advice of members of the Expert Group and then tested that advice in a pilot exercise.

88 The CCNR consisted of four stages: reading; reaching a tentative independent view; discussing those views at a multidisciplinary meeting; and reporting on the outcome of the discussions.

89 All members of a review team were given access to the clinical notes. To the extent that they could be located, relevant perfusion and Intensive Care Unit (ICU) charts, echocardiograms and angiograms, and X-rays were made available to the clinicians on each team as necessary. Each expert read the notes and developed a tentative view of what they showed, from the perspective of his or her own clinical expertise.

90 Each team held review meetings, where case histories were discussed, following a short introduction. Each member of the team contributed from his or her own expertise, drawing on an understanding and knowledge of professional practice at the time. The team collectively reached a view about the adequacy of care in relation to specific aspects of care, as well as in relation to the overall management of the case, including cases in which two or three operations took place.

91 The Inquiry was mindful that differences of approach between the review teams could occur. In order to make any such differences transparent, and to help with the overall interpretation of the exercise, the Inquiry distributed a number of the same case notes across the teams. Teams were not aware when looking at case notes that another team may have already considered them.

92 It needs to be emphasised that the CCNR was a review of that which the notes showed. Accordingly, evidence extraneous to the notes that tended to support or falsify a view taken of the quality of treatment which the notes showed, did not, and could not, itself invalidate conclusions reached as to what the notes themselves showed. It was the pattern of care revealed by the notes, rather than the appropriateness of its conclusions when a case was examined by using evidence extrinsic to the notes, that was of importance.

Phases in the public hearings

93 The Inquiry had two phases of public hearings. Phase One, which commenced on 16 March 1999 and concluded on 9 February 2000, involved hearing evidence about the paediatric cardiac surgical services provided at Bristol between 1984 and 1995. It also dealt with aspects of the provision of paediatric cardiac surgical care nationally, so as to provide a background to events in Bristol. Phase Two took the form of seminars, held between January and April 2000. The Panel read papers and, in public session, heard a range of views about the future and examined the broader issues affecting the NHS, to assist them in making general recommendations.

Phase One hearings

Oral evidence

94 The Inquiry heard 96 days of evidence in Phase One, from 120 witnesses and from experts. Hearings were, generally, held on Mondays to Thursdays, initially three weeks in every four, although as Phase One neared its conclusion hearings were held on seven consecutive weeks.

95 A real-time transcript was produced. Where reference is made in this Annex to the transcript of the evidence, the day and page referred to identify it and the witness.[30]

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[30] Thus 'T47 p. 65' denotes page 65 of the transcript for day 47. A full copy of the Phase One (Oral Hearings) transcript is available in Annex D

96 During the course of the Inquiry a total of 900 documents were displayed in the hearing chamber.

97 When witnesses were called to give oral evidence they were advised in advance, in broad terms, of the areas on which their questioning was likely to concentrate. They were given the opportunity to visit the Inquiry's offices to familiarise themselves with the hearing chamber and to meet the Inquiry Counsel who was to examine them.

98 Each witness called to give evidence could be accompanied by a legal representative. However, as the approach adopted was inquisitorial, Counsel to the Inquiry initially questioned all witnesses. This was sometimes supplemented by questions from the Panel.

99 Participants were entitled to make applications to cross-examine a witness. However, since legal representatives of participants were invited to suggest questions, or lines of questioning, for Counsel to the Inquiry to put to the witness and to identify areas which they wished to be explored, it was anticipated that the occasions on which applications for cross-examination would be made would be limited. In the event, Counsel to the Inquiry were able to meet the requests raised with them by participants and, consequently, no application to cross-examine was in fact made.

100 At the end of questioning by Counsel to the Inquiry, the witness's legal representative had an opportunity to put questions by way of re-examination. The purpose of this was to clarify any area of evidence and to enable the representative to ensure that the witness had given a proper account of him or herself. For that reason it was anticipated that any such re-examination should not generally exceed 15 to 20 minutes and this was the case.

101 Additionally, the legal representative of a witness was given the opportunity to make a short submission to the Panel on the day following the evidence, ordinarily in writing but exceptionally, and at the Chairman's discretion, orally. Where the submission was made in writing and it raised a matter that, in the Panel's view was unclear, clarification was sought. All such written submissions were made public.

102 At the end of Phase One those witnesses who chose to do so, by themselves or through their legal representatives, were also given the opportunity to make a final presentation to the Panel in writing, which was made public, together with a short oral presentation.

103 A feature of the oral hearings was their public and accessible nature. This was achieved, in particular, by the extensive use of information technology. This enabled members of the public in the hearing chamber, in an overflow room on site and in the South West and Wales, to follow the proceedings as they occurred, seeing both the witness or questioner and a copy of any document under discussion. Copies of the transcripts of the evidence and documents displayed during the hearing were available at the hearing and also on the Internet.

104 This openness was important both to satisfy the Panel's duty to hold a public hearing, and to ensure fairness. Any participant, or interested person, could follow what was being said in full detail.

105 Again, as part of the commitment to openness and fairness, all material seen by the Panel has been made public (subject only to redaction in the interests of individual's entitlement to confidentiality).

106 During the oral hearings various innovations were used to help the Panel to hear from a range of witnesses on the same occasion. For example, when clinicians gave evidence one or two experts were usually present. The experts could address questions put by Counsel and they, in turn, could raise questions to clarify or discuss with the clinician, or they could confirm a point of evidence. The dialogue thus created between the witness, expert, and sometimes the Panel, was designed to avoid the adversarial model in which separate experts advise contesting parties. It was intended to be more informed, more transparent and more economical of time. Those legal representatives who expressed a view found it to be entirely beneficial. Another example was the occasion of the last day of the oral hearings, when 11 parents gave evidence in two separate group sessions. Essentially, the physical arrangements of the hearing chamber were changed so that up to six parents could give their evidence at the same session. Counsel put questions to each of the parents in turn and sought to generate a degree of discussion and dialogue on particular matters. The Panel found this particularly helpful.

Visit to the BRI and the BRHSC

107 The Panel visited the BRI and the BRHSC on 22 July 1999, accompanied by members of the Inquiry staff. In particular, at the BRI they saw Wards 5A and 5B (the ICU), the Relatives' Room and the lift used to move children pre- and post- operatively. At the BRHSC, having walked up the hill from the BRI, they visited the Cardiac Catheter Unit, the Echo Room, Ward 36, the ICU, the Main Surgical Ward and the operating theatres, including that built in 1995 to allow open-heart surgery to be performed at the BRHSC.[31]

Phase Two Seminars

108 Phase Two of the Inquiry consisted of seven public seminars that took place in London and Bristol between January and April 2000.

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[31] See Annex B for a full note of that visit

109 The objectives of Phase Two were to assist the Panel in meeting the requirement in their Terms of Reference that they make recommendations for the future and to ensure that those recommendations were relevant, practical and achievable.

110 The seven themes identified for Phase Two were:

- *Acute Healthcare Services for Children:* The quality of children's healthcare and health services.
- *Determinants of Performance:* The factors determining the level of performance of organisations, especially in healthcare and the public sector generally.
- *Culture:* Professional and managerial cultures and their impact on the quality of service.
- *Leadership:* Leadership, vision, change and learning from experience.
- *People:* Education, training, development and governance.
- *Systems:* Safety and risk management, quality and information.
- *Service:* Empowering the public in the healthcare process.

111 Written papers on the selected themes were commissioned from a wide range of organisations and individuals, within and outside the healthcare sector.

112 Day-long seminars were held to discuss each theme. After short presentations from the participants, an invited leader conducted the seminar on the Panel's behalf.[32] There were opportunities for members of the public to put questions to the seminar participants, and members of the news media were in attendance.

113 The seminar participants were drawn from the public and private sector and academic and voluntary organisations and were invited to attend to raise points for discussion and share their relevant expertise. The Panel was advised by one of the Inquiry's Counsel on points of law.

114 The written papers were published, and a summary of each seminar's discussion was prepared and published on the Inquiry's website and made available through libraries and Community Health Council (CHC) offices.

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[32] See Annex B for a list of seminar participants

Preparation of the Final Report

115 The purpose of the Inquiry was not to conduct a trial of those associated with the events under scrutiny but to inquire, make findings and draw lessons. For this reason, and because there is no right to appeal against the views taken and conclusions reached in the Report, it was considered fair that those witnesses whom the Panel were minded to criticise should be aware of the Panel's concerns in advance and given the opportunity to comment.

116 Therefore once a first draft of the Report had been prepared, letters were sent, subject to an undertaking as to confidentiality, to a number of individuals briefly setting out intended criticisms with notice of the evidence on which these were based. Witnesses were given a period of 21 days to respond. The Panel in finalising the Report then considered those responses. This is the only occasion when the Inquiry Panel saw submissions that were not revealed publicly, since to have revealed them in any case where the Panel modified its conclusion would have been unjust to the individual concerned.

Structure of Annex A

117 Annex A is an account of the evidence that the Inquiry took to assist it in discharging its duty under the Terms of Reference. The entirety of the Phase One (Oral Hearings) evidence that went before the Panel is available verbatim in Annex D. This Annex constitutes a permanent record of the salient parts of it.

118 Inevitably, any account is bound to be selective. Even in an account as extensive as this, there may be occasions on which evidence which had some impact upon the Panel in reaching its conclusions will necessarily be touched on only briefly, or even not restated. This does not mean that it was ignored. However, this Annex sets out with the intention of presenting that evidence which was regarded as being of greatest importance to the Panel in making its determination.

119 The broad context within which the specific events at Bristol must be set is first examined from the national context (though, inevitably, there will be frequent references to Bristol, for the sake of economy of text and clarity). Thus this Annex starts with an examination of the manner in which the national, regional and local bodies of the NHS, and national regulatory and professional bodies, functioned in exercising responsibility for health services.

120 The Annex then sets out the mechanisms of audit which were applicable on a national and regional basis, and the national and regional financial organisation that may have had an impact upon Bristol.

121 The Annex then offers an outline of congenital heart disease, its diagnosis and treatment, and examines the evidence of the organisation of neonatal and infant cardiac surgery (NICS) – the treatment of congenital heart disease in the under-1-year-olds – as a supra regional service (SRS), the designation of the BRI as a supra regional centre (SRC) to perform NICS, and the impact of developments in Wales upon the development of Bristol as such a centre.

122 Having set the scene nationally and regionally, the Annex then focuses upon Bristol: first, generally, the organisation of care within the hospital; and, secondly, the delivery of the paediatric cardiac surgical services within it. The care given to children who were patients is set out (broadly speaking) in the order of a child's journey through the process of care: referral, pre-operative care, surgical care, post-operative care, and counselling and support for parents.

123 Towards the end of the account of the evidence, there appears a specific focus first upon the adequacy of the surgical services provided at Bristol, and then on the expression of concerns, and the way in which they were handled, which ultimately led to the setting up of this Inquiry.

124 In order, however, to set the scene, there follows an Introduction giving a short history of the principal developments in the structure and organisation of the NHS that preceded the years covered by the Inquiry's Terms of Reference. It notes some of the milestones during that period, so that the context for the rest of the evidence is properly set.

Structure of Annex B

125 Annex B contains a range of background papers, expert evidence and documents covering four broad areas: the conduct of the Inquiry, the Statistical Evidence to the Inquiry, other background expert papers, and assorted documents relating to the Clinical Case Note Review.

Annex C

Annex C contains The Inquiry's Interim Report "Removal and retention of human material." May 2000.

Annex D

Annex D is a verbatim transcript of the oral evidence heard during Phase One (Oral Hearings).

Chapter 2 – A Historical Background to the NHS

Introduction

1 The services provided to children undergoing paediatric cardiac surgery at Bristol from 1984 to 1995 could not be properly examined without an understanding of the context within which the Bristol Paediatric Cardiac Unit functioned. To inform itself of that context, and to assist the Inquiry in its task to 'make recommendations which could help secure high quality care across the National Health Service' (NHS), the Inquiry sought evidence from interested bodies or individuals, upon the national, regional and local scene. This evidence concentrated upon the years 1984–1995, although it looked also at the years immediately preceding 1984, and also at the changes and developments that have taken place since 1995. The account that follows sets out the evidence relating to 1984–1995 which was received by the Inquiry. But the service that existed in 1984 was shaped by the history of the NHS prior to that date. For this reason, we have attempted to summarise the main features of the history of the NHS from 1948 onwards. This brief history is intended to serve as a useful introduction to the more detailed survey of the years 1984–1995 which follows it.

2 We concentrate principally on care in hospital. In fact, three basic elements make up the NHS. They are: the hospital service, the family practitioner services and community-based services. During its hearings, the Inquiry heard evidence of matters that touched upon all three elements. Children were referred for more specialised investigation and treatment by hospital-based consultants by their general practitioners. After discharge from hospital, they and their families received care from general practitioners, and support from community-based practitioners. Parents whose children had died spoke of the services that were available to help them in the community; or the absence of such support. However, the greatest bulk of the evidence received related to services provided by the hospital sector. This is reflected in the following account which deals at greater length with that sector. Equally, the discussion is restricted to the NHS in England and Wales. The Inquiry's Terms of Reference do not deal with Scotland.

The creation of the National Health Service

3 The structure of the NHS in England and Wales was established by the National Health Service Act 1946 (1946 Act). The new arrangements were launched on 5 July 1948.

4 The delivery of healthcare prior to that date had been achieved through a patchwork of fragmented arrangements. Voluntary hospitals, supported in part by charitable donation, provided care to those covered by insurance or contributory schemes, or who could otherwise afford to pay for care. Other hospitals were owned and managed by local authorities.[1] Hospital surveys carried out during the Second World War revealed not only shortages of beds and buildings in a poor state, but that services were not provided in the areas which most needed them.[2]

5 Family practitioner services were provided then, as now, by general practitioners. The National Insurance Act of 1911 gave, for the first time, entitlement to free access to a general practitioner working on the doctor's panel. Some 21 million workers, but not their families, were covered by this insurance scheme in 1942. The quality of services provided varied widely, as it did in the hospital sector. The distribution of general practitioners did not necessarily correspond to the areas where their services were most needed. General practitioners were independent contractors, not salaried employees of a state-provided medical service. This was a status that they would successfully preserve under the new NHS.

6 The late nineteenth century and early twentieth century saw developments towards establishing the professional status of nurses, opticians, midwives, pharmacists and other providers of medical services. But the provision of community health services was highly fragmented. This was particularly so because the levels of services provided to local inhabitants by local authorities varied greatly.

7 Against this background, Sir William Beveridge's report *'Social Insurance and Allied Services'*[3] recommended the creation of a comprehensive health service, in which the full range of medical and nursing services would be free to each citizen who needed them. These aims were accepted in the White Paper published in 1944, *'A National Health Service'*,[4] and maintained after the Coalition Government of the Second World War years was replaced by a Labour Government in 1945.

8 Under the 1946 Act, it was to be 'the duty of the Minister … to promote the establishment in England and Wales of a comprehensive Health Service designed to secure the improvement of the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness'. The services to be provided to meet these aims were to be free of charge. For the first time, the Minister of Health was made personally accountable to Parliament for hospital and other specialised services. He was indirectly responsible for family practitioner and local health services.

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[1] The hospitals run by local authorities had evolved from the workhouses provided under the Poor Laws. They tended to provide lower standards of care. Voluntary hospitals tended to concentrate on the needs of the acutely ill, rather than those with infectious diseases or the chronically ill. See Ham C., *'Health Policy in Britain',* p. 8 (4th edition, 1999), Macmillan Press Ltd

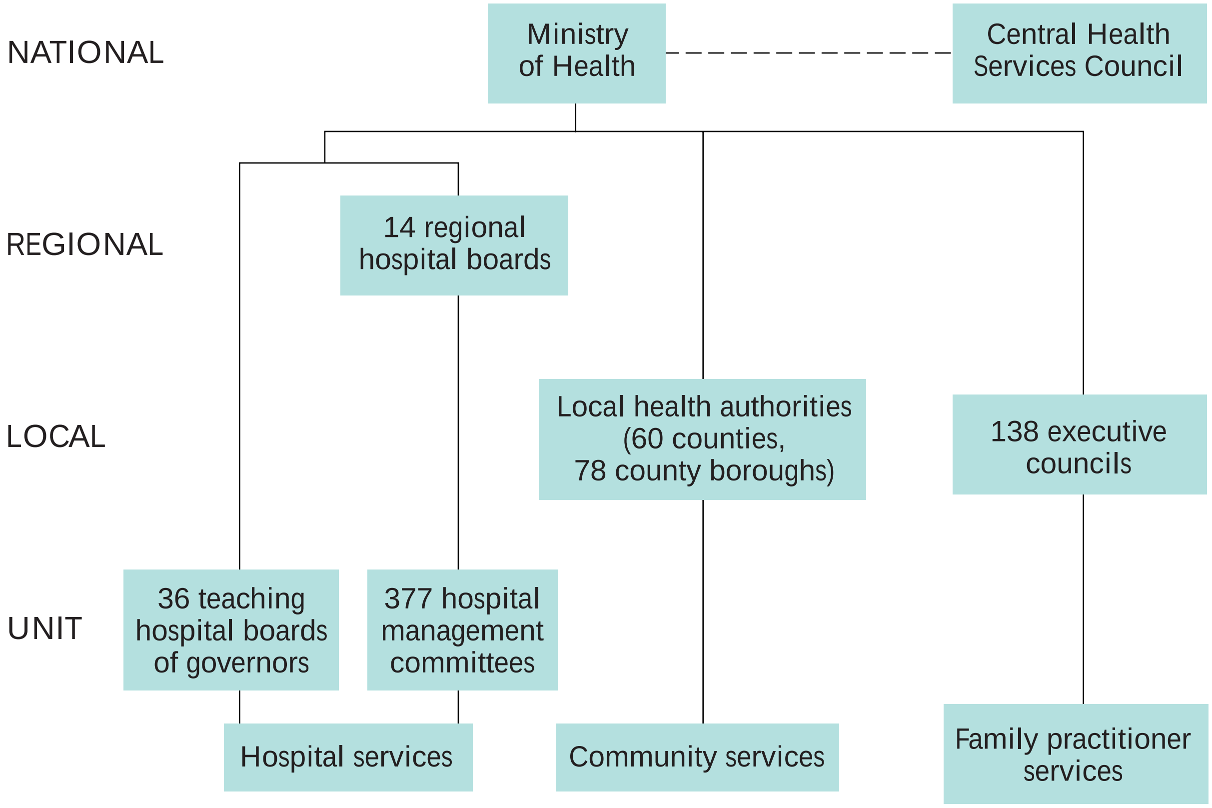
[2] See the survey of the hospital sector from the Nuffield Provincial Hospitals Trust (1946), *'The Hospital Surveys: the Domesday Book of the Hospital Services'*, OUP

[3] Beveridge, W. *'Social Insurance and Allied Services'* (1942), London: HMSO (Cmnd 6404)

[4] *'A National Health Service'* (1944), London: HMSO (Cmnd 6502)

9 The structure of the NHS from 1948–1974 may be summarised as follows:

Table 1: The National Health Service 1948–74 (England and Wales)[5]



10 Hospitals were nationalised. They were managed either by hospital management committees and regional hospital boards, or, in the case of teaching hospitals, by boards of governors responsible directly to the Minister of Health. Funding for the hospitals came from the Ministry of Health directly to the boards of governors of teaching hospitals, or to regional health boards, which in turn passed it to the hospital management committees.

11 Executive councils administered local family practitioner services: that is, general medical, dental and ophthalmic services, and pharmaceutical services. Local authorities were responsible for community health services, including health visitors and district nurses, vaccinations and immunisations, maternal and child welfare, ambulance services and services for the mentally ill and those with learning disabilities who were not in hospital.[6]

12 Negotiations with interested parties, and in particular representatives of the medical profession, ensured that general practitioners retained their status as independent contractors. They had a contract with the local executive councils, rather than being employed by either central or local government. General practitioners were allowed

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[5] Levitt R, Wall A, Appleby J. *'The Reorganised National Health Service'* (6th edition, 1999), Stanley Thornes (Publishers) Ltd. Reproduced with the permission of Nelson Thornes Ltd from *The Reorganised National Health Service 6e*, Levitt, Wall and Appleby, 1999

[6] National Health Service Act 1946, Sections 19–30

to do an unlimited amount of private work (although there was very little demand for private general practitioner services from the general public). Furthermore, salaried hospital doctors were allowed to undertake private work in hospital pay beds, in addition to their contractual duties to the NHS. A system of merit or distinction awards was introduced: hospital specialists who were judged to be meritorious by their peers were given special payments over and above their basic salaries.

13 While there were differences between various groups, there were broad areas of agreement. In particular:

> 'Implicit in the consensus about the general aims of policy was a shared, optimistic faith in progress through the application of diagnostic and curative techniques. In turn, this mirrored the belief that medical science had not only triumphed over disease and illness in the past but would continue to do so in future. On this view, the only problem was how best to create an institutional framework which would bring the benefits of medical science more efficiently and equitably to the people of Britain.'[7]

14 Thus, there was little anticipation that the experience of freely available healthcare would stimulate demand. On the contrary, it was thought that expenditure would gradually decline as the nation became healthier.

The National Health Service from 1948 to 1974

15 During the 1950s policy-makers, administrators and healthcare professionals were given an opportunity for consolidation. Many aspects of the operation of the freshly established service required detailed attention and technical rule-making. Little information was available, for instance, about many features of the institutions that were brought under the new regional boards. Partly as a result of the paucity of data, considerable local autonomy was given to the regional boards and hospital management committees. Within the limits of a fixed budget set by national government, local diversity was considerable, and national policy-making frequently proceeded by exhortation. Administrative staff were recruited by the local boards and committees; there was no national cadre of National Health Service administrators. Medical staff made up a significant proportion of the membership of these administrative bodies.

16 At the level at which doctors treated patients, or that of clinical decision-making, the autonomy of the medical professional was unchallenged. Thus: 'While central government controlled the budget, doctors controlled what happened within that budget'.[8] When, in 1974, the office of the Health Service Commissioner was

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[7] Klein, R. *'The New Politics of the National Health Service',* p. 25 (3rd edition, 1995), Longman

[8] Klein, R. *'The New Politics of the National Health Service',* p. 75 (3rd edition, 1995), Longman

established to investigate patients' complaints, its jurisdiction did not extend to investigating issues of clinical judgment. These were to be dealt with by means of the professional self-regulatory machinery (see Chapter 4), or by the courts.

17 Contrary to the early expectations of steady or reducing costs, the cost of the NHS soon became an issue, as expenditure began to outstrip estimates. Despite the commitment to a free service, charges for spectacles and dentures, for some people, were first introduced in 1951. Prescription charges were first introduced in 1952. Concern over rising costs led to the appointment of the Guillebaud Committee of Enquiry in 1953, with a remit to see how health expenditure could be contained. But it found no evidence of extravagance or inefficiency. On the contrary, although the service had inherited old buildings in poor condition, little money had been spent improving such stock during the 1950s. It was not until the 1960s that the 1962 Hospital Plan led to an expansion of the hospital sector, with proposals for the creation of large district general hospitals serving a population of 100,000–150,000.[9]

18 The Plan demonstrated a growing emphasis upon the need to plan services within the NHS, as well as a faith in the ability of such planning to achieve greater efficiency and rationality in the use of NHS resources. Such an emphasis reflected the pressures on resources exerted by the rising costs of care. The reasons for such rises were debated. They included developments in medical technology and medical pressure to keep pace with such developments; rising expectations on the part of the population; pressures for higher wages and salaries within the service; and the demographic changes caused by an ageing population.

19 The Plan also sought to build on the advantages that the creation of hospital management committees had been able to bring to the organisation and planning of local hospital services. The creation of a national health service, with national pay scales and conditions of service for hospital consultants, had helped to even out the distribution of hospital staff around the country. At the same time, however, professional gulfs between the hospital consultant and the general practitioner began to widen. One of the members of the Guillebaud Committee recorded a concern that the tripartite organisation of the NHS (see Table 1 at para 9) unduly emphasised the importance of the hospitals at the expense of the other two branches of the service. Suggestions that the divisions ought to be reduced by the creation of a more unified management structure followed.[10]

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[9] Although a programme of hospital expansion followed, not all the aims of the Plan were fulfilled, either in terms of numbers of hospitals, or their standards. In May 1970 the *'Hospital Building Maintenance: Report of the Committee, 1968 –70'* (the Woodbine Parish Report), London: HMSO, was published. It criticised hospital maintenance standards and the lack of any overall strategy in the development of health service estates

[10] See for example *'A Review of the Medical Services in Great Britain: Report of the Medical Services Review Committee'* (the Porritt Report), (1962), London: Social Assay; and *'The Administrative Structure of Medical and Related Services in England and Wales'* (published by the Minister for Health in 1968)

20 In 1967 the Joint Working Party on the Organisation of Medical Work in Hospitals issued its first report.[11] The 'Cogwheel' Report[12] saw a need for a more corporate approach to medical administration. It recommended the creation within hospitals of clinical divisions of broadly linked specialties, to ensure efficient deployment of resources and to cope with the management issues that arose within clinical fields. Divisions would be represented on a medical executive committee that would consider major medical policy and planning issues, co-ordinate hospital clinical activities and provide links to nursing and administration. It was hoped that the sharing of information produced by such links would improve the use of resources. In the same vein, hospital activity analyses would provide consultants with better data on the patterns of activity within their hospitals. The Salmon Report, in 1967, set up a new structure for nursing, when it recommended a new hospital nursing structure under the direction of a chief nursing officer.[13]

21 During the 1960s, securing co-ordination and integration between the three wings of the NHS (see Table 1 at para 9) came to be perceived as an increasing problem. Hospital authorities, local authorities and executive councils did not work together to achieve integrated solutions to problems of patient care, such as long-term care for the elderly, that spanned all three sectors. Furthermore, certain services came to be recognised as neglected or 'Cinderella' services, where low standards of care for patients were common. The care of the elderly, the mentally ill and those with learning disabilities were examples. But it proved difficult to shift priorities and spending towards these disadvantaged groups. Medical advocates of such groups, such as consultant psychiatrists and geriatricians, were less influential than doctors in the acute specialties. In general, the provision of community-based services lagged behind hospital services.

22 On 1 November 1968 the Ministries of Health and Social Security were amalgamated to form the Department of Health and Social Security (DHSS). On 1 April 1969 responsibility for the NHS for Wales was transferred from the Welsh Board of Health to the Secretary of State for Wales.

23 By the end of the 1960s a consensus was developing that the tripartite structure of the NHS, established in 1948, was a source of problems. A series of reviews[14] proposed a more integrated system of management. These discussions culminated in the passage of the National Health Service Reorganisation Act 1973 (1973 Act), which introduced changes with effect from 1 April 1974.

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[11] *'First Report of the Joint Working Party on the Organisation of Medical Work in Hospitals'* (the Cogwheel Report), (1967), London: HMSO

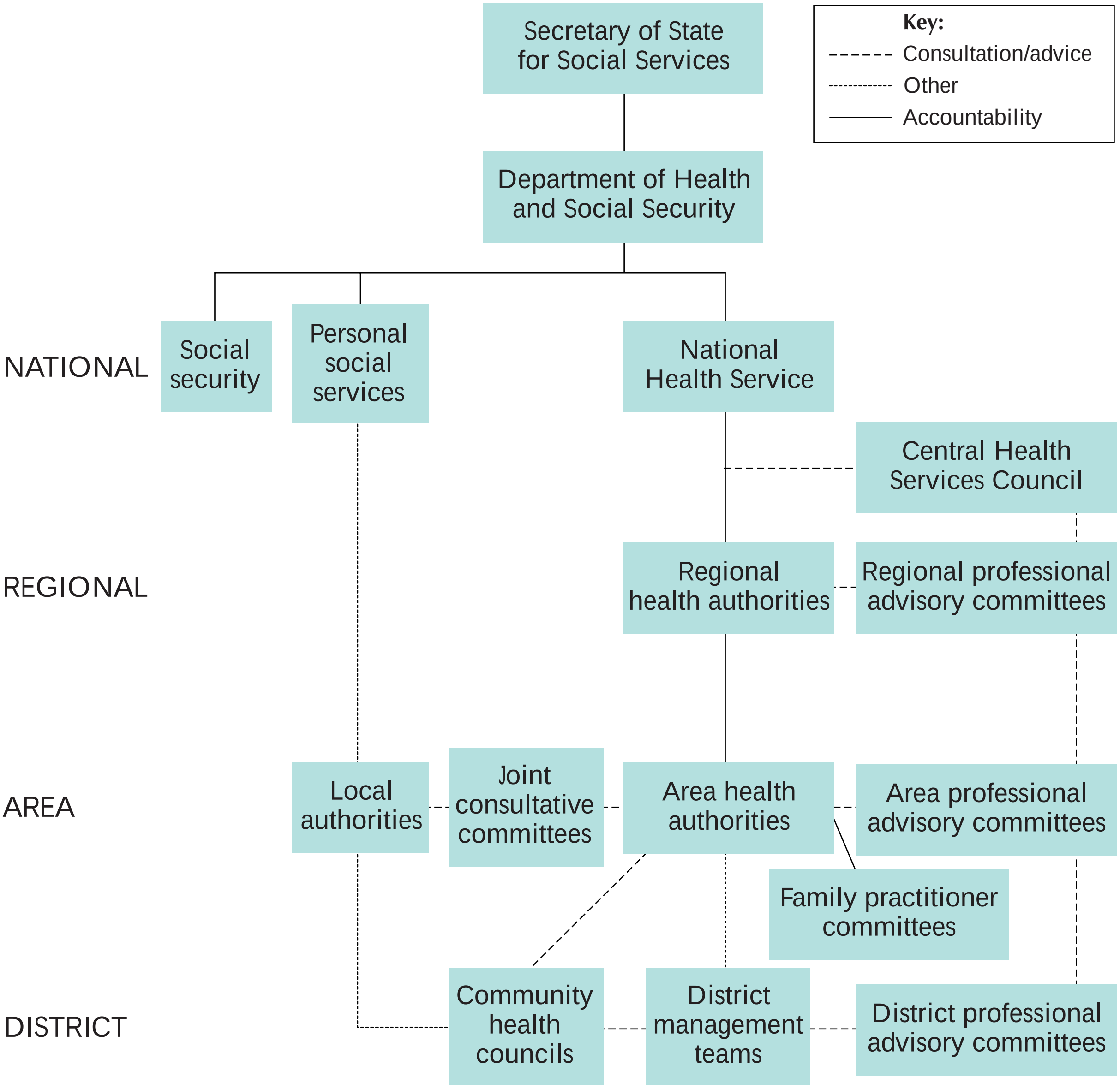
[12] The report, and its successors, received the name because of the design of wheels on the cover

[13] Ministry of Health and Scottish Home and Health Departments, *'Report of the Committee on Senior Nursing Staff Structure'* (the Salmon Report), (1966), London: HMSO

[14] The independent *'Review of the Medical Services in Great Britain'* (the Porritt Report) had suggested redesign in 1962. The Ministry of Health published a Green Paper, *'The Administrative Structure of Medical and Related Services in England and Wales'* in 1968. A further paper followed in 1970, *'The Future Structure of the National Health Service'*. In May 1971, the DHSS published a consultative document, *'The National Health Service Reorganisation',* setting out further proposals on NHS reorganisation

24 Under the 1973 Act, 14 regional health authorities (RHAs) were created in England; amongst them was the South Western RHA (SWRHA). Members of the RHAs were appointed by the Secretary of State for Social Services. They were responsible for planning local health services. Under them, 90 area health authorities (in England) were established, with a Chair appointed by the Secretary of State and non-executive members appointed by the RHA and by local authorities. An area team of officers was established, made up of an administrator, a nurse, a public health doctor and a finance officer. Areas were expected to liaise with local authorities. Most areas were further divided into health districts administered by district management teams. The structure is set out in the following table:

Table 2: The Reorganised National Health Service 1974[15]



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[15] Levitt R, Wall A, Appleby J. *'The Reorganised National Health Service'* (6th edition, 1999), Stanley Thornes (Publishers) Ltd. Reproduced with the permission of Nelson Thornes Ltd from *The Reorganised National Health Service 6e*, Levitt, Wall and Appleby, 1999

25 In Wales, area health authorities were established but no RHA was deemed necessary. Instead, the Welsh Office played the role of both central government, and a regional health authority.

26 The reorganisation aimed to unify health services by bringing under one authority all the services which had previously been administered by regional hospital boards, hospital management committees, executive councils and local health authorities (see Table 1 at para 9). However, in a departure from this principle, general practitioners remained independent contractors. The role of the executive councils was taken over by family practitioner committees (FPCs), responsible for GPs, dentists, pharmacists and opticians. A small number of postgraduate teaching hospitals retained separate boards of governors.

27 It was intended that this reorganisation would bring about better co-ordination between the health authorities and local authorities. To foster this end, the boundaries of the area health authorities were designed to match those of the local authorities providing social services. The two were also required to set up joint consultative committees to assist the process of consultation and collaboration.[16]

28 At a district level, community health councils (CHCs) were introduced to represent the views of the public.

29 In the South West, in addition to the establishment of the South Western Regional Health Authority (SWRHA), the 1973 Act gave rise to other changes. Within the SWRHA, the Avon Area Health Authority (Teaching) was created and, below it, a number of health districts. The Avon Area Health Authority (Teaching) area included some 800,000 people in Bristol, South Gloucestershire and North Somerset but excluded Bath. One of the health districts, Bristol Health District (Teaching), included the Bristol Royal Infirmary and the Bristol Royal Hospital for Sick Children, and served about 360,000 people, mostly within the Bristol area.[17]

1974–1984

30 The reorganised structure did not meet with widespread approval. It was rapidly criticised for containing too many tiers of administrative decision-making; it was said that these led to bureaucracy and delays.[18] District management teams ‘tended to clash with their AHAs on matters of strategic direction.’[19] Administrative costs rose and staff morale suffered. Industrial unrest in the NHS increased. Against this

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[16] The NHS Reorganisation Act 1973 coincided with the reorganisation of local government under the Local Government Act 1972

[17] WIT 0038 0005 Ms Charlwood

[18] The Royal Commission (see footnote 20) summed up the criticisms as (a) too many tiers; (b) too many administrators, in all disciplines; (c) failure to take quick decisions; and (d) money wasted

[19] Levitt R, Wall A, Appleby J. *‘The Reorganised National Health Service’* (6th edition, 1999), Stanley Thornes (Publishers) Ltd

background, a Royal Commission was established in 1976.[20] It was asked to consider 'the best use and management of the financial and manpower resources of the National Health Services'. When it reported in 1979, it recommended that there should be only one level of administrative authority below the level of the regional health authority.

31 In December 1979 the DHSS and Welsh Office published a consultative paper entitled *'Patients First'*.[21] This proposed a strengthening of management at a local level, with greater delegation of responsibility to hospital and community levels; and removing the area tier and establishing district health authorities to combine the functions of areas and the existing districts. The professional advisory machinery and the planning system would also be simplified, to ensure that voices were better heard within regional and other health authorities.

32 These discussions resulted in the Health Services Act 1980 (1980 Act). The 1980 Act prepared the way for disbanding the AHAs and enabled the creation of 192 new district health authorities (DHAs) in England.[22] These DHAs came into operation on 1 April 1982. In many parts of the country, the correspondence between the boundaries of health authorities' areas of responsibility, and those of the local authorities, was however lost. Within districts, an emphasis was placed upon devolving management down to smaller units of management. These might be hospital or service based; there was considerable local variation.

33 FPCs were given an independent status as employing authorities as a result of changes announced in November 1981.[23]

34 The changes made in the structure of the NHS may be seen in Table 3.

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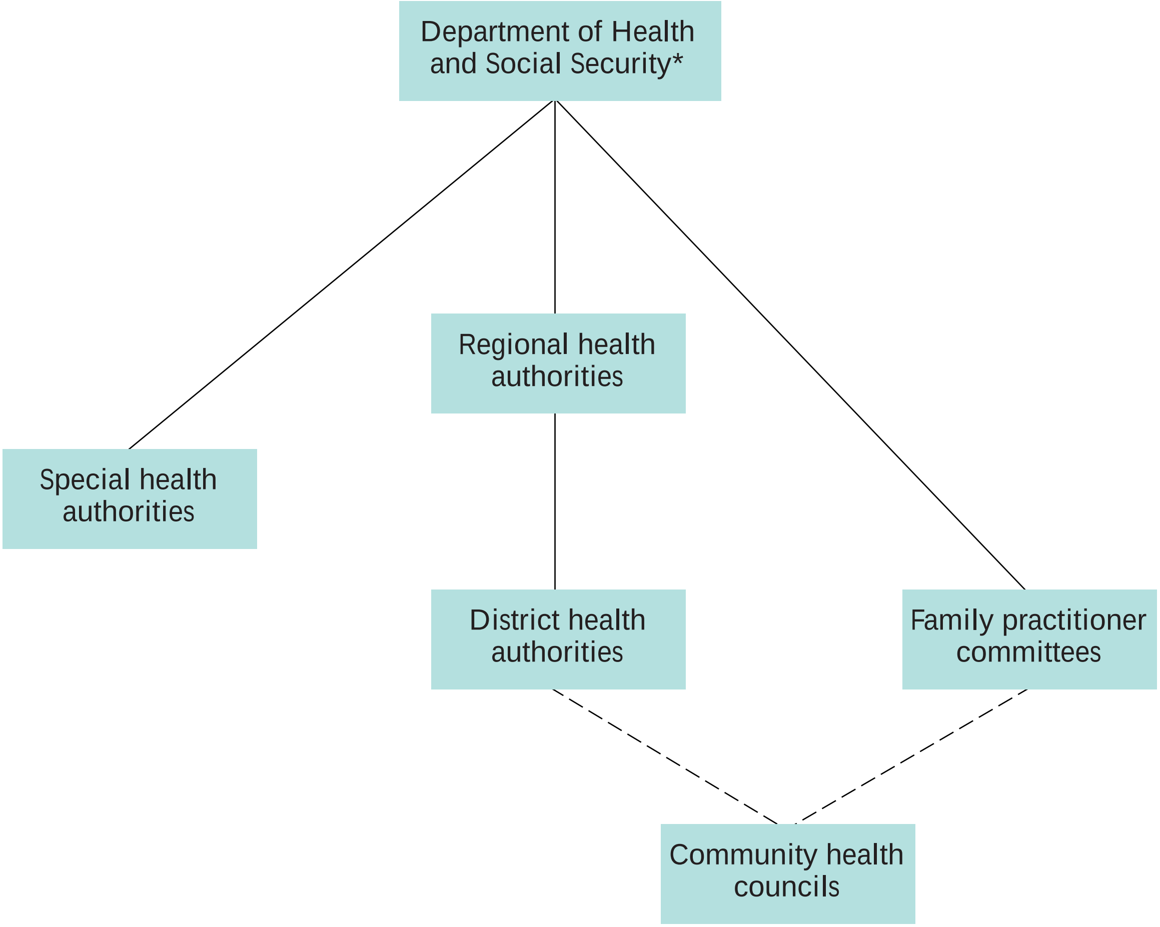
[20] Royal Commission on the National Health Service, *'Report of the Royal Commission'* (1979), London: HMSO (Cmnd 7615)

[21] DHSS and Welsh Office, *'Patients First'* (1979), London: HMSO

[22] Changes followed a review of local arrangements by the regional health authorities

[23] The changes were made in the Health and Social Security Act 1984. They were effective from 1 April 1985

Table 3: The structure of the NHS, 1982–91[24]



*The DHSS became the Department of Health in 1988.

35 The main responsibility of Special health authorities (SHAs) was to run postgraduate teaching hospitals in London.

36 Slightly different arrangements were made in Wales. In respect of Wales, *'Patients First'* noted that there was already only one tier of health authorities below the Welsh Office. These AHAs had the advantage of boundaries that were fully coterminous with county councils, but they were comparable in population and resources to the DHAs proposed for England. Stability was therefore possible. A review by areas of their district sub-structures was however proposed, with a view to eliminating formal district structures whilst remaining sensitive to the needs of local communities and to the need to delegate decision-making, so far as possible, to the level at which patient services were provided. [25]

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[24] Ham C. *'Health Policy in Britain'* (4th edition, 1999), Macmillan Limited. Illustration reproduced with the kind permission of Macmillan Limited

[25] DHSS and Welsh Office, *'Patients First'* (1979), London: HMSO

37 In the South West, the Avon Area Health Authority (Teaching) was abolished on 1 April 1982 and replaced by the Bristol & Weston District Health Authority (B&WDHA). The B&WDHA consisted of the former Bristol Health District (Teaching) and Weston Health District (which had merged in 1978). The B&WDHA formed one of 11 DHAs under the SWRHA. Others included Frenchay DHA and Southmead DHA.[26]

38 The attempts to increase delegation to the periphery and to decrease central prescription that may be seen in the 1982 reforms did not endure.[27] Rather, central scrutiny and direction intensified, as Ministers sought to wrest greater efficiency or higher outputs from the NHS. In 1982, a system of annual performance reviews was launched. Ministers held meetings with regional Chairs, to set and then monitor progress towards targets. The regional Chairs in turn held similar meetings with the districts within their constituencies, setting up a chain of review.

39 During the financial year 1981/82 area health authorities were required to make efficiency savings in order to generate funds for new developments. Subsequently, in 1984, the efficiency savings programmes were renamed 'Cost Improvement Programmes'. It was calculated that the administrative costs of the service fell, as a result of the reduction in the number of management tiers effected by the 1982 reorganisation.

40 From 1982 NHS managers carried out a series of cost-effectiveness scrutinies into issues such as transport services and residential accommodation. They were modelled on the studies carried out by the retailer Sir Derek Rayner into the Civil Service. In August 1982 a review of NHS audit arrangements was announced.

41 In September 1983 the first set of performance indicators was published. These included information about clinical services, finance, manpower and estate management. The purpose of their development was to allow health authorities to compare performance with other health authorities. The performance indicators were criticised for various reasons. Some of the criticism centred on the fact that they contained data about activity or outputs but not outcome; presentation was late; there were doubts as to their accuracy; and they were unable to measure quality.[28]

42 In September 1983 the DHAs were required to invite tenders from in-house staff and outside contractors in order to test the cost-effectiveness of their own catering, domestic and laundry services.

43 In 1983 the Griffiths Report was published.[29] It found the lack of a clearly defined general management function to be a weakness in the NHS. At each level of management, no one person was accountable for action. It recommended that all

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[26] WIT 0038 0005 Ms Charlwood

[27] Klein, R. *'The New Politics of the National Health Service',* p. 143 (3rd edition, 1995), Longman

[28] See also WIT 0038 0006 Ms Charlwood, which notes that the DoH subsequently shifted emphasis from performance indicators to health service indicators, 'which were more concerned with helping HAs to plan and monitor the delivery of services'

[29] *'The NHS Management Inquiry'* (October 1983), London: DHSS; HOME 0003 0001. See also Chapter 4

levels within the NHS should operate under the control of a single general manager or chief executive. The report sought to introduce a new management culture into the NHS and thereby give managers more prominence. Hospital doctors should be involved in this: such clinicians should accept that with clinical freedom came a management responsibility. Further, according to Klein:

> ‘One of the report’s central arguments was that the management task revolved around delivering a good product to the consumer: “Businessmen have a keen sense of how they are looking after their customers. Whether the NHS is meeting the needs of the patient and the community, and can prove that it is doing so, is open to question.” Thus Griffiths put two new questions on the NHS agenda, which became increasingly salient over the following decade. First, was the NHS producing the right kind of goods? Second, was the quality of the goods being produced adequate?’[30]

44 The report also recommended the establishment of a Health Services Supervisory Board, to determine policy and objectives, and an NHS Management Board, to perform an executive role. The regional and district Chairs were to ensure that the process of securing accountability and review extended through to unit level.

45 In June 1984 the circular *‘Implementation of the NHS Management Inquiry’*[31] authorised the adoption of these recommendations and required DHAs and units to appoint a general manager. In Bristol, Dr John Roylance was appointed District General Manager of the B&WDHA in January 1985. He was instructed to produce a management structure for the B&WDHA by 30 April 1985. B&WDHA approved this in May 1985.[32]

Main events, 1984–1996

46 The chapters that follow develop particular features of the structure that has been outlined, and deal with it in some detail from 1984 onward.

47 However, it may be helpful to identify briefly some of the main events affecting the structure of the NHS after 1984, until just after the end of 1995, so as to provide a reference point for much of the evidence later set out in this Annex.

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[30] Klein, R. *‘The New Politics of the National Health Service’,* p. 151 (3rd edition, 1995), Longman

[31] *‘Health Services Management: the Implementation of the NHS Management Inquiry*’, Circular HC 84(13), London: DHSS

[32] WIT 0038 0009 Ms Charlwood

48 The period was dominated by the development and introduction of the *'Working for Patients'* reforms announced by the Government in 1989.[33] This process of reform began when in January 1988, following extremely high levels of expressed concern about health service funding and its inadequacies in the late 1980s, the Prime Minister announced a fundamental review of the NHS. The review took place quickly. The reviewing team were members of a Cabinet Committee. They worked without the public consultation and participation that had characterised, for instance, previous Royal Commissions. This exclusion of the professional and public interest groups was one of the reasons why the changes proposed attracted unprecedented levels of denunciation when they were announced.

49 In January 1989 the work of the Committee was published in the form of the White Paper, *'Working for Patients'*.[34] It rejected models of privately funded healthcare. Instead, it proposed an 'internal market' in the NHS by separating 'purchasers' from 'providers'. Health authorities would purchase services from independent NHS trusts, after assessing local needs and developing a strategic assessment of, or plan for, those needs. They would also monitor the delivery of the services that they had agreed to commission. GPs also would be offered the option of becoming 'fundholders', able to purchase most services on behalf of their patients. Such a system of funding would, it was said, create an incentive towards the more efficient use of resources, with more attention paid to the services that patients, or 'consumers', wanted.

50 The details of the new system proposed were further developed in a series of 'Working Papers' published by the DoH. These covered topics such as fundholding, the structure and responsibilities of NHS trusts, and medical audit. The Working Paper No 6, *'Medical Audit',*[35] established as a government policy the principle that all clinicians should participate in review and audit of their practices. A professionally led Audit Advisory Committee should support medical audit at a regional level. By April 1991, each district should also have established a District Medical Advisory Committee to plan and monitor a comprehensive programme of medical audit. But such audit programmes should be medically led, by an advisory committee chaired by a senior clinician.[36]

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[33] Other developments included the split of the DHSS, in July 1988, into separate departments covering Health (DoH) and Social Security (DSS); and efficiency initiatives such as the income generation programme launched in 1988 to discover ways in which health authorities could generate additional funds by means such as placing retail outlets in hospital premises. On the former, see also Chapter 6

[34] DoH, *'Working for Patients'* (1989), London: HMSO (Cm 555)

[35] HOME 0003 0124

[36] For further details, see Chapter 18

51 The concept of NHS trusts was further explained in Working Paper No 1.[37] Each would be a self-governing trust, headed by a trust board whose chairman was appointed by the Secretary of State. The board was responsible for the management of the hospital. Specifically, it was required to submit an annual report to the Secretary of State; to ensure that revenue matched outgoings, and to achieve the financial objectives that might, from time to time, be set by the Secretary of State.[38] Ultimately, the Secretary of State remained in control, at least in so far as he was able to remove trust officers from post in specified circumstances. The trust, a provider of services, would derive its income from contracts with purchasers, notably local health authorities and general practitioner fundholders. Further, consultants' contracts would in the future be held directly by such trusts, rather than by RHAs, and there would be discretion to make local financial settlements or introduce non-standard terms of employment.

52 Although the Working Papers clarified some aspects of the changes that the Government sought to introduce, many aspects of the new system remained unclear. Further, following the passage through Parliament of the National Health Service and Community Care Act 1990 (1990 Act), the reforms were to take effect on 1 April 1991: a demanding timetable for change. Thus, as the reforms were introduced, local health authority staff, hospital managers and clinicians were required to exercise discretion in deciding how they should take effect at a local level.[39]

53 Funding for some specialised, supra regional services remained centralised. The work of the Supra Regional Services Advisory Group (SRSAG) continued. Thus, until early 1994 the purchaser-provider split did not affect the funding of paediatric cardiac surgery for the under-1s.[40]

54 In May 1989 the NHS Policy Board was created in the place of the old Health Service Supervisory Board, with the Secretary of State as the Chairman. The NHS Management Executive (the NHSME) was also created in the place of the former NHS Management Board.[41] It was chaired by the Chief Executive of the NHS. The intention was to sharpen and focus the split between responsibilities for policy, on the one hand, and

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[37] *'Self-Governing Hospitals'*; HOME 0003 0028

[38] See the NHS and Community Care Act 1990, which established the legal framework of hospital trusts, especially Section 10, and also regulations made under this Act, especially the *'NHS Trusts (Membership and Procedure) Regulations 1990',* SI 1990/2024 (amended by SI 1990/2160). These regulations set the maximum number of directors at 11. Two were to be appointed by the RHA. The Secretary of State appointed the remainder. The tenure was not to exceed four years, but reappointment was allowed. The regulations set out circumstances in which disqualification would occur (e.g. bankruptcy, sentences of imprisonment, loss of independence as a result of Trade Union office or membership of a health service body. The executive directors of the trust were to include the chief officer, the finance officer, a medical practitioner and a registered nurse or midwife. A committee composed of the chairman and non-executive directors of the trust appointed the chief officer. Once appointed, the chief officer joined that committee in order to appoint the other executive directors of the trust. Standards were generally clarified when in April 1994, the Secretary of State issued a Code of Conduct addressing issues of accountability, probity and openness: DoH '*Code of Conduct, Code of Accountability'*(1994); circulated with EL(94)40, DoH, London

[39] 'The DoH was able to issue only general guidance on the implementation of the 1990 Act; it was left to NHS managers to work out the details. This gave them even more power than they had assumed under Griffiths, but exacerbated tensions between them and their clinical colleagues despite the increased opportunities for doctors themselves to be become involved in managerial decision-making.' Levitt R, Wall A, Appleby J. *'The Reorganised National Health Service'* p. 20 (6th edition, 1999), Stanley Thornes (Publishers) Ltd. See also Ham C. *'Health Policy in Britain'* p. 42 (4th edition, 1999), Macmillan Limited

[40] This topic is dealt with in further detail at Chapter 7

[41] See also Chapter 4

management or implementation on the other. The distinction was symbolised by the move (in 1992/93) of the NHSME from London to Leeds.[42]

55 During 1990 the NHSME set up seven regional 'outposts' to assist in establishing the NHS trusts and monitoring their performance.[43] One such outpost was set up in Bristol, in a separate location from the RHA.[44]

56 The nature of the accountability and scrutiny arrangements for trusts which developed can be seen in an account of such arrangements written by the NHS Executive in 1994:

> 'Trusts will remain primarily accountable to purchasers for the delivery of care through NHS contracts. They will be held to account by the provider arm of the NHS Executive regional office for meeting their statutory financial duties … Monitoring of Trusts' financial duties and approval of annual and strategic business plans will be undertaken by the provider arm of regional offices following the approach developed by the former outposts …'[45]

57 On 1 April 1991 the 1990 Act came into effect. The 'first wave' of 57 NHS trusts and 306 GP fundholders was launched. The structure of the NHS from 1991 to 1996 is set out in the following table:

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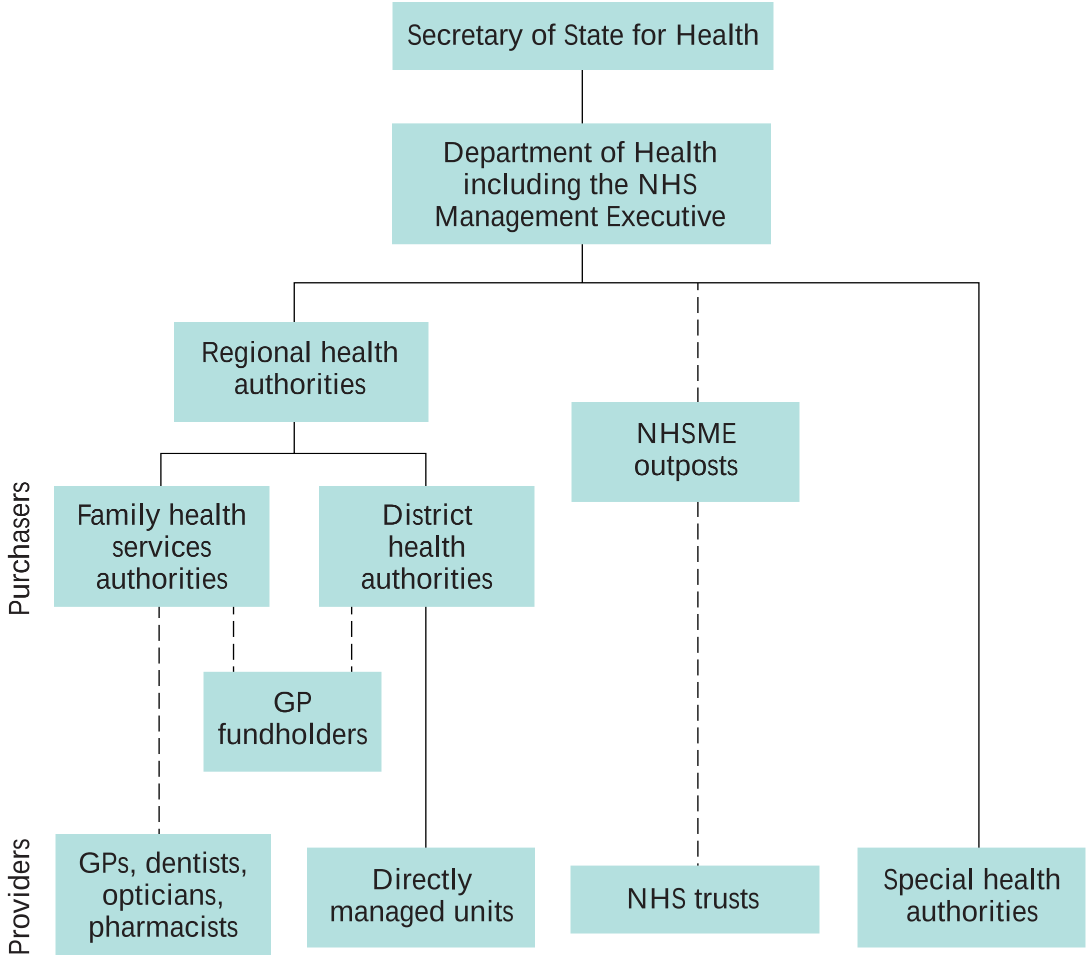
[42] See Chapter 4

[43] See Chapter 5 for further details of the functions of the regional outposts

[44] Until 1994, when it was resited within the RHA's premises

[45] *'Managing the New NHS: Functions and Responsibilities in the New NHS'* (1994), NHSE. The paragraph continued: 'There will be limited direct monitoring by regional offices of certain non-financial aspects of Trusts' performance which cannot be pursued through NHS contracts, including national policy initiatives such as Opportunity 2000 and junior doctors' hours.' See also paras 68–73 below for the structural changes proposed and implemented in 1993–1996

Table 4: The structure of the NHS in England, 1991–96[46]



58 The United Bristol Healthcare (NHS) Trust (UBHT) and Weston Area NHS Trust, which had existed in 'shadow' form from 21 December 1990, were formally established on 1 April 1991. Property rights and liabilities, including contracts of employment, were transferred to these trusts.

59 Several other local changes occurred. The B&WDHA was abolished with effect from 1 October 1991. In its place, Bristol & Weston, Frenchay and Southmead DHAs merged to form a new Bristol and District Health Authority (B&DHA), serving about 840,000 people. The B&DHA became responsible for strategic health policy and planning, and for the purchase of services from NHS trusts using service agreements.[47] In addition, it retained direct managerial responsibility for those hospitals or units that had not opted for self-governing status as at 1 April 1991.

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[46] Ham C. *'Health Policy in Britain'* (4th edition, 1999), Macmillan Limited. Illustrations reproduced with the kind permission of Macmillan Limited

[47] WIT 0038 0007 Ms Charlwood

60 The regions were also remodelled, by being given boards of executive and non-executive directors. The chairman of the board and the five non-executive members (who included a chairman of a family health service authority (FHSA) and a person connected to the local medical school) were appointed by the Secretary of State. The strategic role of the region, in setting performance criteria and ensuring that plans were being achieved, was further emphasised. They were also expected to take a lead in ensuring that the changes set out in the 1990 Act were successfully implemented.

61 DHAs were now required to place contracts with local NHS trusts for the purchase of services required by the resident population. These contracts were not legally binding;[48] they might better have been described as 'service agreements'. 'Extra-contractual' referrals catered for those patients who needed a particular treatment, operation or package of care not already provided for in a contract between their DHA, and the institution to which they were to be referred. Such additional costs had to be met by the DHAs on an individual basis.

62 Prior to placing contracts, however, the DHA was expected to assess what local health needs were, and to develop, with the assistance of its public health team, a strategy for meeting them. But:

> 'In practice, the impact and influence of the needs assessment process on the priorities and purchasing decisions of districts was limited, for a number of reasons. First, districts were under enormous time pressure to complete their annual contracting rounds. Many public health departments lagged behind because it takes time to carry out properly informed needs assessments. Second, health authorities had problems with the lack of epidemiological and medical information required to do proper needs assessments … Third, it was necessary to reconcile results of needs assessments with spending budgets to produce a set of actual purchasing priorities. Although a needs assessment may reveal a "need" for medical care and treatment, it does not (and cannot) reveal anything about whether and how one particular need should be met in preference to another.'[49]

63 The 'internal market' was slow to develop. Initially, achieving a 'steady-state' rather than risking disruption of existing services was considered to be particularly important. The health authorities' first year's contracts were therefore based upon the existing referral patterns to trusts. Further change was slow or limited, for a number of reasons. First, the information needed to compare services and their costs often did not exist. If it did, it tended to lie in the hands of the providers rather than the purchasers. Second, many services were not readily amenable to 'competition' from alternative providers. When factors such as access (or travel costs) by the local population were taken into account, many local trusts were natural monopoly providers of many services. Block contracts for services tended to be used, sometimes differing little from the global budget allocations they had replaced. Patients might then follow contracts, rather than vice versa. Thus, limited progress was made towards

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[48] Where purchaser and provider were in dispute, the region was expected to act as arbitrator

[49] Levitt R, Wall A, Appleby J. *'The Reorganised National Health Service',* p. 42 (6th edition, 1999), Stanley Thornes (Publishers) Ltd

developing an internal market, and co-operation and partnership in service development between purchasers and large local providers was a common approach.[50]

64 In October 1991 the Patient's Charter[51] was published as part of a national policy initiative to define standards of service within public services. It set out a list of rights or guarantees of service for patients, but these standards were not legally enforceable. Purchasers, however, did use them to monitor the quality of care or levels of service being provided under the contracts with their providers. For example, the guarantee that patients should wait no longer than two years for an operation was one of the waiting list indicators that was scrutinised.

65 On 1 April 1992 a second wave of NHS trusts and GP fundholders began operation.

66 The 1992 White Paper, *'The Health of the Nation'*,[52] adopted a wide public-health approach to securing a 'continuing improvement in the general health of the community'. The paper recognised that health was the product of a wide range of factors, including lifestyle and the environment; achieving good health required more, therefore, than managing a service which aimed to cure illness or disease.
All government action should be co-ordinated to assist in the aims of producing a healthy environment, healthy homes and healthy workplaces. These general aims were also more closely focused in 25 specific targets; for example, securing a reduction in the number of deaths from coronary heart disease, or in the percentage of the population that was overweight. There was, in other words, a new interest from the government in tackling the causes of disease and premature death.

67 Also in 1992 the Clinical Outcomes Group was established to promote a multi-professional approach to clinical audit. No longer would doctors, nurses and other professional groups conduct audit separately. The group placed an emphasis on linking clinical audit to other programmes such as resource or risk management, quality assurance, research, development and education.[53]

68 In April 1993, 139 new NHS trusts came into being, making a total for England of 289. By 1 April 1994, there were a total of 419 NHS trusts and 96 per cent of hospital and community health funding was spent on services provided by trusts. Further, some 9,000 GPs had become fundholders, representing over half of all eligible practices and serving approximately 36 per cent of the population.[54]

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[50] 'Whatever the preferred approach, the outcome was the same: the internal market became a *managed* market in which competition and planning went hand in hand.' Ham C. *'Health Policy in Britain'*, p. 43 (4th edition, 1999), Macmillan Limited

[51] HOME 0001 0001 – 0013

[52] DoH (1992), London: HMSO (Cm 1986)

[53] See Chapter 18 for a more detailed account of aspects of audit during this period

[54] The process had been assisted by periodic reductions in the number of patients required to be on a GP's practice list before the practice became eligible for fundholding status, and by the development of different models of fundholding

69 The implementation of the changes first outlined in 1989 provoked further examination of the structure of the NHS and whether its shape was apt to manage the reorganised system. In October 1993, in *'Managing the New NHS,'* the Government announced plans for a further restructuring exercise. Its ultimate aim was to abolish the regional health authorities and to reorganise the existing NHS Management Executive so as to create eight regional offices, each headed by a regional director, which would replace the RHAs and the existing NHSME outposts. However, new legislation would be required to abolish the RHAs. In the interim, the Secretary of State proposed that, from 1 April 1994, RHAs should be reduced in number from fourteen to eight, thus creating common boundaries with the NHSME's new regional offices. The Government commented that, as a result of the reforms:

> 'RHAs no longer have the wide-ranging planning and line management responsibilities that they had in the previous hierarchical system. In recent years they have played a key role in implementing the NHS reforms, but that role is diminishing as purchasers build up their skills and experience. Monitoring of Trusts, which will make up the vast majority of service providers by April 1994, is the responsibility of seven NHSME outposts. RHAs have already reduced in size.'[55]

70 The reforms announced also aimed to support the developing liaison between DHAs and FHSAs, in order to strengthen local purchasing arrangements. Mergers of these two bodies would not only be permitted for the first time, but encouraged by the creation of integrated DHAs/FHSAs, in the shape of new area health authorities, to enable integration of purchasing across primary and secondary care boundaries.

71 Accordingly, the boundaries of the fourteen RHAs in England were altered on 1 April 1994 to reduce their numbers to eight. The SWRHA and Wessex RHA were re-formed into the South & West RHA (S&WRHA). On the same date, NHS Executive regional offices were established, sharing common boundaries with the remaining regional health authorities.

72 The Health Authorities Act 1995 (1995 Act) gave the necessary statutory authority to the abolition of the RHAs and to mergers of DHAs and FHSAs. B&DHA and Avon FHSA anticipated these developments by making arrangements to meet jointly, under the name of the Avon Health Commission, in order to conduct business. Formal meetings of the two authorities ratified the Commission's decisions immediately afterwards.[56]

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[55] *'Managing the New NHS: a Consultation Document',* NHSME, 1 November 1993, para 2.3

[56] WIT 0038 0007 Ms Charlwood

73 When on 1 April 1996 the 1995 Act came into force, the S&WRHA, the B&DHA and the Avon FHSA were abolished. The South and West Regional Office of the NHS Executive inherited most of the functions and responsibilities of the former SWRHA.[57] The Avon Health Authority (Avon HA) was established, serving a population of some 982,000 in the areas of the new unitary local authorities of Bath & North and East Somerset, City of Bristol, North Somerset and South Gloucestershire.[58] The Avon HA continued the tasks of planning, and purchasing or commissioning, services that had been the function of the B&DHA since 1991, but with additional responsibility for people residing in the Bath area.

Conclusion

74 The paragraphs above have given the briefest sketch of the changes that were implemented in the NHS from its inception, and then from 1984 to 1996. The account has not sought to summarise the many and varied views, or research performed, upon the nature and effect of the far-reaching changes introduced in the middle of the period of the Inquiry's Terms of Reference. It is hoped that a short introduction to these changes may assist by reminding readers of the backdrop to the more detailed account of events in Bristol, to which the following chapters now turn.

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[57] WIT 0038 0008 Ms Charlwood. See also *'Managing the New NHS: a Consultation Document'* (NHSME, 1 November 1993), and *'Managing the New NHS: Functions and Responsibilities in the New NHS'* (NHMSE, 1994). These documents noted that the regional offices would take over the functions of the RHAs; would develop the purchasing function in the NHS; and would take over the monitoring of NHS trusts from the NHSME outposts. They would not be involved in detailed operational management and would be smaller than the old regional health authorities

[58] WIT 0038 0008 Ms Charlwood

Chapter 3 – Developments in the UK, in the Diagnosis and Treatment of Congenital Heart Abnormalities in Children, 1984–1995

This chapter was written for the Inquiry by Dr Eric D Silove , MD, FRCP, FRCP(E), FRCPCH, consultant paediatric cardiologist, Birmingham Children's Hospital.

The illustrations used in this chapter have been reproduced with the kind permission of Heartline.

Introduction

1 This is a concise account of the history of the development of diagnosis and treatment of congenital heart disease[1] in children in the United Kingdom, with special reference to the period 1984 to 1995. It is written for the lay person.[2] It presents:

- a concise history of the development of cardiac surgical services for children with congenital heart disease in the United Kingdom, with special reference to the period 1984 to 1995;
- a description of methods of diagnosis and strategies of management in general terms;
- the differences between the normal heart and hearts with congenital abnormalities;
- a discussion of specific heart abnormalities in terms of the problems that they present, the symptoms they cause, the methods by which they are diagnosed and the strategies of their management; and
- in general terms, the consequences of not operating compared with the benefits and risks of operations for specific abnormalities.

2 In any medical service, there is no precise point at which a new development takes place. It is an evolutionary process, determined by numerous factors which may occur separately or together. These include human technical skills, technological advances, new drugs and new strategies. There are also intangible factors such as new ideas, the courage to pursue them, research, organisation of multidisciplinary teams, and the application to the service in question of techniques and skills used in other disciplines. The many related ethical issues demand constant review.

3 Until the latter part of the 1950s very little surgical treatment was available to children with congenital heart abnormalities anywhere in the world. In 1954, W Lillehei, an American cardiac surgeon at the University of Minnesota, first used a machine to take

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[1] The terms 'congenital heart abnormality' and 'congenital heart disease' are usually interchangeable

[2] This chapter does not include the range of detailed references which would be found in an academic article. The reader requiring further detail should consult Kirklin JW, Barratt-Boyes BG. *'Cardiac Surgery: Morphology, Diagnostic, Natural History, Techniques, Results and Indications'* (2nd edition, 1993), Edinburgh and New York: Churchill Livingstone

over the work of the heart while he stopped it and opened it in order to repair an abnormality. This was soon emulated in a number of centres around the world. In 1958 the first open-heart operation on a child in the United Kingdom was performed using the heart-lung bypass machine. During the early 1960s surgery was performed on increasing numbers of children in the UK, in an increasing number of centres. There were few publications of surgical results and little was known of the expectations of survival. Operations continued to be undertaken because there was the wide recognition that without such attempts, children with the more serious congenital heart abnormalities had very little chance of surviving into adulthood. During the latter part of the 1960s and early 1970s there was an explosion of reports of surgical results and by the early 1970s paediatric cardiac surgery had been established in around half of the major regions in the UK. Patients with more complicated abnormalities tended to be referred to two or three centres with the greatest experience.

4 In the late 1970s there was increasing recognition of the need to concentrate paediatric cardiac surgery in a limited number of 'supra regional' centres, especially in the case of infants under the age of 1 year. In 1983 the Department of Health established a mechanism, the Supra Regional Services Advisory Group (SRSAG), for funding a small number of highly specialised services. In 1984 the services funded in this way were expanded to include paediatric cardiac surgery, and nine centres were funded to provide this service.[3]

The perspective of children with congenital heart disease

5 The birth of a baby with congenital heart disease (CHD) can be devastating news for the parents. A congenital heart abnormality occurs in six to eight of every 1,000 livebirths.[4] In other words, every year in the UK, around 3,500 babies are born with congenital heart abnormalities. Approximately 50% of these babies have a relatively mild abnormality which may cause no problems for the child at any stage in life and may even 'cure' itself spontaneously. In some, it may require a surgical procedure later in life which can be curative. At the other extreme, some babies will die within hours or days if they do not have emergency medical and surgical treatment. Overall, about 50% of babies born with congenital heart disease will not survive into adult life without surgery. Thus, a heart abnormality can have far more serious consequences than most other physical problems that may be present at birth.

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[3] See Chapter 7

[4] Dickinson DF, Arnold R, Wilkinson JL. 'Congenital Heart Disease among 160,480 Liveborn Children in Liverpool 1960 to 1969. Implications for Surgical Treatment'. '*British Heart Journal*' July 1981; 46(1): 55–62

6 Children who are born with heart disease need and receive care from many different nurses and doctors at any one time and over the years.

7 Cardiologists and surgeons have a significant role in the care of children who have congenital heart disease. Many other clinicians and healthcare workers are also likely to be involved in a hospital care episode, not least nurses, anaesthetists, perfusionists (technicians who run the heart-lung bypass machine), pharmacists and physiotherapists. If the child dies, a pathologist is also likely to be directly involved.

8 For a few children, a heart problem can be diagnosed, treated, and indeed cured, in one episode of care in hospital.

9 For many children, the care process is complicated and protracted: it may involve an initial diagnosis followed by a series of surgical procedures and other treatment over a period of years. An operation in early infancy may only be an initial operation in a plan of treatment.

10 Children with heart abnormalities who need heart surgery may have either ‘closed-’ or ‘open-’ heart surgery. A ‘closed’ operation means that the heart or major arteries are operated on whilst the heart is still beating. An ‘open-’ heart operation means that the heart is stopped whilst the surgery takes place, and the blood flow to the child’s vital organs is supported by a heart-lung bypass machine.

11 There is a wide spectrum of heart abnormalities. Even though diagnostic labels are given to individual children, no two children’s hearts are identical. Thus the best operative management is not always clear, and normally the relevant clinicians would come together to discuss and agree a plan of treatment for each child. There may be several options both for the type of surgery and for its timing.

Diagnosis and initial assessment

12 A serious congenital heart abnormality will usually be recognised or suspected within a few days after birth, often while the baby is still in the newborn unit of the hospital. In that case the paediatrician will ordinarily make early contact with a paediatric cardiologist.

13 In some babies there may be no obvious symptoms and signs for several days or weeks. In those cases, the parents, the midwife, health visitor or general practitioner will be involved in recognising a problem. Referral to a paediatrician usually follows. If a heart abnormality is judged to be likely, the paediatrician will also decide how urgently a paediatric cardiologist should be consulted.

14 The paediatric cardiologist is responsible for the initial assessment and diagnosis of a congenital heart abnormality. When necessary, he initiates emergency medical treatment and at an early stage involves a surgeon in planning the timing and strategy of management. Perhaps the cardiologist's most important function is the identification and diagnosis of heart abnormalities and heart disease. The decision to proceed with cardiac surgery is a decision made between the family, the cardiologist and the cardiac surgeon, and of course the patient, to the level of his understanding.

15 If it is thought that surgery may be required, the cardiologist is expected to provide a clear picture of the cardiac abnormality. In order to make a diagnosis, the paediatric cardiologist will use various technologies which have advanced significantly during the past 20 years. They are principally: (1) the use of ultrasound scanning which is non-invasive (known as echocardiography), and (2) cardiac catheterisation which is invasive and consequently involves some risk to the patient.[5]

Echocardiography

16 Echocardiography is the name given to the use of ultrasound scanning to produce images of the heart. During the late 1970s and early 1980s echocardiography became widely used to define congenital heart abnormalities and by 1982–1984 some definitive articles and textbooks had been written on the subject. By 1984 most paediatric cardiologists in the UK were using echocardiography in order to provide a reasonably accurate initial diagnosis. This was true as regards most of the abnormalities that have been of particular concern to the Inquiry: Atrial Septal Defect (ASD), Ventricular Septal Defect (VSD), Atrio-Ventricular Septal Defect (AVSD), Tetralogy of Fallot,[6] Transposition of the Great Arteries (TGA), hearts with one effective ventricle and Truncus Arteriosus. Others, such as Coarctation of the Aorta and Total Anomalous Pulmonary Venous Drainage (TAPVD), could be diagnosed by the use of echocardiography, but less easily. It was expected that in some cases there would be uncertainty about the diagnosis and the finer details. In such cases, it was then necessary to supplement the echocardiographic diagnosis by using the techniques of cardiac catheterisation.

Doppler echocardiography

17 During the mid-1980s, an ultrasound 'Doppler' technique became available which enabled cardiologists to measure the velocity of blood flow within blood vessels. From these measurements it became possible to calculate pressures in certain chambers of the heart which previously could only be derived from direct measurements using cardiac catheterisation (see para 20).

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[5] Ultrasound scanning is a procedure in which some jelly is placed on the chest and a small pencil-like probe is held lightly on the skin. A cardiac catheterisation is invasive in the sense that the skin is punctured with a needle which is then guided into a blood vessel. A thin tube (or catheter) is then guided by various manoeuvres into the blood vessel and is advanced along the larger blood vessels into the heart

[6] Also referred to as 'Fallot's Tetralogy'

Colour-flow mapping of Doppler echocardiography

18 Towards the end of the 1980s and during the early 1990s, colour mapping of the ultrasound Doppler signals created the facility to observe the nature of blood flow in the heart and major blood vessels and enabled clearer demonstration of abnormal holes and valves as well as abnormal connections of blood vessels. By around 1992 these techniques had become sufficiently well developed for virtually all paediatric cardiologists to be able to rely on them. Many of the patients who in earlier years would have been subjected to cardiac catheterisation could now have their condition diagnosed by these modern ultrasound techniques. Echocardiography, with all of its developments, is also an ideal method for assessing the post-operative state of the heart, both in the operating theatre and later in the intensive care unit (ICU), the wards and the outpatient department.

Transoesophageal echocardiography

19 In the early 1990s, ultrasound probes were designed which could be passed from the mouth into the oesophagus (food-pipe or gullet) which runs through the chest, just behind the heart. This has enabled cardiologists to obtain very clear pictures of those structures of the heart that are reasonably close to the oesophagus. The technique has also become very useful for looking at the structures of the heart during surgery without interfering with the surgeon's operating field.

Cardiac catheterisation

20 This invasive investigation has always been the 'gold standard' for diagnosing congenital heart abnormalities. It involves inserting a long, fine tube (catheter) into either the vein or artery (or both), usually at the top of the leg (femoral vein and artery), usually through a needle puncture, and then guiding the catheter into the heart. Pressures are measured within the different chambers of the heart and the blood vessels leading into and out of the heart. Blood samples are taken to measure their oxygen content. In order to obtain pictures of the structure of the heart and its abnormalities, an imaging technique called 'angiocardiography' came into widespread use around the 1950s. X-ray contrast material or dye is injected into specified chambers of the heart through the catheter and its passage through the chambers and the blood vessels is recorded on X-ray film or by video techniques.

21 The overall risk to the patient of cardiac catheterisation has been low throughout the 1980s and onwards, the mortality being around 1%. However, the risk to the small infant is significantly greater for several reasons. Any procedure in an infant who is already sick and in heart failure adds to the risk. A general anaesthetic is usually given. The blood vessels and heart are small structures and there is a risk of damaging them during the procedure. It is preferable to avoid doing a cardiac catheterisation if sufficient information can be obtained by non-invasive methods. However, it must always be remembered that a cardiac surgeon requires as complete a diagnostic picture as is possible before embarking on an operation.

Management strategies

22 All members of the cardiac team, including paediatric cardiologists, cardiac surgeons, anaesthetists, intensivists (doctors who specialise in intensive care), nurses and perfusion technicians, must work closely together in caring for each patient. There is an important reliance on the cardiologist for an accurate clinical assessment and detailed diagnosis of the abnormalities. Common practice during the period 1984–1995 was that discussions between cardiologists and surgeons took place on a formal basis at least once a week in conferences concerning groups of patients, and more frequently on an informal basis concerning individual patients. The decision concerning an operation depended upon open discussions and teamwork, especially when existing techniques were modified or when new methods were introduced. As indicated above, the decision to proceed with cardiac surgery was a decision made between the family, the cardiologist, the cardiac surgeon and of course the patient where able.

23 Emergency management of a baby with a cardiac abnormality is primarily undertaken by the paediatric cardiologist. There is usually a telephone discussion between the paediatric cardiologist and the referring paediatrician in order that appropriate initial treatment can be instituted both before and during the transfer to the cardiac unit. Depending on the condition of the baby, the cardiologist might also discuss the case with an intensivist or anaesthetist and arrangements might be made for admission to the ICU. The cardiologist and the intensivist together will then administer appropriate drugs to support the baby’s heart, lungs and other organs while further investigations and discussions are undertaken. Throughout this period, support from nursing staff will be given together with the necessary counselling. All aspects of the baby’s care and their impact on all members of the family will be considered.

24 From the 1980s onwards, the trends towards the use of newer technologies and towards earlier surgery for certain cardiac abnormalities created increased demands on paediatric cardiologists. These demands include diagnostic accuracy, intra-operative support by means of echocardiography in theatre, and also the diagnostic assessment of the post-operative result.

25 At the appropriate time, the surgeon will undertake either an ‘open’ or a ‘closed’ operation. Closed-heart surgery is mostly concerned with operating on structures close to the heart, without the need to stop the heart from beating and open the heart itself. Examples include: creating connections between blood vessels in order to promote an increased flow of blood to the lungs (shunt operations); relieving or removing narrowed areas of blood vessels (e.g. repair of Coarctation of the Aorta); creating a narrowing of the main artery to the lungs in order to reduce the blood flow (pulmonary artery banding); and tying off abnormal blood vessels (e.g. ligation of a Patent Arterial Duct). Open-heart surgery usually involves opening the heart. It thus requires the heart to be stopped after blood flow has been diverted from the heart and lungs though a heart-lung bypass machine which, as the name suggests, takes over the role of the heart and lungs in providing oxygen to, and removing carbon dioxide from, the blood. The particular advantages to the surgeon are that there is a clear field of vision, and that the necessary valuable time is available for the repair in question to be undertaken.

26 Surgical techniques constantly evolved during the 1980s and 1990s. Important new operations were more widely undertaken in the UK including, for example, the Arterial Switch and the Fontan procedure. There were trends towards earlier surgery for specific lesions (e.g. Truncus Arteriosus and CAVSD) and towards primary correction rather than interim procedures (e.g. for VSD). Many of these trends were made possible by improvements in equipment and technology. Some of the more important of these were improvements in the cannulae[7] used for heart-lung bypass and in improved design of the heart-lung bypass machine used to support children who had open-heart surgery. There were also significant improvements in control and correction of clotting defects resulting in the shorter duration of operation and less bleeding post-operatively. In addition, there were improvements in illumination (surgical headlights) and magnification (surgical glasses).

27 It is not only the surgeon who performs interventions on the cardiovascular structures. It was during the mid-1960s that cardiologists first created a hole in the wall between the two upper chambers of the heart (the atriums) in babies with TGA. From about 1982 cardiologists began to undertake more interventions by means of cardiac catheterisation within the heart using newer technology. This meant that some operations which involved opening the chest, and which previously would have been done by a surgeon, were no longer necessary. Examples include: the stretching of narrow valves by means of an inflated balloon at the tip of the catheter; inserting devices into the heart or blood vessels in order to close holes or block off blood vessels; and inserting devices (known as ‘stents’) into the heart or blood vessels in order to open up narrowed areas.

28 A child who undergoes a surgical procedure, or a diagnostic procedure such as cardiac catheterisation, requires an anaesthetic. Anaesthetists have expertise in the various techniques and treatments needed to maintain patients in a state whereby the necessary surgical procedures can be carried out in a safe manner. They are responsible for determining whether a patient is in a condition to be safely anaesthetised and undergo an operation. They are important members of the team during cardiac operations, especially during open-heart procedures. Together with the perfusionists they monitor the condition of the patient and advise on the use of drugs to maintain the stability of the patient. They maintain observation of the monitors that are attached to the patient, recording the electrocardiogram (electrical heart tracing), blood pressure in different parts of the body, blood oxygen values, inhaled and exhaled gases and other measurements.

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[7] For the purpose of cardiopulmonary bypass, a cannula is a plastic or metal tube connected to tubing that leads to the heart-lung bypass machine. It is inserted into the aorta, or the right atrium, or the great veins. Blood is pumped through the tubing and the cannula into the aorta, and is drained from the right atrium or great veins through a cannula and tubing back to the heart-lung bypass machine

Post-operative care

29 There have been significant changes in intensive care, most notably an improved understanding of cardiovascular physiology in neonates and infants, which has contributed to the significant improvement in mortality rates amongst these babies. In the early years covered by the Inquiry it would have been the practice in the majority of units for surgeons to take primary responsibility for post-operative care while anaesthetists were chiefly involved in managing the child's ventilatory support. From the early 1990s onwards, some centres started to involve anaesthetists more fully in the management of the care of children in intensive care, with anaesthetists taking on clinical sessions dedicated to the ICU. In some units this had, by 1995, evolved to the point where a full-time intensivist (usually an anaesthetist) had been appointed to the ICU.

30 From the early days of cardiac surgery it has normally been the practice for all members of the multidisciplinary team to be fully involved in the management of the child in the ICU, all providing their particular skills. During the early 1980s these arrangements tended to become more formalised in most of the major centres. Commonly at least one ward round would occur every day, attended by the cardiac surgeon, cardiologist and anaesthetist or intensivist, and often by other members of the multidisciplinary team. Decisions were made as a result of discussion on those ward rounds. Examples of such decisions include the need for the cardiologist to perform an echocardiogram, for the surgeon to insert a chest drain, for the anaesthetist or intensivist to change the ventilator settings or for changes to be made in intravenous therapy.

The cardiac nurse

31 The role of the cardiac nurse deserves special mention. Nursing is obviously an activity involved in all aspects of care. Apart from routine observations and administration of various treatments, the nurse has an important role in providing appropriate explanations to the child, where possible, and to the family, and in preparing them for the anticipated hospital admission, investigation or operation, and for their expectations on the ICU. In particular, the nurse needs to make an interpretation of observations which is appropriate for the age of the child and to take appropriate action in response to changes in observations. There needs to be an appreciation of when the child is in pain and how that should be managed. Communication with parents and giving them care, support and counselling are essential. In those sad cases when a child dies, the nurse is usually the first professional to be involved in supporting the parents in their bereavement.

Long-term post-operative management

32 After discharge from hospital, the results of the operation continue to need careful assessment for many years. This is generally undertaken by the paediatric cardiologist, often sharing the care with the consultant paediatrician in the referring hospital. Non-invasive investigations are undertaken in order to assist with the longer-term assessment. From time to time, the cardiologist ordinarily discusses the development of any problems in an individual case with the cardiac surgeon. It is often necessary to plan further hospital admissions at certain designated times for investigations that cannot be undertaken in the outpatient department. Many patients need follow-up into adult life, and for that purpose there has been a trend during the latter part of the 1990s for some cardiologists to specialise in the management of adults with congenital heart disease.

An outline of some of the types of congenital heart disease

33 In order to understand the process by which paediatric cardiac surgical services developed in the UK over the past two decades, it is helpful to explain and review the development of many of the operations that were highlighted during the Inquiry. This, in turn, requires a brief account of the structure and function of the normal heart and circulation so that congenital heart abnormalities and their treatment can be better appreciated. An excellent account of the abnormalities is given in the booklet '*Heart Children'* published by a parents' group, the Heart Line Association.[8] The Association has most helpfully given the Inquiry permission to use the illustrations from the booklet which are reproduced below.

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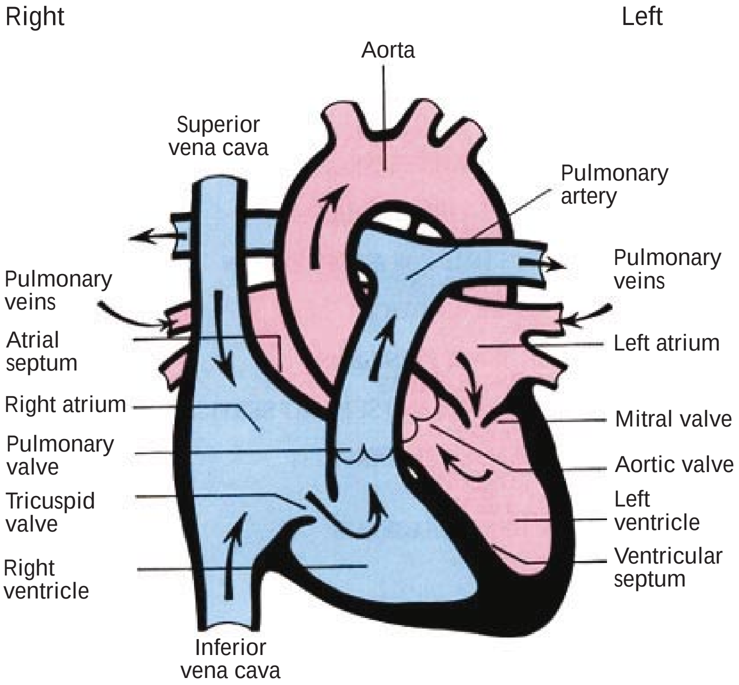
[8] *'Heart Children: A Practical Handbook for Parents of Children with Congenital Heart Problems'* (1992), Heart Line Association. Available from the Heart Line Association, Rossmore House, 26 Park Street, Camberley GU15 3PL

The normal heart

Figure 1: Normal circulation



The overall size of the heart in a newborn baby, weighing 3kg, is roughly the size of a walnut (4 x 2 x 3cm). In this diagram the individual chambers and blood vessels are not shown correctly to scale.

34 Figure 1 and subsequent diagrams show the heart as viewed from the front of the patient, so that all the structures that are on the right side of the patient are on the reader's left, and vice versa. In the normal heart, the left ventricle pumps blood, rich in oxygen, into the aorta which then gives branches known as arteries to all of the body. The oxygen is taken up by the muscles and organs of the body, and the blood with reduced oxygen then flows back to the heart in the veins which lead to two larger veins, the superior and inferior vena cava, and then into a chamber of the heart, the right atrium. The blood then flows into the right ventricle, which pumps it into the pulmonary artery, and into the small blood vessels in the lungs. As the blood passes through the lungs it absorbs oxygen and then returns to the left atrium of the heart. It then flows into the left ventricle which again pumps the oxygenated blood through the aorta to the body. Within the heart are valves which ensure that blood normally flows from atriums to ventricles, and from left ventricle to aorta, and from right ventricle to pulmonary artery, and does not flow backwards into the chamber from which it had originated or had been pumped. In all the diagrams, it is convenient to show the blood rich in oxygen as pink, and the blood from which oxygen has been extracted as blue.

The heart with a congenital abnormality

35 There are two principal consequences ((a) and (b)) of being born with a heart abnormality. These are set out below. It is essential to understand them as background to the descriptions of the specific abnormalities which follow.

(a) The abnormality may cause one of the pumping chambers (ventricles) to fail to work properly. In general terms this is known as 'heart failure'. A patient may be in heart failure for days, months or years depending on how severely the ventricle's function is compromised. Congenital heart abnormalities may cause heart failure for a number of possible reasons:

- There may be too much blood flowing through the ventricle, causing it to be 'volume loaded'.
- There may be too little blood flowing through the ventricle, causing it to be too small to function normally.
- The ventricle may be required to pump blood against a higher resistance than normal (such as through a narrow valve) causing it to be stretched and put under strain.

(b) The blood which returns in the main veins from the body to the heart and which should flow to the lungs in order to be re-oxygenated, may be diverted and be pumped to the body again without additional oxygen. This causes the skin of the baby or child to have a blue appearance, known as 'cyanosis'. More important, all of the organs then receive less oxygen than normal. If the lack of oxygenation is mild, the baby or child will not be seriously affected, apart from tiring more easily than normal children, and being at risk of other complications, especially in the presence of a serious infection. If the lack of oxygenation is more profound, the function of the other organs may also be affected and this can be most serious for the brain, liver or kidneys.

Generally a child will have one or other of these types of abnormality, but there are some rare conditions where a child may have both types.

The specific heart abnormalities and procedures referred to in the Inquiry

Introductory comments

36 The heart abnormalities discussed in the following text include most of those that have been of special interest to the Inquiry. They help to illustrate trends in the development of cardiac services and approaches to management of children with abnormal hearts. Each abnormality is discussed in relation to the structural problem, its effect on the function of the heart and the overall effect on the patient. Methods of diagnosis and their development are also described. The surgical approach and any changes over the period 1984 to 1995 are touched on briefly. Important trends are identified in relation to some of the abnormalities and surgical procedures. The text does not address in any detail the mortality rates, the longer-term effects of some of the operations, or other risks. Comprehensive information on mortality rates in the UK between 1984 and 1995, including an evaluation of the strengths and weaknesses of the data sources on which they are based, can be found in a paper by Dr David Spiegelhalter et al, commissioned for this Inquiry.[9]

37 In general terms, post-operative complications may occur after any operation but are more likely after the more complex procedures. Complications may involve the heart itself or may affect other organs. The more common serious cardiac complications include heart failure; damage to the blood vessels that actually supply the heart muscle with blood (the coronary arteries); disturbance of the heart rhythm such as ‘heart block’ when the heart beats very slowly or alternatively when it has episodes of beating very fast or irregularly. Organs that may be seriously affected include the brain, kidneys, liver and gut. Some of the complications which affect other organs may be more serious than complications affecting the heart itself.

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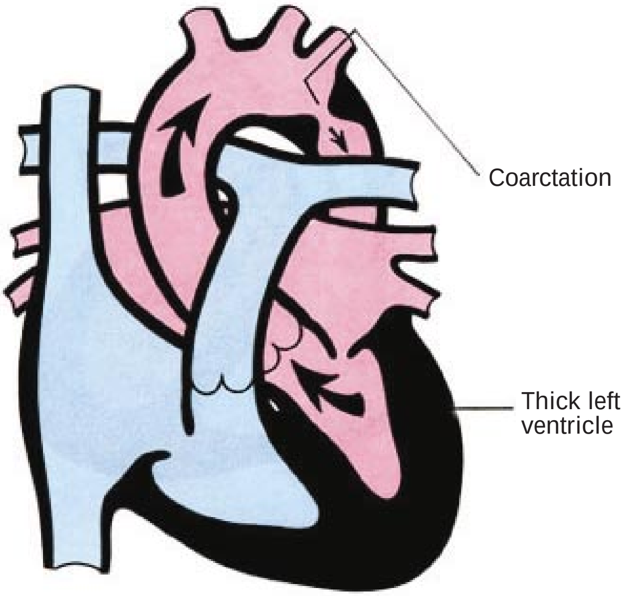
[9] Spiegelhalter D, et al. *‘Overview of Statistical Evidence Presented to the Bristol Royal Infirmary Inquiry Concerning the Nature and Outcomes of Paediatric Cardiac Surgical Services at Bristol Relative to other Specialist Centres from 1984 to 1995’*. See Annex B

Coarctation of the Aorta

Figure 2: Coarctation of the Aorta



The problem

38 There is a narrowing of the aorta, usually just below the first main branches of the aorta to the head and arms. Coarctation of the Aorta usually occurs on its own, with no other associated abnormality. Commonly it is recognised in a baby between the ages of around 1 to 4 weeks. The narrowing causes the left ventricle to work much harder than normal in order to pump blood to the lower part of the body. Consequently the left ventricle may fail to pump blood adequately (heart failure). If the narrowing is less severe, the baby may not show signs of heart failure, but over a period of months or occasionally years, will usually develop a high blood pressure in the upper part of the body. This can have all of the serious complications commonly found in older people with high blood pressure. These complications include stroke, coronary artery disease, heart failure and kidney failure.

Diagnosis

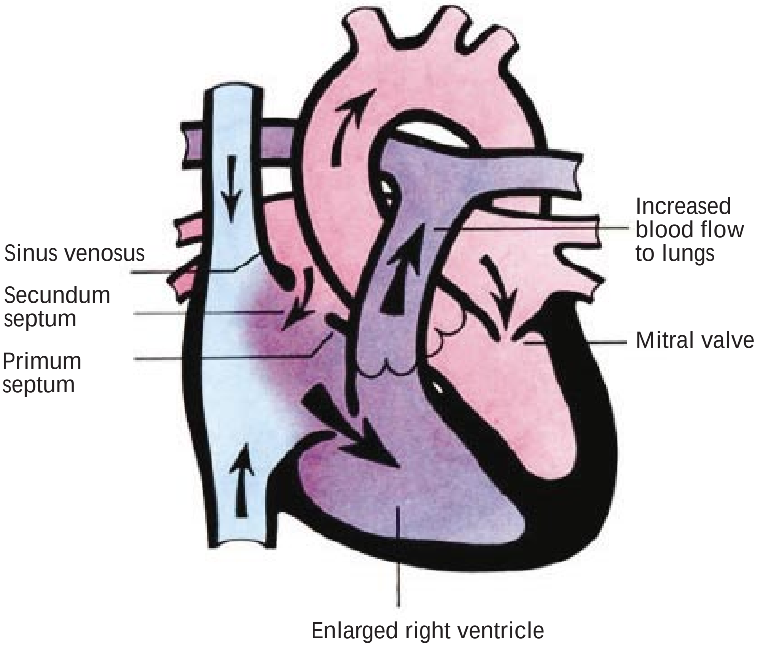
39 The baby becomes very breathless and unwell. Coarctation is usually suspected when the cardiologist cannot feel the pulses in the legs. The diagnosis is confirmed by echocardiography. Occasionally it is necessary to proceed to cardiac catheterisation in order to be certain of the diagnosis.

Management

40 In the newborn baby who is in heart failure, an operation is undertaken as an emergency in order to relieve the narrowing of the aorta. It is almost always a closed operation but in some cases it may be necessary to use heart-lung bypass. The expected survival rate after surgery during the 1980s was reasonably good. It has improved during the 1990s, largely due to better facilities for accurate diagnosis, newer techniques and, particularly, improvements in post-operative care. It was less good during the 1970s, largely because post-operative intensive care was less sophisticated. Occasionally, coarctation can occur in association with several other common congenital heart abnormalities and when it does, the risks are compounded over and above the expected sum of the risks for coarctation and the other abnormality.

Atrial Septal Defect (ASD)

Figure 3: Atrial Septal Defect



The problem

41 There is a defect or hole in the wall (septum) between the two upper chambers of the heart, the left and right atriums. The hole might occur in any part of the atrial septum. The common defect is the one illustrated, known as a secundum ASD. In the presence of an abnormal hole, blood flows along the path of least resistance. Normally the resistance to flow is much lower in the blood vessels to the lungs than in those to the body. Therefore, in an ASD, blood flows from the left atrium to the right atrium, so that a larger volume of blood than normal then flows into the right ventricle and to the lungs. The chambers of the right side of the heart become ‘volume loaded’ but it is rare for heart failure to develop during infancy or early childhood.

Diagnosis

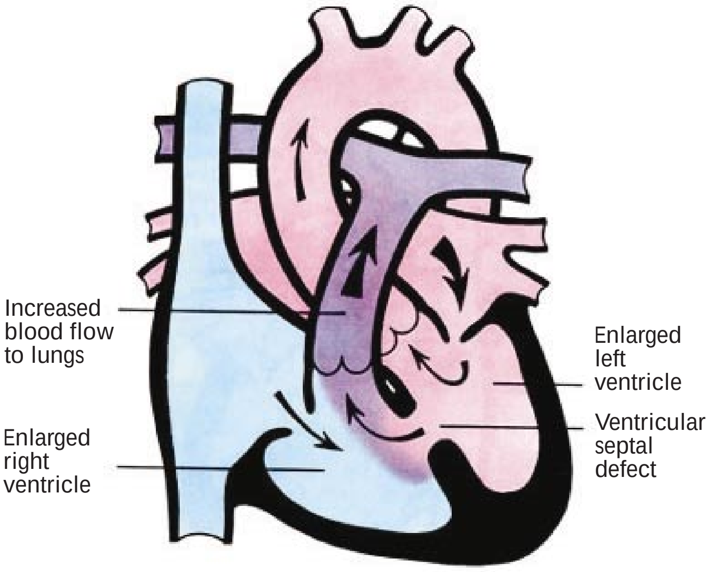
42 The diagnosis has been made reliably by echocardiography since the early 1980s. The advances in technology have served to enhance the precision and accuracy of demonstrating the site and nature of the defect. It is rare for the cardiologist to need to resort to cardiac catheterisation.

Management

43 It is recommended that the defect should be closed during childhood in order to prevent problems in adolescence or early adult life. During the period of the Inquiry's Terms of Reference, an ASD would be closed by means of an open-heart operation but since the mid-1990s technology has evolved to allow just over a third of these defects to be closed by means of cardiac catheter devices. Throughout the 1980s and onwards, the risk of undertaking open-heart surgery in order to close an ASD has generally been regarded as very low.

Ventricular Septal Defect (VSD)

Figure 4: Ventricular Septal Defect



The problem

44 There is a hole (defect) in the wall between the two ventricles of the heart. The size of the hole determines whether or not the function of the heart will be compromised. It has been estimated that approximately 65% of all VSDs are too small to create a problem for the child and will probably become smaller with the passage of time, some even closing spontaneously. The VSDs with which the Inquiry was concerned were those which were large and therefore required surgical closure.

45 With each heartbeat, the two ventricles together pump blood out of the heart, the left ventricle to the body and the right to the lungs. In VSD, the blood flows normally from both ventricles, and also through the hole along the pathway of least resistance, i.e. volume of blood flowing to the lungs then returns to the left atrium and to the left ventricle. The increased volume load on the left ventricle contributes to that chamber of the heart becoming 'stretched' with consequent reduced function or 'heart failure'.

46 There are some babies in whom a large VSD does not cause heart failure because the blood vessels to the lungs behave abnormally and provide an increased resistance to lung blood flow. In those cases, the expected increased flow of blood to the lungs with the consequent increased return of flow to the left heart chambers does not occur. Therefore, the left ventricle does not become sufficiently volume loaded for its function to become compromised. However, the problem is equally serious because the pressure in the blood vessels to the lungs increases and, in time, permanent changes take place in those vessels. This condition is known as pulmonary hypertension or pulmonary vascular disease and it progresses over the years, causing death in late adolescence or early adulthood. It is essential to recognise this problem within the first few months of life before pulmonary vascular disease becomes permanent.

Diagnosis

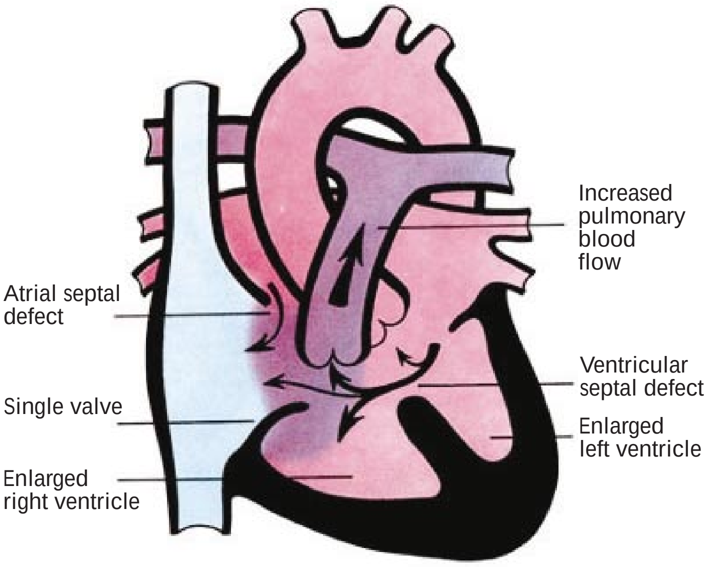
47 The baby becomes progressively more breathless to the extent that he is unable to complete feeds, fails to gain weight and becomes more hungry, requiring more frequent feeds and eventually becomes so exhausted that he has to be helped temporarily by being fed through a tube passed from the nose, down the oesophagus and into the stomach. The diagnosis is made by examining the baby and is confirmed by echocardiography. As explained above under ‘Echocardiography’, advances in technology have considerably enhanced the accuracy of identifying the site and nature of the defect. From the mid-1980s it was common for babies to be subjected to cardiac catheterisation in addition to echocardiography. By the mid-1990s, evolving technology and experience enabled the diagnosis, in most cases, to be made sufficiently accurately using echocardiography alone. However, there continue to be some babies in whom it is necessary to obtain additional information by cardiac catheterisation.

Management

48 In the presence of heart failure, medical treatment is only of temporary value and a relatively early surgical operation becomes necessary. Surgical closure of a VSD is an open-heart procedure. The technical difficulty, if any, relates to the nature and position of the defect within the ventricular septum. The age and the size of the baby are also factors. During the early to mid-1980s, the mortality rate in the UK for closure of a VSD in infancy was significantly higher than in older children. During the 1990s the mortality rate reduced substantially for all age groups.

Complete Atrio-Ventricular Septal Defect (CAVSD)

Figure 5: Complete Atrio-Ventricular Septal Defect



The problem

49 The defect involves the whole area of the junction of the upper and lower chambers of the heart, i.e. where the atriums join the ventricles. There is a large hole between the lower portion of the atriums and the upper or 'inlet' portion of the ventricles and this is associated with a significant abnormality of the valves separating the atriums from the ventricles. The valves in effect become a common atrio-ventricular valve, and the severity of the defect depends largely on the supporting attachments of the valve to the ventricles and whether the valve allows dominant flow from the right atrium to right ventricle and from left atrium to left ventricle. The overall problems are similar to those of VSD but are more complicated. There is an increased flow of blood to the lungs through both the ventricular and atrial components of the defect. In addition, the abnormal atrio-ventricular valve invariably leaks, so that when the ventricles contract, blood flows not only forwards to the body and the lungs, but also backwards into the atriums. The back-pressure effect on the atriums causes congestion of blood in the left atrium in particular, and this in turn causes congestion in the veins draining the lungs. The effect on the baby is to worsen the heart failure that is associated with an isolated VSD and to hasten the onset of pulmonary hypertension. It should be mentioned that CAVSD is found in approximately one-third of babies who have Down's syndrome, but it also occurs as an isolated abnormality.

Diagnosis

50 The symptoms are similar to those of VSD with breathlessness, difficulty in feeding and failure to gain weight. The diagnosis may be anticipated by examining the baby and by a characteristic abnormality of the electrocardiogram (ECG) but the confirmation is obtained by echocardiography. In the present day, and even from the mid-1980s to the mid-1990s, a complete diagnosis could usually be made by echocardiography alone. From the late 1980s onwards, technological advances have helped to improve the accuracy of recognising all components of the abnormality. In some cases, it may also be necessary to do cardiac catheterisation in order to assess the question of pulmonary hypertension and to obtain a clearer impression of whether the two ventricles are each of adequate size to allow for surgical closure of the defect.

Management

51 The initial management is the medical treatment of heart failure and usually tube-feeding in order to encourage growth. The surgical procedure is a complicated open-heart operation involving closure of the defects between the atriums and the ventricles, and separation of the common atrio-ventricular valve into two separate valves. Since the time when surgical treatment first became possible, it has been recognised that surgical correction is the ideal approach, preferably during the first few months of life in order to cure the heart failure and to prevent the high incidence of the progression of pulmonary hypertension.

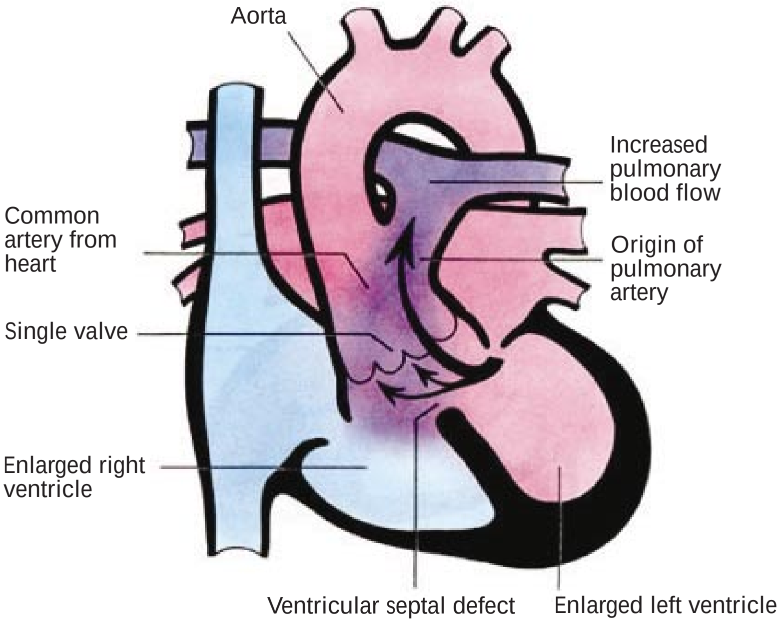
52 In the mid-1980s cardiologists and surgeons were faced with the quandary of knowing that surgical correction of CAVSD carried a high risk, especially in babies under the age of 1 year. There was a tendency to delay the operation until the baby had grown because it was considered that the risk would then be lower. However, it was recognised that this was often at the cost of the baby developing irreversible pulmonary vascular disease (pulmonary hypertension) in which case an operation was no longer possible.

53 Towards the beginning of the 1990s changes in the operative technique and probably other factors in management of care led to a significant reduction in reported mortality and by the mid-1990s most centres in the UK were able to achieve good results.

54 It is important to recognise that even after an apparently successful corrective operation, problems can continue for children with CAVSD. Usually these relate to a continued leak back through the atrio-ventricular valve from the left ventricle to left atrium. In those cases, later surgical repair or even replacement of the valve may become necessary, often some years after the original operation.

Truncus Arteriosus

Figure 6: Truncus Arteriosus



The problem

55 Truncus Arteriosus is very rare, occurring in fewer than 1% of congenital heart abnormalities, but it has provoked a great deal of interest. In order to understand the nature of the abnormality it is helpful to recall that in the normal heart the aorta arises from the left ventricle and the pulmonary artery from the right. In Truncus Arteriosus, a single large arterial trunk arises from both ventricles, and there is a large VSD just below the trunk. Soon after its origin from the ventricles, the arterial trunk gives rise to large pulmonary arteries and then it continues as the aorta. Both ventricles pump blood simultaneously into the trunk which consequently receives both deoxygenated blood from the right ventricle and oxygenated blood from the left. If this blood were evenly mixed, one would expect that the relatively high contribution of deoxygenated blood would cause obvious blueness or cyanosis (see para 35). Indeed, careful measurement of the blood oxygen content does reveal some degree of deoxygenation but this is usually very mild.

56 The more important effect of the abnormality is that there is the usual tendency for blood flow to take the path of least resistance, i.e. to flow preferentially into the pulmonary arteries and to the lungs. Blood flow to the lungs tends to be torrential with a large return of oxygenated blood to the left heart. Therefore the flow of oxygenated blood from the left ventricle into the common trunk is many times more than that from the right ventricle. Consequently, the effect of the deoxygenated blood flowing to the aorta is considerably reduced, accounting for the relative lack of cyanosis.

57 The presenting effects on the baby are similar to those seen when there is a large VSD. The increased volume of blood flowing to the lungs and returning to the left side of the heart causes heart failure in the same way as described for VSD. The heart failure tends to develop much more rapidly and with greater severity with the result that 70% of babies with Truncus Arteriosus do not survive beyond the age of 3 months if left untreated.

58 Not uncommonly, there is another related problem involving the valve between the arterial trunk and the two ventricles. The valve may open well but may not close fully, with the consequence that blood that has been pumped from the ventricles into the arterial trunk may leak back into the ventricles. This adds to the amount of work done by the ventricles and hastens the development of heart failure.

59 Another associated abnormality that may accompany Truncus Arteriosus is known as 'interrupted aortic arch', which is an extreme form of Coarctation of the Aorta. Babies with this combination usually present during the first week of life and their general condition may deteriorate quite rapidly without intensive treatment and early surgery.

Diagnosis

60 The baby usually presents during the first few weeks of life with evidence of severe heart failure. The diagnosis can usually be made quite accurately by echocardiography alone. At least this has been true since the early 1990s when colour-flow Doppler mapping of blood flow became routinely available. During the 1980s it was usually possible to diagnose the presence of Truncus Arteriosus with echocardiography but the precise nature of the origin of the pulmonary arteries from the arterial trunk could not always be defined. In some patients there is the additional problem of an associated interrupted aortic arch which may be very difficult to diagnose. In those cases, both then and today, additional investigation by cardiac catheterisation may need to be undertaken.

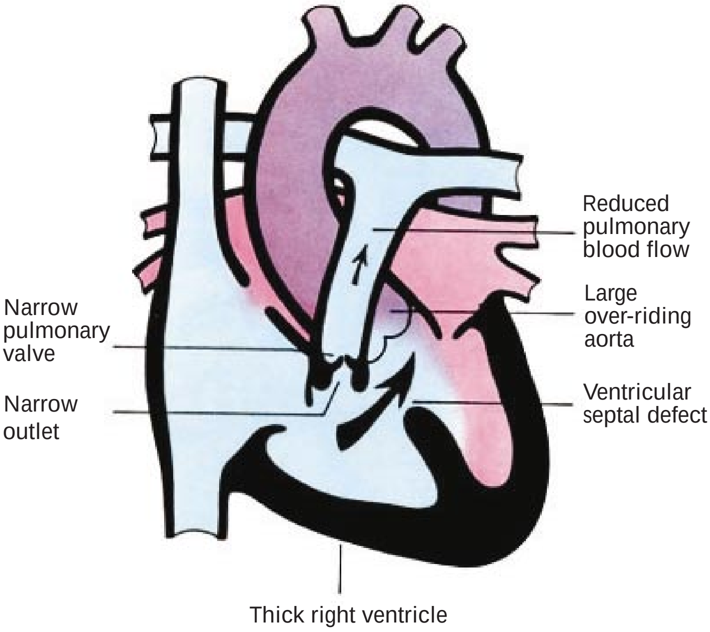
Management

61 Because the newborn infant with Truncus Arteriosus is usually so ill, the standard drugs for the treatment of heart failure are of limited value. The baby often, but not always, requires early treatment in the ICU with the support of a ventilator. Surgical correction is usually undertaken in babies who are less than 6 weeks old. The operation is a major open-heart procedure and is complex. Essentially the VSD is closed in such a way that all the blood flow from the left ventricle is directed into the common arterial trunk. The pulmonary arteries are separated from the trunk, which is then reconstituted as a single large artery, and it becomes the new aorta. The pulmonary arteries are connected to a tube or conduit, if possible a piece of donated human aorta or pig's aorta, and the conduit is connected to a surgically created opening in the right ventricle. In some cases a conduit with a human or pig's valve is used. In this way the right ventricle pumps blood directly to the pulmonary arteries while the left ventricle pumps to the aorta. If the truncal valve is leaking it may need to be repaired and this can be a significant complicating factor in determining outcome.

62 Because Truncus Arteriosus is such a rare condition, very few operations are done in any one centre each year. It is therefore difficult to assess with certainty the mortality rates across the UK during the period covered by the Inquiry's Terms of Reference. In the mid-1980s corrective operations on babies under the age of 1 year were considered to carry a very high risk of death. The results improved during the late 1980s to the early 1990s but by 1995 the operation still carried a very high risk, even in those cases in which there were no associated complicating problems.

Tetralogy of Fallot

Figure 7: Tetralogy of Fallot



The problem

63 This abnormality is the commonest form of cyanotic congenital heart disease. It occurs in just under 10% of all babies with congenital heart abnormalities. There is a large VSD in the same portion of the ventricular septum as was described for Truncus Arteriosus. The aorta arises dominantly from the left ventricle but overrides the VSD so that there is a tendency for blood to flow into the aorta from both the left and the right ventricle. There is also a narrowing of the outflow from the right ventricle to the pulmonary artery (pulmonary stenosis). The severity of the narrowing varies from one patient to another. Its effect is to increase the resistance to blood flow from the right ventricle to the lungs. The flow of blood to the lungs is reduced and instead, blood then flows along the path of least resistance. In that case it is from the right ventricle, through the VSD and into the aorta. In other words, deoxygenated blood flows from the right ventricle to the body, together with the oxygenated blood from the left ventricle. Consequently, the child shows the features of cyanosis.[10] The greater the severity of the pulmonary stenosis, the more severe is the degree of cyanosis.

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[10] See para 35

64 Those babies who have severe reduction in blood flow to the lungs and more profound cyanosis present early in the newborn period and require early measures to improve pulmonary blood flow. Others, whose pulmonary stenosis is less severe, may not show any symptoms until they are several months old, or not even until they become toddlers. All children with Fallot's Tetralogy are limited in their physical activities and are at risk of complications. The most common of these is the occurrence of 'spells' in which the baby suddenly becomes extremely blue and floppy and often loses consciousness for a few minutes. Recovery is usually rapid but on rare occasions an attack can be fatal. Spells are caused by the outflow tract of the right ventricle becoming suddenly narrower as a result of a form of 'spasm' of the right ventricular muscle below the pulmonary valve. When the spasm is relieved, the baby recovers from the spell. Another most serious complication is related to bacteria entering the blood stream from an apparently mild infection of the skin or throat. Instead of passing normally to the lungs where the bacteria are trapped and often cause a minor or occasionally more severe lung infection, they pass from the right ventricle, through the VSD to the body and may settle in the brain causing an abscess which can prove fatal. For all of these reasons it is desirable that a child with Fallot's Tetralogy should have a corrective operation as early as it can safely be done.

Diagnosis

65 The diagnosis is usually suspected on the basis of the presenting symptoms and by examination of the patient. It is usually confirmed by echocardiography and on that basis, the initial plan of management can be undertaken. Before proceeding to corrective surgery, additional investigation by cardiac catheterisation has been regarded as mandatory in some centres in order to demonstrate every fine detail of the abnormality. In the mid-1980s the diagnosis could usually be made confidently using echocardiography. The evolution of ultrasound technology during the late 1980s and towards the mid-1990s has enabled cardiologists to be even more confident of some of the finer details of the abnormality. Nevertheless a number of questions that are important to the technical approach of a corrective operation are better answered by proceeding to cardiac catheterisation.

Management

66 Throughout the period covered by the Inquiry's Terms of Reference, i.e. from the mid-1980s to the mid-1990s, the management of the child with Fallot's Tetralogy would have followed a similar pattern in most centres.

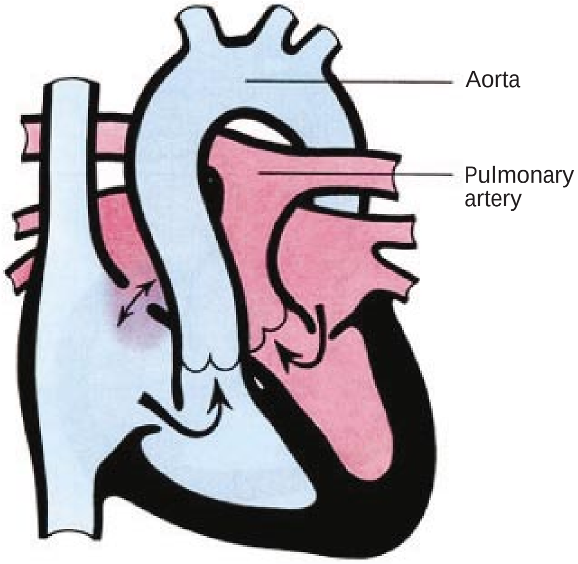
67 The newborn baby with severe cyanosis initially requires an increase in the blood flow to the lungs. During fetal life, an artery known as the arterial duct normally connects the aorta and the pulmonary artery. It normally closes within the first two to three days of life but it can be kept open by using a drug, prostaglandin E. By keeping the duct open, blood flows from the aorta through the duct into the pulmonary artery and even if this is the only source of blood flow to the lungs, it is usually sufficient for survival and stability in the short term. However, it is unusual for a baby with Fallot's Tetralogy to become severely cyanosed so soon after birth and it is more usual that the duct will have closed by the time that he is first seen. In such a case it is necessary to undertake an emergency operation known as a 'shunt' in which a small tube is used to connect a branch of the aorta to the pulmonary artery. This is the type of operation first described in 1945 by Blalock and Taussig. Shunt operations have improved in both technological and technical terms since the mid-1980s and the mortality has fallen significantly since then.

68 It is more usual for the cardiac team to be faced with a baby whose cyanosis has increased significantly around the age of 2 to 4 months, often associated with cyanotic spells. In those babies it has been usual to begin medical treatment initially with a drug known as a beta-blocker in order to try to reduce spasm of the right ventricular outflow tract. This is a temporary measure and is followed within days or weeks by a shunt operation. In those circumstances the risk of a shunt operation is somewhat lower than when performed in the newborn period.

69 Corrective operations are 'open-heart' procedures. Some babies may undergo primary corrective repair if they are large enough and if the abnormality is not too complicated. If they have had a previous shunt operation, it is necessary to close the shunt. The VSD is closed using a patch so that left ventricular blood flows entirely into the aorta. The pulmonary stenosis is relieved, both by cutting open the pulmonary valve, and usually by opening the right ventricular outflow tract and widening it by inserting a gusset. The pulmonary artery branches themselves may be narrowed and often need to be reconstructed. The operation can be relatively routine or quite complicated, depending on how much reconstructive work is necessary. The mortality rate in the UK fell significantly between the mid-1980s and the mid-1990s. There had been many reports from centres of excellence in the United States of low mortality rates in the mid-1980s and in the centres of excellence in the UK similar results were expected.

Transposition of the Great Arteries (TGA)

Figure 8: Transposition of the Great Arteries



The problem

70 This is one of the commonest of the cyanotic congenital heart abnormalities. For a clearer understanding of the abnormality, a brief recapitulation may be helpful. The great arteries are the aorta and the pulmonary artery. The left ventricle normally connects to the aorta into which it pumps oxygenated blood, and the right ventricle connects to the pulmonary artery into which it pumps deoxygenated blood. When the great arteries are transposed, the left ventricle connects to the pulmonary artery and the right ventricle to the aorta. Deoxygenated blood returns from the body to the right side of the heart and should then flow to the lungs to be oxygenated. Instead it is again pumped out to the body. Similarly, oxygenated blood returning from the lungs to the left side of the heart is pumped again to the lungs. In order for the baby with TGA to survive, it is essential that some of the oxygenated blood should cross over to the right side of the heart and then to the body. Similarly some of the deoxygenated blood should cross over to the left side of the heart in order to flow to the lungs to become oxygenated. In the fetus there is normally a hole in the wall between the left and right atriums, and there is also an arterial duct[11] connecting the aorta and the pulmonary artery. These fetal structures normally remain open for several hours after birth and the blood flow through them allows for the necessary crossover of blood between the left and right sides of the heart. The baby is usually slightly blue at birth, and the cyanosis increases as the communications between the two sides of the heart become smaller. Unless emergency measures are undertaken the baby's condition deteriorates rapidly and he does not survive. Some babies with TGA are born with additional abnormalities, one of the commonest being VSD. In that case, an additional communication between the two sides of the heart may result in the cyanosis being quite mild but the baby then suffers from the additional problems associated with a VSD. The term 'Taussig-Bing' syndrome is used to describe a VSD which is just beneath the pulmonary artery so that there tends to be a considerable flow of blood to the lungs.[12] Other associated abnormalities that occur not uncommonly are pulmonary stenosis, and Coarctation of the Aorta, and they add additional problems in the overall progress and management of the baby.

71 There is a particular problem relevant to the management of TGA which is important. The heart requires a blood supply to the heart muscle. This comes from the coronary arteries, which branch off from the aorta almost as soon as that great artery arises from the left ventricle in the normal heart, or from the right ventricle in TGA. The flow into the coronary arteries depends on the blood pressure in the aorta being at least normal, and it is important that oxygenated blood flows to the heart muscle. The logical operation in TGA is one in which the great arteries are disconnected from their transposed positions and reconnected so that they receive blood respectively from the correct ventricles. Therefore it is clear that during the operation the coronary arteries need to be moved over together with the aorta. There are technical difficulties associated with this delicate part of the operation and it is important that the cardiologist and the surgeon both have as clear an understanding as possible of the branching of the coronary arteries in each individual case.

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[11] See the section on the management of Tetralogy of Fallot in this chapter

[12] See the section on the diagnosis of Ventricular Septal Defect (VSD) in this chapter

Diagnosis

72 Transposition of the Great Arteries was one of the earliest of the diagnoses that could be made confidently using echocardiography. Throughout the period covered by the Inquiry's Terms of Reference, almost all centres in the UK would have used echocardiography alone in order to obtain a complete diagnosis of TGA together with most of the other associated abnormalities. The sensitivity and accuracy of detecting the associated abnormalities have been enhanced by the use of ultrasound Doppler and colour-flow mapping. An important element of the echocardiographic diagnosis is to try to visualise the origins and branching of the coronary arteries in order to alert the surgeon if there is likely to be anything unusual. There are always a few cases in which cardiac catheterisation still becomes necessary as, for example, when there is any uncertainty about certain diagnostic details.

Management

73 From the late 1970s, the initial emergency management of almost all newborn babies with severe cyanotic congenital heart disease has been to treat with prostaglandin E in order to keep the arterial duct open. In TGA this is usually rapidly effective in improving the blood oxygenation by encouraging more blood flow to the lungs and more flow through the hole between the two atriums. Then, by means of a cardiac catheterisation technique, a larger hole is created in the wall between the atriums. This is known as 'balloon atrial septostomy'. Improvements in the design of the equipment for this procedure have simplified it significantly and it is now regarded as relatively safe and routine. There have been minor developments related to balloon atrial septostomy between the mid-1980s and mid-1990s. They have been influenced largely by improvements in intensive care management. Instead of moving the baby to the cardiac catheterisation theatre, the procedure is often performed in the intensive care unit using echocardiography in order to visualise the cardiac catheter and the cardiac structures. Most babies with an adequate hole in the atrial septum can survive and thrive for many months.

74 In the mid-1980s the standard approach after balloon atrial septostomy was to discharge the baby home, then plan further investigations with a view to an operation at around 6 months of age. The precise timing depended on the general condition of the baby and on the degree of cyanosis during the period of follow-up. Although it was recognised that the logical operation would have been to 'switch' the great arteries to their 'correct' ventricles, the technicalities of moving the coronary arteries had not been adequately mastered. Therefore the type of operation that had been performed since the mid-1960s was undertaken, namely the Mustard procedure or the Senning procedure.

75 Both of these operations employ the same principle. Deoxygenated blood returning from the body is diverted so that it flows to the left ventricle (instead of the right), then to the lungs. Similarly, oxygenated blood returning from the lungs is diverted so that it flows to the right ventricle and then to the aorta. Thus instead of the left ventricle pumping blood to the body, the right ventricle continues to do this work and the left ventricle continues to pump blood to the lungs. Since the operation was first designed, it has been questioned as to whether the right ventricle was capable of sustaining the demands of pumping at a higher pressure than if it were providing blood flow to the lungs. The operation is very effective and enables children to lead normal lives but in the longer term, complications have been reported, mostly during late adolescence or early adult life. Therefore considerable efforts were made during the 1980s to perfect the more logical Arterial Switch operation.

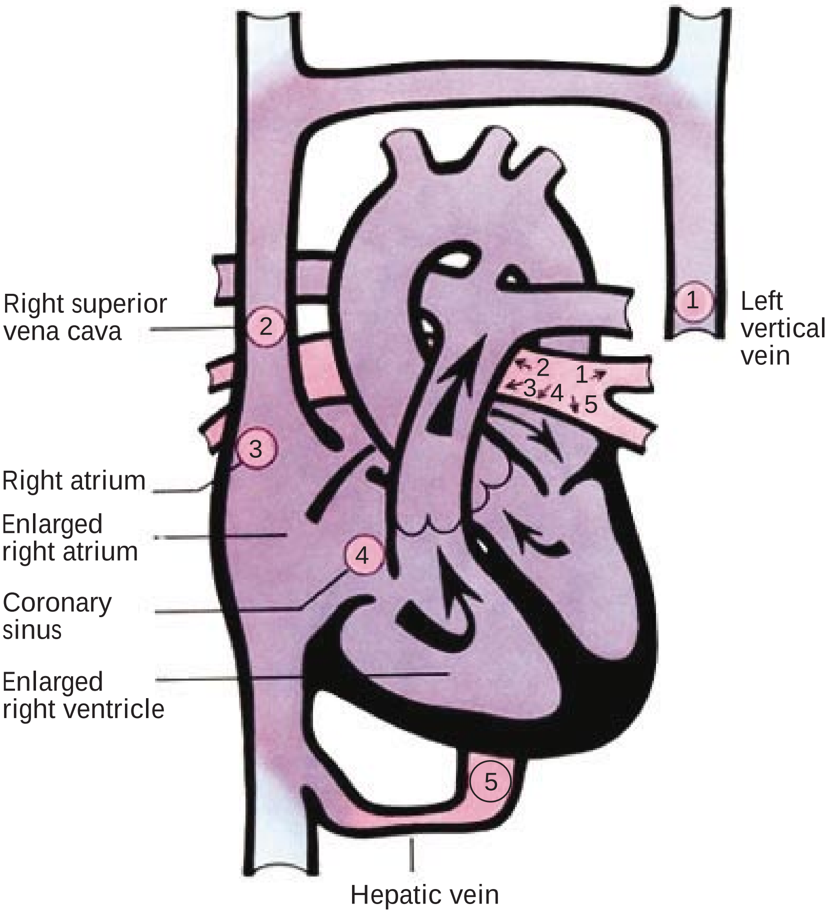
76 During the 1980s there were some isolated reports of Arterial Switch operations being done in the United Kingdom but virtually all centres continued to rely on the Mustard and Senning procedures. Meanwhile, considerable advances in the Arterial Switch technique were made in a few centres in the United States and in Europe and Australia. Towards the end of the 1980s a few centres in the UK were obtaining good or satisfactory results by using the Switch procedure and by the early 1990s the operation had become well established in most of the major centres. By the mid-1990s it was expected that all major centres would have been performing the Arterial Switch operation instead of the Mustard or the Senning procedure with a reasonable expectation of good results. It was recognised that the major technical problem with the Switch procedure continued to be related to the difficulty of relocating the coronary arteries. Surgeons began to appreciate that if the coronary artery anatomy was particularly difficult, it was advisable to ask for help, if at all possible, from one of the few surgeons with a wide experience of dealing with the problem. Great reliance was ordinarily placed on the paediatric cardiologist to recognise that a coronary abnormality might be present in an individual case.

77 Associated additional abnormalities create more work for the surgeon and consequently complicate the technical procedure. Each of the additional abnormalities must be repaired in addition to the Arterial Switch being carried out. There is one notable exception. Some children with TGA also have a VSD together with pulmonary stenosis. If the VSD is high in the ventricular septum and just below both great arteries it is often more convenient to perform the so-called Rastelli operation. In this procedure a patch is placed on the defect in such a way that flow from the left ventricle is diverted through the VSD and into the aorta. This process necessitates closing the connection between the left ventricle and the pulmonary artery. Then a valved conduit is placed between the right ventricle and the pulmonary artery.

78 Most patients who have survived the Arterial Switch operation have an uncomplicated course but it is essential that they are kept under regular review and are assessed by echocardiography for evidence of any of the later complications. Some of these patients need further operations or cardiac catheter interventions in order to remedy problems such as narrowing of the pulmonary arteries or very occasionally significant leaking of the aortic valve. Although there is the expectation that children undergoing the Arterial Switch operation are likely to have better long-term results that those with the Mustard or Senning operation, not many patients have had a sufficiently long post-operative period in order to be able to confirm that belief.

Total Anomalous Pulmonary Venous Drainage (TAPVD)

Figure 9: Total Anomalous Pulmonary Venous Drainage



The problem

79 TAPVD is rare, comprising around 1% of all congenital heart abnormalities. A successful operation can usually ensure uncomplicated survival, whereas 80% to 90% of babies with TAPVD die before their first birthday if they are not treated surgically. All of the pulmonary veins draining blood from the lungs should normally be connected to the left atrium. In TAPVD they drain instead into the right atrium, or more commonly into one of the veins from the body which eventually drains into the right atrium. The diagram (Figure 9) demonstrates the different possible sites to which the pulmonary veins commonly drain. It is essential that the hole in the wall between the atriums, normally present in the fetus, remains open in the newborn baby so that blood returning from the lungs can flow from the right to the left atrium and then to the body. Much of the blood returning from the lungs to the right heart is again pumped to the lungs together with blood returning from the body. The increased flow causes the right ventricle to become volume loaded and also causes lung congestion. If the inter-atrial hole is too small, then the flow to the right ventricle and the lungs is even greater, with consequently worsening congestion. It is more usual for right to left atrial flow to be adequate in which case there is still volume-overload of the right ventricle together with lung congestion, but there is sufficient oxygenated blood flowing to the body. The pulmonary veins most commonly connect to one of the veins from the upper part of the body and this is usually associated with the fewest severe emergency problems. When the pulmonary veins connect to one of the veins draining the lower part of the body, the blood often has to flow through the liver before it reaches the main lower vein joining the right atrium. The passage of blood, by going through the liver, or even through a more tortuous route, is considerably slowed down, and the pulmonary venous drainage is essentially obstructed, causing severe congestion of the lungs. Babies will then often present within hours after birth with severe breathlessness and cyanosis, and resuscitation may be difficult.

Diagnosis

80 Newborn babies with TAPVD present with severe breathlessness and cyanosis and are often confused with those who more commonly have a primary lung problem, known as ‘respiratory distress syndrome’. The diagnosis of TAPVD by echocardiography can be extremely difficult, and was even more so in the mid-1980s when colour-flow mapping was not available. The diagnosis depends on showing that the pulmonary veins are not connected to the left atrium, and also being able to visualise their connection to an abnormal site. Even when colour-flow mapping is used, it may be difficult to identify the flow in the pulmonary veins. Cardiologists, despite being meticulous in searching for the confirmation or rejection of the diagnosis of TAPVD, may remain uncertain of its presence. The baby with either TAPVD or with respiratory distress syndrome is usually so ill that there is reluctance to undertake cardiac catheterisation because of the considerable risk.

Management

81 Most babies with TAPVD are very ill when the diagnosis is made. Normal pre-operative supporting measures are undertaken while arrangements are being made for corrective surgery. Pre-operative measures might include the admission to the ICU and support on a ventilator. The operation is a major procedure using an open-heart technique but the majority of the operation takes place outside the heart, the only intra-cardiac element being the connection of the pulmonary veins to the left atrium. In the mid-1980s the operative risk was significantly higher than it became in the early and mid-1990s. The better results were due largely to improvements in early diagnosis as well as in pre-operative intensive care, surgical techniques and post-operative management. The most difficult cases have always been those in whom the pulmonary veins tended to be obstructed in some part of their course.

82 After successful repair it is unusual to have significant longer-term problems. Occasionally the pulmonary veins become obstructed at or near the surgical connection to the left atrium and re-operation becomes necessary. Most babies proceed to lead trouble-free, uncomplicated and normal lives.

The Fontan procedure

83 Thus far, the second half of this chapter has focused on the diagnosis and management of a number of specific abnormalities. This section takes a different perspective, and considers one important procedure, the Fontan procedure, which may be used to help children who present with a range of heart abnormalities.

The problem

84 There is a group of patients who have only one effective ventricle instead of two. The commoner abnormalities in this group are one of the following:

- A single ventricle pumps blood into both great arteries (the aorta and pulmonary artery).
- Two ventricles are present but one is too small to perform its normal function.
- The connections between the atriums and ventricles are unsuitable for an operation that would separate the ventricles into two effective chambers that would then pump blood into the appropriate great arteries.

Figure 10: Tricuspid atresia

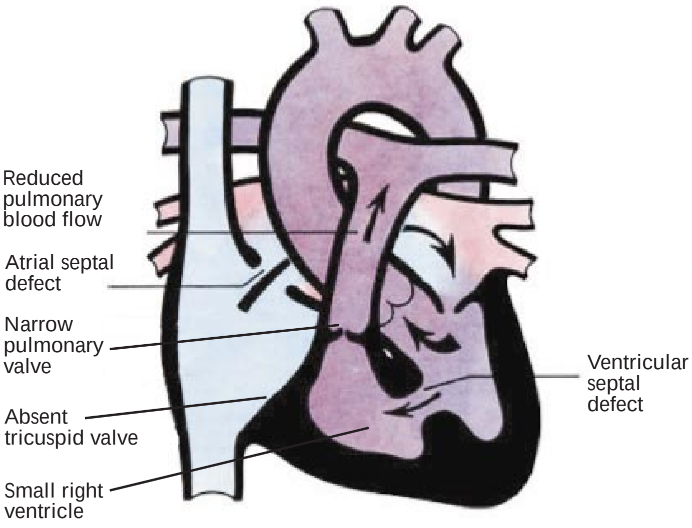
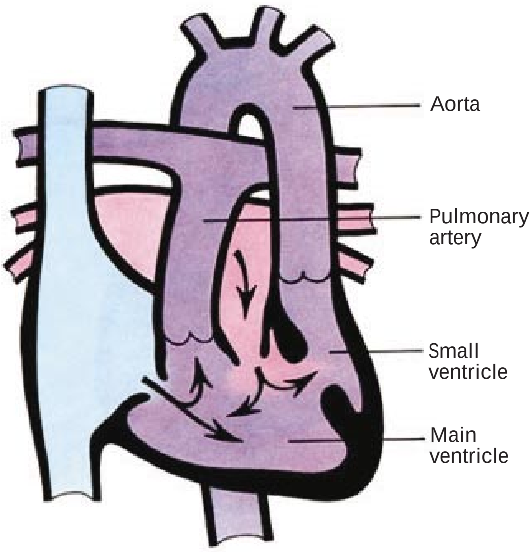


Figure 11: Double inlet ventricle



85 For illustrative purposes, diagrams of two examples are shown above, namely tricuspid atresia and double inlet ventricle.

- In the normal heart the tricuspid valve opens to allow blood to flow from the right atrium to the right ventricle. In tricuspid atresia, the valve fails to develop. Consequently, all the deoxygenated blood that enters the right atrium must flow through the hole that is normally present in the wall between the two atriums in the fetus and newborn baby. Blood flows into the left atrium, then the left ventricle and then into the aorta. In other words, deoxygenated blood flows into the aorta, and causes the baby to be cyanosed (blue). The baby needs a series of medical and surgical procedures in order for it to have adequate blood flow to the lungs and consequently to survive and grow.

- In double inlet ventricle all the blood from both atriums flows into an effectively common ventricle and then out to both great arteries. The overall result is a considerable increased flow of blood to the lungs. The effects on the baby are similar to those described for a VSD (see paras 44–46).
- There are complicated forms of AVSD in which it is technically not possible to separate the two ventricles surgically so that each can function independently. The baby has all the features already described for CAVSD (see para 49) but there is a structural problem in relation to the atrio-ventricular valves such that separation into two valves is not technically possible.
- In hypoplastic[13] left or right ventricle there is a very small ventricle that is incapable of functioning independently in order to pump blood into either the aorta or the pulmonary artery respectively.

Diagnosis

86 In all of the congenital heart abnormalities described earlier, the importance of a careful and complete diagnosis has been repeatedly emphasised. The same principles apply to the diagnosis and assessment of abnormalities in which there is only one effective ventricle. Demands are therefore made on all of the diagnostic skills of the cardiologist. Careful echocardiographic assessment is essential in planning the initial procedure. When necessary, additional cardiac catheterisation is carried out.

Management

87 All of these conditions usually require at least one preliminary operation. The overall aim is that eventually the child will have the type of operation that was first performed in 1968 by Francis Fontan in Bordeaux. He connected the right atrium directly to the pulmonary artery in a patient with tricuspid atresia. Thus instead of the blood being pumped by the right ventricle into the pulmonary artery, it flowed there passively from the right atrium. The operation ensures that the ventricle pumps blood to the aorta and to all of its branches and that the blood returning from the body in the main veins is all diverted to the pulmonary arteries. Blood returning from the lungs flows normally into the left atrium and then into the effectively single ventricle which again pumps the blood to the body.

88 The Fontan operation itself, or one of its modifications, does not usually present major technical difficulties. Its success depends on the careful preliminary preparation of the patient by means of one or more palliative operations. The first surgical procedure is usually undertaken either in the newborn period or in the first few months of life.

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[13] The term ‘hypoplastic’ is used to refer to a tissue or organ that is under-developed, usually due to a decrease in the number of cells

Depending on the underlying problem, it may be a shunt operation in order to increase the pulmonary blood flow, or it may involve banding of the pulmonary artery in order to decrease the flow. In some cases a more complicated operation may be undertaken in order to re-route blood flow into the aorta and pulmonary arteries; this is known as the 'Damus-Kay-Stansel procedure'. Then since the late 1980s, most patients between the ages of 4 months and 1 year have had a further operation in which the superior vena cava (the main vein draining the upper part of the body) is connected directly to the pulmonary artery. It achieves blood flow from the upper part of the body going directly to the lungs and in that sense is essentially halfway towards the Fontan operation.

89 The cardiologist and the surgeon need to plan all stages of the timing and the overall management together, always bearing in mind that the ultimate goal will be the Fontan procedure. Throughout the period of management of the child it is important to recognise the importance of assessing the sizes of the pulmonary arteries and judging whether the resistance to blood flow through the lungs has remained normal. It is uncommon for the Fontan procedure to be undertaken in a child below the age of around 3 years.

90 A few weeks or months before the proposed date of the Fontan operation, detailed investigations are undertaken, including cardiac catheterisation and angiocardiography (see para 20). The suitability of the patient for the operation is determined by the detailed assessment of the function of the effective ventricle and of the structure and function of the pulmonary blood vessels. The chief guiding principle is that the resistance to blood flow through the lungs should not be higher than normal, because if it is, there will be a back-pressure effect in the main veins draining the body, with potentially serious consequences. The pressures and blood flow in the pulmonary arteries are measured and the resistance to flow is calculated. It is also necessary to visualise the pulmonary arteries and their branches and to ensure that there are no areas of narrowing that might cause some increase in the resistance to flow. At the time it might be advisable for the cardiologist to use interventional catheter techniques, i.e. balloon dilatation,[14] in order to enlarge any narrowed areas. It is also important that the function of the ventricle is shown to be adequate and that the presence and severity of any valve leaks within the heart are demonstrated.

91 The Fontan operation or one of its modifications is an open-heart procedure. The technical problems relate largely to the underlying abnormality and the nature of any preliminary operations that may have been performed during earlier years. During the 1980s the 'classical' Fontan operation was generally performed. It consists of making a direct connection between the right atrium and the pulmonary artery. Because the pressure in the right atrium is then higher than normal, it becomes distended over the years and blood tends to swirl around in the chamber without moving forward efficiently into the pulmonary artery. Blood flow becomes sluggish and there is a tendency for small clots to form. When the clots advance into the pulmonary arteries,

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[14] Balloon dilatation – a specially designed cardiac catheter is passed into the narrow portion of the pulmonary artery. A balloon, incorporated into the catheter, is inflated under pressure to a pre-determined diameter. The balloon is then deflated and together with the catheter is removed

they may block the smaller vessels. This, in turn, increases the resistance to blood flow into the pulmonary arteries with a consequent further increase in the right atrial pressure. The other effect of the right atrial distension is to make the heart vulnerable to rhythm disturbances with consequent deterioration of the function of the heart.

92 During the early 1990s several different strategies or modifications were introduced, some of which were used in combination:

- One was to create a more tube-like connection between the right atrium and the pulmonary artery by channelling the main veins more directly to the connection.
- Another was to make a small hole (about 5 mm in diameter) in the wall between the two atriums. This allowed blood to flow from right to left atrium and tended to reduce the right atrial pressure but had the disadvantage of making the child slightly cyanosed.
- In some centres anticoagulant drugs have been given routinely in all patients in order to reduce the incidence and risk of clots forming in the right atrium and pulmonary arteries.

93 Overall, the results depend largely on the pre-operative factors that were described above. Early post-operative problems after the Fontan procedure are relatively common and do not necessarily depend on the pre-operative findings. They relate to the higher pressure in the main veins draining the body and the back-pressure effect and congestion of many of the organs. The heart itself needs to adjust to a set of unusual circumstances and often requires drug support for several days post-operatively. Careful management of fluid intake and fluid balance is often critical. Despite the most meticulous care it is not uncommon for children to accumulate fluid in the space surrounding the lungs (pleural effusions), and chest drains are often necessary for many days or even for weeks after the operation. The absorption of food from the gut may be inefficient for a period of time and this, too, requires careful attention. Occasionally the kidneys function inefficiently and may require support.

94 All the above post-operative problems usually resolve within a period of a few weeks and the child may lead a full and comfortable life for many years. The main noticeable problem is a lack of stamina compared with other children but participation in short bursts of vigorous activity is usually achieved. In the longer term, especially in association with the ‘classical’ Fontan operation, rhythm disturbances and fluid accumulation become significant problems in many of these patients as they go through late adolescence or early adult life. It is hoped that the longer-term effects of the modified operations and the associated medical treatment will be more favourable.

Chapter 4 – National Accountabilities and Roles

The National Framework: responsibilities for healthcare

1 The period covered by the Inquiry's Terms of Reference is from 1984 to 1995. The background to that period, in terms of the NHS, has been set out in Chapter 2. Most of that information is common knowledge. However, the way in which the system actually worked may not be familiar, except to those intimately involved with it. Accordingly, the Inquiry sought evidence as to this. In particular, it was concerned to know who *in practice* exercised authority, and who *in practice* accepted responsibility for the parts of the service relevant to the Terms of Reference.

2 The evidence started with a broad overview of the health service, across the nation. It focused progressively on the specific circumstances of Bristol. However, it is always necessary to remember the broader context within which that particular evidence was set, and it is thus with a review of that evidence that this section begins.

3 Across the period, a number of divisions in function and responsibility at national level must be distinguished. First, different Departments of State had responsibility for different aspects of healthcare. At the outset of the period the government department within whose ambit hospitals came was the DHSS. In July 1988 the DHSS was split into two departments: the DoH and the DSS. The DoH was then concerned with care in hospitals, primary care and community health services.

4 Within the NHS itself, a consequence of the Griffiths Report[1] was a separation of 'policy' from 'management'. The Report had:

> '… recommended not only the introduction of general management in the NHS, but also the reform and strengthening of the Department's[2] internal organisation and mechanisms for discharging its responsibilities in respect of the NHS. Although the reform was intended to improve the Department's performance across the board, there was to be a particular emphasis on policy implementation and performance management in respect of the NHS.'[3]

This split between policy and management is sometimes expressed as a division between strategy and operations.

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[1] HOME 0003 0001; the Griffiths Report

[2] At that time, the DHSS

[3] WIT 0040 0001 Sir Graham Hart

5 The Griffiths Report also said:

> '2. The NHS … still lacks a real continuous evaluation of its performance against criteria such as those set out above [concern with levels of service, quality of the product …] …
>
> '3. It therefore cannot be said too often that the National Health Service is about delivering services to people. It is not about organising systems for their own sake. In proposing the NHS in 1944, the Government declared that:
>
> "– the real need is to bring the country's full resources to bear upon reducing ill health and promoting good health in all its citizens;" …
>
> '7. … Real output measurement, against clearly stated management objectives and budgets, should become a major concern of management at all levels.'[4]

6 Policy issues were the responsibility of a policy directorate, the Health and Social Services Policy Group, within the Department (DHSS/DoH).[5] Following Griffiths' recommendation, the Health Service Supervisory Board was established:

> '… to determine the purpose, objectives and direction for the health service, approve the overall budget and resource allocations, take strategic decisions and receive reports on performance and other evaluations from within the health service'.[6]

The Health Service Supervisory Board 'advised on the strategic direction of the NHS'.[7]

7 The NHS Management Board was established at the beginning of 1985[8] and 'had responsibility for the Department's management functions with respect to Health Authorities, particularly finance and performance review'.[9] The NHS Management Board reported to the Health Service Supervisory Board.[10]

8 In May 1989 the NHS Management Board was remodelled to form the NHS Management Executive (NHSME). In the same month, the Health Service Supervisory Board, which had not met for almost a year, was reshaped into the NHS Policy Board chaired by the Secretary of State.[11] The NHSME and NHS Policy Board were parallel bodies: the NHS Policy Board dealt with policy formulation; NHSME with management and policy implementation.

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[4] HOME 0003 0012 and HOME 0003 0014; the Griffiths Report

[5] WIT 0040 0003 Sir Graham Hart

[6] Edwards, B. '*The National Health Service 1946–1994: A Manager's Tale*', (1995), Nuffield Provincial Hospitals Trust

[7] WIT 0335 0004 Sir Alan Langlands

[8] WIT 0040 0001 Sir Graham Hart. Sir Graham said the Management Board was set up in '1984/85', T52 p. 21

[9] WIT 0335 0003 Sir Alan Langlands

[10] Edwards, B. '*The National Health Service 1946–1994: A Manager's Tale*', (1995), Nuffield Provincial Hospitals Trust

[11] Edwards, B. '*The National Health Service 1946–1994: A Manager's Tale*', (1995), Nuffield Provincial Hospitals Trust

9 The separation of lines of report was, it appears,

> '… founded on the assumption, on the belief, indeed, that the Chief Executive role could only be effectively carried out if the Chief Executive was himself an accounting officer in his own right'.[12]

10 A further distinction in function between the Chairman of the NHS Management Board (subsequently Chief Executive of the NHSME) on the one hand and the Chief Medical Officer for England on the other needs to be borne in mind. The Chief Medical Officer (CMO) acted as an advisor to the government but was also concerned with clinical health issues, whereas the Management Board and NHSME were concerned with NHS management issues.

11 The split between *policy* and *management* was, in the view of Sir Graham Hart, Director of Operations at the NHS Management Board 1985–1989 and Permanent Secretary, DoH 1992–1997, based upon two beliefs.[13] The first arose from the fact that the Management Board, following Griffiths, was a very new organisation. It had so great a task in terms of getting the Griffiths Report implemented that it was considered wise to keep work such as policy and strategy separate, to ease the load. The second belief was that it would be beneficial to separate policy from management and the implementation of policy, because doing so would clarify the respective issues. This theoretical clarity was, however, clouded by the fact that the Management Board and NHSME nonetheless had responsibility for policy on issues which were essentially those of management:

> '… for example, in relation to personnel practice in the NHS, in relation to finance, how the NHS should be financed, how much money it should have, how that should be distributed …'[14]

12 The division between policy and management was ended in 1995, following the Banks Report in the previous year.[15] Responsibility for all NHS policy matters was transferred to the NHS Executive. (The NHSME consequently dropped the word 'Management' from its title.) Sir Graham endorsed the view of Mrs Banks saying:

> '… that it would be better to include the policy for the NHS and about the NHS in the Executive'.[16]

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[12] T52 p. 91–2 Sir Graham Hart

[13] T52 p. 8 Sir Graham Hart

[14] T52 p. 9 Sir Graham Hart

[15] WIT 0040 0006 Sir Graham Hart

[16] T52 p. 10 Sir Graham Hart, Director of Operations at the NHS Management Board 1985–1989 and Permanent Secretary, DoH 1992–1997

13 Sir Graham Hart told the Inquiry that he agreed with this view. He thought that a split between responsibility for management and for policy had not been the best organisation. He said:

> '… I always felt it was important for the Executive to be closely involved in … responsibility for the whole range of NHS policies, which is the position that we achieved in 1995…'[17]

Lines of reporting

14 The Health Service Supervisory Board was chaired by the Secretary of State. The NHS Management Board reported to the Secretary of State through its Chairman. Its successor, the NHSME, reported to the Secretary of State through its Chief Executive. The wider DoH reported to the Secretary of State through the Permanent Secretary.

The CMO and the NHS Executive

15 The Chief Executive of the NHSME was a manager, not a clinician. The CMO and his staff were mostly clinicians. Medical staff with the DoH reported to the CMO more widely during the earlier period of the Inquiry than during the later period. Following the Banks Report, medical staff of the DoH, apart from a half dozen or so secretariat staff, reported either to the Permanent Secretary or to the Chief Executive of the NHS and '… the Chief Medical Officer therefore had no direct reporting medical staff'.[18]

16 Despite the difference of background between the CMO and his staff on the one hand, and the Chairman/Chief Executive on the other, the evidence was that there was no inherent priority of view on any issue between them. Sir Christopher France, Permanent Secretary, DoH 1988–1992,[19] emphasised that:

> '… the decision-making process … always relied on weighing the merits of the various arguments, whatever their source, and not on recourse to some set of rules which purported to indicate which should prevail. Such "rules" simply did not exist.'[20]

17 Although the NHS is a national health service, the posts of Chief Executive and CMO, as described, were appointments in respect of England alone. Each of England, Scotland, Wales and Northern Ireland had its own NHS Chief Executive, and its own CMO. Each reported to the relevant Permanent Secretary (e.g. at the Welsh Office and Scottish Office, which were responsible for the health services in those countries).[21] There was no formal structure or committee dealing with matters of interest or importance common to each of the four constituent parts of the UK. However, there was an informal meeting once or twice a year between the Chief Executives and the

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[17] T52 p. 11 Sir Graham Hart

[18] T66 p. 4–5 Professor Sir Kenneth Calman, former CMO

[19] WIT 0055 0001 Sir Christopher France

[20] WIT 0055 0002 Sir Christopher France

[21] T52 p. 93–7 Sir Graham Hart

relevant Permanent Secretaries, and there was contact at more junior levels on an 'as required' basis between the DHSS/DoH and the Welsh and Scottish Offices. [22] According to Professor Sir Kenneth Calman, the CMOs for England, Scotland, Wales and Northern Ireland also met at two-monthly intervals between 1989 and 1998.[23]

18 Because of the close geographical proximity of Wales to Bristol, the consequent ease with which patients from South Wales could be transported to Bristol, and evidence that the development of cardiac surgical services for infants had an influence on the Bristol unit, the Inquiry also studied the relevant structure of health services in Wales.

19 Healthcare delivery in Wales was not[24] under the auspices of the DoH.[25] Instead, NHS provision in Wales is one of the responsibilities of the Welsh Office, both administratively and financially.

20 Mr Peter Gregory, Director of the NHS in Wales from March 1994 to 1999, stated in his written statement:

> 'The Department of Health was, throughout the period 1984–95, the "lead" UK Health Department, although the Secretary of State for Wales had the responsibility of providing a health service for the people of Wales.'[26]

21 In oral evidence, he said:

> 'The NHS legislation places upon the Secretary of State for Wales the duty of providing health services in Wales. That is not a duty which falls on the Secretary of State for Health.
>
> 'The Secretary of State for Wales has, therefore, the statutory powers to provide health services. As a consequence, the Secretary of State takes decisions about health services in Wales which are relevant to the circumstances of Wales. The Secretary of State is, of course, a member of the United Kingdom cabinet and that imposes its own political restrictions which are not unimportant in terms of developing policies ...'[27]

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[22] T52 p. 93–7 Sir Graham Hart

[23] T66 p. 75–6 Professor Sir Kenneth Calman

[24] And was not at any point during the Terms of Reference

[25] The Departments of Health and Social Security were separated on 26 July 1988 (see evidence of Sir Christopher France, Permanent Secretary to the DHSS until 26 July 1988 after which time he became Permanent Secretary to the DoH, WIT 0055 0001)

[26] WIT 0058 0001 Mr Gregory

[27] T10 p. 72–3 Mr Gregory

The role of the CMO (Wales)

22 Professor Gareth Crompton, CMO for Wales between 1 January 1978 and 31 August 1989, stated in his written statement to the Inquiry:

> 'My role, as CMO Wales, was to be the chief adviser on medical matters arising from and pertaining to the statutory functions of the Secretary of State for Wales. I was, also, the head of the Health Professionals Group.'[28]

The role of the Welsh Medical Committee

23 There was at the relevant time a Welsh Medical Committee which:

> '… is a statutory Advisory Committee to the Secretary of State for Wales. It has a formal function enshrined in the NHS legislation for advice on medical matters to the Secretary of State. … It has been in existence for many years and is the central focus for medical advice to the Department and the Secretary of State [for Wales].'[29]

Links between the Welsh Office and the DoH

24 Mr Gregory explained the links, both formal and informal, between the Welsh Office and the DoH in these terms:

> 'Given the greater resources of the Department of Health, and the need for consistency across England and Wales, or the whole UK, which the medical, nursing and other professions' governing bodies made desirable, the Welsh Office has always sought close informal and formal relationships with the Department of Health.' [30]

25 Mr Gregory said in his statement that liaison between the departments was provided by:

> 'a. Meetings of the 4 UK Chief Medical Officers (CMO) usually quarterly.
>
> 'b. Observer status at the National Specialised Commissioning Advisory Group (NSCAG) and before that its predecessor the Supra Regional [Services] Advisory Group (SRAG) [SRSAG].
>
> 'c. CMO attendance as observer at meetings of the General Medical Council (GMC).
>
> 'd. CMO attendance at meetings of the Joint Consultants' Committee (JCC).

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[28] WIT 0070 0001 Professor Crompton

[29] T10 p. 6 Mr Gregory

[30] WIT 0058 0001 Mr Gregory. See also comment by Sir Alan Langlands in Chapter 7 paras 239–240 concerning the responsibility of the DoH for supra regional services

> ‘e. Observer status on the Joint Planning Advisory Group (JPAG) and following its demise, on the Advisory Group for Medical Education, Training and Staffing (AGMETS).’[31]

26 The nursing links which Mr Gregory identified as existing were:

> ‘a. Meetings of the 4 UK Chief Nursing Officers (CNOs) quarterly.
>
> ‘b. CNO [Wales] has observer status on the Standing Nursing and Midwifery Advisory Committee (SNMAC). This was, and still is, a Committee to advise the Secretaries of State responsible for the health services in Wales and England on nursing and nursing related issues.’[32]

27 Mr Gregory gave written evidence that the administrative links that existed were:

> ‘a. regular meetings of Health Department Accounting Officers (Permanent Secretaries and heads of the NHS in each country).
>
> ‘b. informal meetings of the 3 or 4 Health Departments to discuss issues of mutual interest in respect of specialised services.’[33]

28 Mr Gregory also gave evidence of the less formal links that existed between departments:

> ‘On all sides, there has been regular contact with colleagues in the Department of Health face to face, and by letter and telephone. Ad hoc meetings were arranged where it was thought necessary.’[34]

The influence of DoH policy on the Welsh Office

29 Mr Gregory told the Inquiry that:

> ‘... the Department [Welsh Office] … would not have, I believe, regarded itself as completely fettered in its discretion ...’[35]

30 Mr Gregory added:

> ‘The Department’s [Welsh Office’s] position … would … have been very significantly influenced by the Supra Regional Advisory Group’s conclusions ...’[36]

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[31] WIT 0058 0001 Mr Gregory
[32] WIT 0058 0002 Mr Gregory
[33] WIT 0058 0002 Mr Gregory
[34] WIT 0058 0002 Mr Gregory
[35] T10 p. 73 Mr Gregory
[36] T10 p. 73 Mr Gregory

31 In short, the evidence to the Inquiry was to the effect that, although the Welsh Office, in theory, had discretion to decide its own health policy for the people of Wales, this discretion was, in reality, influenced by the policy being pursued by the DoH in England. The influence of the DoH's policy on the Welsh Office was particularly strong in those specialisms that were part of the group of services which fell under the auspices of the DoH's Supra Regional Services Advisory Group (SRSAG).

32 Before focusing on evidence as to the respective responsibilities which the DoH and NHS took for the clinical care of any individual patient, one further matter should be mentioned. In 1992–1993 the NHSME relocated from London to Leeds. Although Sir Graham Hart told the Inquiry that this placed a strain on communications at least for a while, there was no clear evidence before the Inquiry that it adversely affected decision-making.

Perceptions of responsibility

33 It was suggested to Sir Graham that it was the view of the DoH that the responsibility for the individual patient lay ultimately with the doctor. He responded:

> 'I think the truth is that there is a shared responsibility but a lot of people, organisations and people are involved in this. It is the Secretary of State's responsibility, with his Department, for example, to make sure that enough money is provided so that the Health Service can be run properly. That is his responsibility. It is the responsibility of every consultant or every consultant in the NHS to practise according to good standards of professional conduct and competence. It is the responsibility of the Trust or the Health Authority or whatever that employs that doctor to make sure that he is a suitably qualified person; that he or she has the necessary resources in order to carry out the work that he or she has to do; and at least to supervise in some way or other the quality of what is done.
>
> 'So I think it would be very simplistic, if I may say so, to suggest that there is one person or one organisation which is wholly responsible and has an undivided and total responsibility for this. But I think one can explain properly, and I hope I have done so but I may have failed to do so, pretty well precisely where the boundaries of responsibility are and how they fit together.
>
> 'One has to use words like — I do think, just again to say it, the primary responsibility, when you or I or any of us puts ourselves in the hands of a doctor or the Health Service, the primary responsibility for what takes place lies with the individual doctor. But it is a responsibility which inevitably he shares with his employer, if he is working in a hospital. And the Health Authority or the Trust itself obviously has also to share some of the responsibility higher up the line, because higher up the line also has a part to play. But the centre of gravity, so to speak, has to be at the level of the individual patients. It cannot be satisfactorily discharged from someone sitting in Westminster or Whitehall. We are talking about, you know, millions of events per year of an intensely personal kind involving individuals

> which they passionately care about, and it is quite wrong, really, I think, in any sense, to overplay the central responsibility. I hope, I sincerely hope, that is a realistic description and a proper description of how things are and how they should be, rather than simply seeking to step aside from responsibilities.'[37]

34 Sir Alan Langlands, Chief Executive of the NHS Executive 1994 to 2000, gave evidence to similar effect:

> 'Q. … the Inquiry has heard two opinions about the responsibility or otherwise of the Department of Health, and by that I mean the Supra Regional Services Advisory Group and the Ministers to which it reported, for the quality of the paediatric cardiac services. One is that because it was the Department of Health which as it were provided the money, and which also had direct contractual relationships between the unit and itself, so that this service stood outside the normal purchaser/provider territory, it was the Department that was responsible for ensuring or monitoring and assessing the quality of the service that was being provided.
>
> 'The alternative view that has been expressed by officials within the Department of Health is that it was the health authorities – this is "health authorities" unspecified – that retained that role as part and parcel of their public health functions and that the funding mechanism that was represented by the Supra Regional Services Advisory Group did not alter that basic public health responsibility. Can you comment on that conflict of views?
>
> 'A. I do not think I am willing to choose either/or. I think I fall back on my point. What I want to avoid at all costs is any notion that somehow no-one is responsible, because I do not believe that to be the case, but I believe that the clinicians directly involved in provision of that service have some responsibility. Health authorities and the Trust which was the home to that service have some responsibilities, as we discussed earlier this morning, and the Department of Health clearly had some responsibilities, not just in relation to resource allocation in my view, back to this point about systemic failure, but to ensure that there was a system in place that ensured that these services were being properly provided. I think that the crucial thing would be to be absolutely sure in each of these cases that the roles and responsibilities, the distinctive roles and responsibilities of each of these players, was adequately defined.'[38]

35 In relation to supra regional services, Sir Graham Hart was later to say that the roles were not, in his view, adequately defined.[39]

36 The Inquiry was told that the DoH, under the direction of the Secretary of State, had responsibility for: (i) policy rather than operations[40] (thus the provision and the

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[37] T52 p. 107–8 Sir Graham Hart

[38] T65 p. 61–2 Sir Alan Langlands in the context of questions about responsibility for supra regional services

[39] WIT 0040 0001 Sir Graham Hart

[40] WIT 0335 0008 Sir Alan Langlands

distribution of resources in the form of money, capital development and to an extent the workforce, and the determination of policy for and about the NHS was undoubtedly a responsibility that the department accepted);[41] (ii) 'more problematically'[42] for ensuring the implementation of policy and a high standard of performance by the NHS. ('Performance' is to an extent an ambiguous word, the meaning of which has changed over time: it may have to be understood as referring to finance, rather than clinical outcome. Sir Alan Langlands emphasised the requirement upon the NHS Executive to 'manage the performance of the NHS – including securing and allocating NHS resources …'[43] and told the Inquiry that, in 1999, finance and performance were linked in one post within the NHS Executive HQ;[44] Dr Peter Doyle, Senior Medical Officer, DoH, told the Inquiry that when the Performance Management Directorate was set up at the DoH, the performance with which it was concerned was 'primarily' to be understood in the financial sense.[45])

37 This range of responsibilities was reflected in the formal accountability of local administration. After 1991, local administration was increasingly carried out by trusts. Sir Alan told the Inquiry:

> '… all Chief Executives of NHS Trusts and Health Authorities have, since 1995, been designated as "accountable officers". This will be extended to Chief Executives of Primary Care Trusts. This means that they are answerable to Parliament through me for the efficient and proper use of the resources in their charge. In case of serious management failure they would be expected to accompany me to answer personally before the Parliamentary Public Accounts Committee'.[46]

The legal accountabilities of a trust to the Secretary of State (and hence those matters over which the DoH would have immediate control) were predominantly concerned with financial performance and management.[47]

38 Further, following the introduction of hospital trusts, the NHSME set up regional 'outposts' to monitor the financial performance of trusts.[48] The function of these was described as:

> '… very much based on the financial arrangements of the trust; they were there — not I think exclusively, but certainly one of their main functions was to monitor the financial health, to handle capital allocation, that kind of thing.'[49]

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[41] WIT 0040 0001 Sir Graham Hart

[42] WIT 0040 0001 Sir Graham Hart

[43] WIT 0335 0008 Sir Alan Langlands

[44] NHS Executive HQ, as at September 1999; the post holder had responsibility for 'monitoring and analysis of NHS performance'

[45] T67 p. 50 Dr Doyle. It should be noted that the Performance Assessment Framework introduced in 1999 now has responsibilities which specifically include assessment of 'health outcomes of NHS care'

[46] WIT 0335 0009 – 0010 Sir Alan Langlands

[47] HOME 0002 0202; *'Managing the New NHS'*

[48] T52 p. 85–6 Sir Graham Hart

[49] T52 p. 86 Sir Graham Hart

39 In reviewing the evidence as to the extent to which (and the sense in which) the DoH and the NHSME accepted responsibility for the care of patients, a distinction has to be made between non-clinical and clinical care. To the extent that the DoH and the NHSME were concerned with 'quality', it was defined until recently by reference to non-clinical care: the Patient's Charter, when introduced in October 1991, focused on non-clinical standards. The purchaser-provider contracts tended to focus on cost, volume and other non-clinical measures.[50]

40 When looking, on the other hand, at responsibility for the quality of clinical care, the DoH (including the NHSME) appeared to some observers to regard itself as having very little responsibility. According to Dr Phillip Hammond, a local GP and journalist:

> '… the DoH seems to show little appetite to have a "controlling mind" and appears unable to act to protect patients without the full agreement of the relevant professional bodies who are, by their nature, self-protective'.[51]

41 The evidence given on behalf of the DoH was, indeed, that it adopted a 'hands-off' approach so far as individual clinical care was concerned (this approach was said to be changing during the period with which the Inquiry is concerned).[52] Thus, Sir Alan Langlands said, in relation to the early 1990s, when asked about interventions by the Department in response to a trust's apparent failure to provide a proper quality of care (at least in relation to failure to meet numerical targets in respect of finance or waiting lists):

> '… mixed messages emerged from the Department of Health. On the one hand there was a clear signal that we should, from a regional perspective, have a definite hands-off approach in relation to trusts. On the other hand, we would be expected from a regional level to pick up the pieces if something was going wrong. So that was a time of rather confused accountabilities in that regard.' [53]

42 A number of reasons for such a hands-off approach were advanced by those from the DoH who gave evidence. First was clinical freedom. Sir Graham Hart recalled:

> '... if you go back to my early days, so to speak, of involvement in all this, which would be in the 1960s, and even roll it forward to the early 1980s, really, there was a feeling around – this can be oversimplified – that clinical freedom meant that the centre – Ministers, in effect – should keep out of anything to do with the practice of medicine …'.[54]

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[50] T65 p. 51 Sir Alan Langlands

[51] WIT 0283 0043 Dr Hammond

[52] T65 p. 13 Sir Alan Langlands

[53] T65 p. 13 Sir Alan Langlands

[54] T52 p. 33 Sir Graham Hart

43 He also observed:

> 'There was a deeply-rooted reserve on the part of the Department – shared by the professions – about Departmental involvement in clinical performance. This was in general seen as the preserve of clinicians, individually and to some extent collectively.'[55]

44 This view was echoed by clinicians themselves, with an emphasis on individual rather than collective responsibility. Indeed, the latter was discounted. For instance, Professor Leo Strunin, President of the Royal College of Anaesthetists (RCA), told the Inquiry that:

> '... it was fairly common back ten years when people thought, "Well, as long as I am doing a good job it is not actually my problem what is occurring around me"'.[56]

45 Such a view was emphatically expressed by Dr John Roylance, Chief Executive of the UBHT 1991–1995, from the perspective even of local management:

> 'Q. Can we have your statement, WIT 108, page 20. I am going to ask you in a moment about the paragraph beginning: "In respect of senior medical staff ... ." Did you regard medical staff as professionals?
>
> 'A. Yes.
>
> 'Q. In effect, once appointed, was it part of the consequence of clinical freedom that they were self-teaching and self-correcting?
>
> 'A. Yes.
>
> 'Q. Did you take the view, therefore, that it was not for managers to interfere?
>
> 'A. I recognised that it was impossible for managers to interfere.
>
> 'Q. So essentially, the clinician at the bedside made the decision which he or she thought was in the best interests of the patient?
>
> 'A. Yes.
>
> 'Q. And management felt that it could not, and should not, interfere?
>
> 'A. And does not, in any part of the Health Service.'[57]

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[55] WIT 0040 0002 Sir Graham Hart

[56] T14 p. 4–5 Professor Strunin

[57] T24 p.14–15 Dr Roylance

46 A second reason for not accepting responsibility for individual clinical outcomes was that national responsibility for local activity would be impracticable. A third was that there was no effective power in central management to intervene. A fourth was that in any event the responsibility for the individual patient's care lay elsewhere, principally with the hospital doctor (or at least the consultant).

47 The first of these reasons has already been outlined. Part of it was a view as to the proper role of central government in creating (in respect of services such as paediatric cardiac surgical services) the '… right kind of environment in which the tendency would be towards limitation and specialisation' as opposed to '... putting down an absolutely rigid framework within which there was no room for movement at all.'[58] Part of it was a view (held by the profession itself), that the DoH should not get 'involved with anything to do with the clinical treatment of patients'[59] since this was the proper preserve of the individual clinician.

48 The second reason, the impracticability of taking responsibility at national level for local operations, was described as follows by Sir Alan Langlands:

> '… it is impossible, and certainly undesirable, for the NHS Executive to monitor the treatment of individual patients or patient groups';[60]

and by Sir Graham Hart:

> 'It is simply impracticable for the Secretary of State to be in any detailed sense responsible for what goes on every day in every hospital ... it is quite impractical, and I think wrong, for the Secretary of State or the Department on his behalf to try to superintend or supervise or be involved in routinely what is going on in each and every hospital, health centre and so on. It is just not practicable.'[61]

49 The third reason, the lack of powers, was expressed in the following terms in relation to hospitals *before* trust status was introduced:

> '… if the Secretary of State had tried to, as it were, put on his hobnailed boots and go down to a particular place and say, "Stop doing that". You could have done it, but it might not have been very wise and I think you would have had to have had some very good specific reasons, not just general reasons.'[62]

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[58] T52 p. 25–6 Sir Graham Hart

[59] T52 p. 36 Sir Graham Hart

[60] WIT 0335 0002 Sir Alan Langlands

[61] T52 p. 3–4 Sir Graham Hart

[62] T52 p. 24 Sir Graham Hart

50 Sir Alan Langlands said (in respect of the time *after* trust status was introduced) that the Secretary of State for Health could not tell trusts what to do:

> 'The NHS (Management) Executive was to manage the NHS primarily through Health Authorities. NHS Trusts were given greater freedom to manage more of their own affairs. They were accountable to the NHS Executive for meeting their financial targets and to Health Authorities through the contracting process for the volume and quality of services they provided. The Secretary of State had no power to direct NHS Trusts in respect of the services they provided.'[63]
>
> 'Q. … the members of the Trust Board, and in particular the Chairman, were appointed, were they not, by the Secretary of State?
>
> 'A. That is correct, and the Secretary of State, while having no powers to direct Trusts in the way at that time that he would direct health authorities, and that would be the contrast I would make, did, however, have powers to remove the Trust Chairman or the Trust Chairperson and members of the Trust Board.
>
> 'Q. On specified grounds?
>
> 'A. On specified grounds.
>
> 'Q. Were those grounds linked to the financial performance of the Trust or were they more widely framed?
>
> 'A. I could not remember offhand what the legislation says, but certainly the interpretation on the rare occasions when this in my experience happened was drawn more widely than just financial failure.
>
> 'Q. More widely so as to encompass what factors?
>
> 'A. In my experience of this, to encompass factors like the breakdown of the relationship between the non-executive group, the managers and sometimes the clinical staff in the hospital. In other words, where relationships became dysfunctional to the point at which they impeded the proper work of the Board.'[64]

51 The DoH's apparent position, therefore, was that the best that could be done from the centre was to exercise persuasion to influence local units. Thus Sir Graham Hart said:

> 'I think it is very questionable what, as it were legal powers the Secretary of State would actually have had to stop a unit from carrying out … procedures';[65]

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[63] WIT 0335 0004 – 0005 Sir Alan Langlands

[64] T65 p. 7–8 Sir Alan Langlands

[65] T52 p. 21–2 Sir Graham Hart

and Sir Alan Langlands noted that:

> 'The Secretary of State, in legislation, had no power to direct Trusts [which may have been in difficulty because of the quality of service they were providing], but would seek to influence these Trusts and would use the team that supported him or her, the management team, to exert that influence. So whilst there was no direct power, there was very strong central influence where things were going wrong … .'[66]

52 One means of persuasion was the use of CMO's letters issued to publicise good practice.[67] However, there was no mechanism to monitor compliance with the advice and guidance in relation to clinical issues which was seen to be the prime concern of others, such as the Royal Colleges. Thus former CMO, Professor Sir Kenneth Calman said:

> 'The Department of Health from time to time issues guidance on management, but not generally in relation to clinical practice unless based on professional views from outside the Department.'[68]

53 The perceived lack of power, the need for persuasion rather than coercion, and the view as to the proper role of central Government, were reflected in a reluctance to become involved in controversy:

> '... if Ministers might be tempted to tread down that path of involvement and intervention, then they could be pretty sure that there would be a tremendous row about it with the profession, and that is something which you certainly do not want to do without forethought';[69]

> '… a Minister would always think twice or three times about, as it were, entering into a controversy with a particular unit or series of units by saying, "I want you to stop doing this", unless, as I say, there was some really good evidence';[70]

and (with specific reference to the de-designation of a particular unit as a supra regional centre):

> '… if [the Minister's] only ground for doing it was, "We have this general policy which is in favour of these procedures being done in a few centres and that is why we have supra regional services and you are not one of the chosen few, so to speak, so I want you to stop for that reason", I think that would be [a] very difficult argument to carry off in a situation of public controversy.'[71]

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[66] T65 p. 11 Sir Alan Langlands

[67] T66 p. 18 Professor Sir Kenneth Calman

[68] WIT 0336 0003 Professor Sir Kenneth Calman

[69] T52 p. 37 Sir Graham Hart

[70] T52 p. 22 Sir Graham Hart

[71] T52 p. 22 Sir Graham Hart

54 The fourth reason, that the responsibility for the quality of clinical care lay elsewhere, was stated by witnesses who gave evidence on behalf of the DoH. Sir Graham Hart said that the mainstay of quality was in the hands of healthcare professionals themselves and the trusts who selected and employed them:

> ‘A. … the mainstay of quality, as I have tried to say throughout, the main safeguard as far as patients and the public are concerned, should lie in the qualifications and the professional conduct and whatever of the people who are chosen very carefully to carry out this work — the consultants.
>
> ‘Q. The doctors?
>
> ‘A. The doctors, and the other professional staff who work with them. And in the hands of the people who employ them, the trusts and so on and so forth. That is the main safeguard.’[72]

55 Doctors themselves did not easily acknowledge this notion of collective responsibility, even that of clinical teams:

> ‘... [the concept in] most doctors’ minds [was that] … of accountability primarily to the patient and peers.’[73]

56 Sir Graham Hart thought that:

> ‘It must be the case that the primary responsibility for clinical practice, wherever it is, lies with the doctors actually carrying it out. They do not get a very good airing on this, but actually that is the foundation of this whole system.’[74]

57 Professor Sir Kenneth Calman’s view was that the immediate treating clinician would ‘probably’ have responsibility for the delivery of care, adding:

> ‘I say that because it would be the consultant who would have the overall responsibility, rather than the doctor in training themselves.’[75]

58 Sir Graham echoed Sir Kenneth’s view as to the role of the consultant, but expanded on the context:

> ‘It is the personal responsibility of the consultant to carry out their work conscientiously and competently, and on the people who employ them, which in this case is the Trust or before that the Health Authority. So of course they have a primary responsibility.’[76]

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[72] T52 p. 103–4 Sir Graham Hart

[73] WIT 0051 0003 Sir Donald Irvine

[74] T52 p. 101 Sir Graham Hart

[75] T66 p. 20 Professor Sir Kenneth Calman

[76] T52 p. 101–2 Sir Graham Hart

59 A clinician taking responsibility for his own practice may not secure good clinical care for an individual where he may lack the insight, skills, knowledge or perspective to appreciate what constitutes proper care in the context, even though his complete integrity is in no doubt. The Inquiry sought evidence, therefore, as to the level at which (and by whom, apart from the individual clinician) responsibilities for the competence of a clinician were discharged.

60 Sir Alan Langlands thought that guarantees of good clinical performance (at least between 1989 and 1999) derived from:

> '… the practice of individual clinicians and clinicians working in teams. The commitment of these individuals and teams to agree the standards of practice that they are trying to achieve, to audit and compare progress against these … .'[77]

61 Above the clinical team, Sir Kenneth regarded responsibility as lying with the employing trust[78] and then the Regional Director of Public Health or the GMC:

> 'A. If you are working in a team or a group of individuals, if there is a competence issue, then that might be picked up and be dealt with at that level, for example. Beyond that, it would be the Trust through the Medical Director or in pre-1989 terms, Medical Superintendent. Beyond that, it would be the governing body or Trust Board, and beyond that, to the Regional Director of Public Health.
>
> 'Q. And beyond the Regional Director of Public Health?
>
> 'A. It would depend on the issue, but if this was an issue of competence, it would go to the General Medical Council.' [79]

62 Both Sir Alan and Sir Kenneth explained further the role and responsibilities of the Regional Director of Public Health. Sir Alan said:

> 'Within the NHS Executive we have alerted staff to the procedures they should follow if they are approached with informal reports of poor clinical performance. In all cases the information should be passed to the Regional Director of Public Health who takes responsibility for ensuring that adequate investigation and follow-up actions are taken.'[80]

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[77] T65 p. 56 Sir Alan Langlands

[78] The composition of the Trust Board is outlined in Chapter 8

[79] T66 p. 21 Professor Sir Kenneth Calman

[80] WIT 0335 0017 Sir Alan Langlands

63 Sir Kenneth told the Inquiry:

> 'Q. Is it the case that the Director of Public Health at the Regional Health Authority would be regarded within the Department of Health as being part of the Department of Health, albeit at a lower level than the central level?
>
> 'A. Yes, and in fact over the period of time as part of this Inquiry, it would be seen very much as part of it, and indeed, nowadays the regional office is part of the enquiry.
>
> 'Q. So it is a false distinction to talk of the Department of Health and then the Director of Public Health; the distinction would be between central and regional aspects of the Department; is that accurate?
>
> 'A. That is a very neat way of producing it. I saw Dr Scally [Regional Director of Public Health] as very much part of us, if you like.
>
> 'Q. Does the same apply to the Regional Medical Officer?
>
> 'A. Exactly the same. I mean, some of the relationships, going back a little bit further, are slightly different, but in general, that would be the same principle, yes.'[81]

64 Central responsibility for individual clinical outcomes was therefore not accepted, for the four broad reasons identified in evidence and examined in paras 42–63 above. Acceptance of responsibility for the provision of services of a particular type was also limited.

65 As to the provision of services, the view from the centre was that:

> 'By 1984 this responsibility [for providing hospital services] fell for the most part on about 200 District Health Authorities [DHAs], which were accountable to 14 Regional Health Authorities (RHAs) which in turn were accountable to the Secretary of State.'[82]

66 Sir Graham told the Inquiry:

> 'A. Back in the 1980s Districts were, as you know, responsible for the management of the individual hospitals, yes.
>
> 'Q. And the District responsible to the Region?
>
> 'A. Correct.

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[81] T66 p. 91–2 Professor Sir Kenneth Calman

[82] WIT 0040 0001 Sir Graham Hart. The statutory responsibilities of the RHAs and DHAs are dealt with in Chapter 5

> ‘Q. And the Region to the centre?
>
> ‘A. Correct.’[83]

67 Central power was, however, diluted by the structure. Sir Graham Hart told the Inquiry:

> ‘… there are a whole series, many hundreds of statutory bodies set up by Parliament, who are responsible for running the services locally, and who have a responsibility to decide what goes on in those hospitals. That is bound, and very properly, to dilute the power which lies at the centre.’[84]

68 In addition to issues of responsibility and influence, there were practical difficulties that hindered the development of methods for the measurement and assessment of the quality of clinical performance. Sir Graham told the Inquiry:

> ‘Q. … [quoting the Griffiths Report] “Surprisingly, however, it [the NHS] still lacks a real continuous evaluation of its performance against criteria such as those set out above … . Rarely are precise management objectives set. There is little measurement of health output. Clinical evaluation of particular practices is by no means common and economic [evaluation] of those practices extremely rare.” Leaving aside the economic evaluation and leaving aside the question of output, the number of operations done, clinical evaluation of particular practices is by no means common. In this paragraph as a whole, what Griffiths appears to be observing and, the implication is, complaining about, is that the NHS had no proper measurement of the quality of the care it was providing in general terms. First of all, from your own perspective, was he probably right about that, at the time?
>
> ‘A. Yes. I mean, I would say, I think, what he was saying was that there was no system, if you like. Some of these things happened, but they did not happen in an organised and systematic way. I think that is true. He was spot-on, there.[85]
>
> ‘The 1983 report to the Secretary of State by the late Sir Roy Griffiths recommended not only the introduction of general management in the NHS, but also the reform and strengthening of the Department’s internal organisation and mechanisms for discharging its responsibilities in respect of the NHS. … there was to be a particular emphasis on policy implementation and performance management in respect of the NHS. This was an area of activity in which the Department had already begun to recognise the need for improvement. …[86]

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[83] T52 p. 73–4 Sir Graham Hart

[84] T52 p. 27 Sir Graham Hart

[85] T52 p. 35–6 Sir Graham Hart

[86] WIT 0040 0001 Sir Graham Hart

> ‘Although much data on clinical outcomes and performances was available [in the 1980s], it was not used systematically, except in limited contexts, and then by professional organisations. National systems such as the Confidential Enquiry into Maternal Deaths were very much the exception.[87]
>
> ‘As I have said I think later on in the statement, the Department’s responsibilities – functions, at any rate – tend to be very much of a kind of strategic and general kind related to policy, to the provision and distribution of resources, and at a high level, I suppose, the implementation of policy and performance, although, as I say in my statement, I think these are rather more problematical areas and ones where, over the years, I think probably the position has changed somewhat.’[88]

The Performance Management Directorate

69 A Directorate within the DoH dealt specifically with ‘performance management’. The potential significance of this for the Inquiry arises from a letter of 21 July 1994, in which Dr Doyle wrote to Professor Gianni Angelini, Professor of Cardiac Surgery, University of Bristol, as follows:

> ‘It has recently been brought to my attention that there are concerns about the mortality rates for paediatric, especially neonatal and infant, cardiac surgery performed at the BRI. … If there is a problem and, for any reason, you are not able to reassure me that it has been resolved, the circumstances are such that I would be obliged to seek the help of colleagues in the Performance Management Directorate, who would doubtless raise the matter formally with the Trust. It is highly likely that some sort of formal enquiry would follow.’[89]

70 Counsel to the Inquiry asked Dr Doyle:

> ‘Q. So the performance [that the Performance Management Directorate addresses] is to be understood in the sense of keeping to financial targets, is it?
>
> ‘A. Primarily financial, but there are also other elements, other guidances that have gone out to Trusts, so if there is a clear failure of Trust management in any issue, then the performance directorate would certainly want to be involved because in whatever area of Trust management there is a clear breakdown, this then becomes the responsibility of the Trust Board, the Chairman, the Chief Executive, to deliver on those bits of guidance that have gone out to the Trusts. So they would certainly want to know about clear evidence that a Trust had failed in its duties. If a Trust failed to resolve a situation like this, that is a failure of Trust management.

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[87] WIT 0040 0002 Sir Graham Hart

[88] T52 p. 4 Sir Graham Hart

[89] UBHT 0052 0287; letter from Dr Doyle to Professor Angelini, 21 July 1994

‘Q. So performance management, largely financial but also other management aspects. What would they do? What could they do?

‘A. I think that would depend on the circumstances. Clearly the Secretary of State has the right to set up any form of investigation or enquiry.

‘Q. That is the Secretary of State. What about the Performance Management Directorate?

‘A. The Performance Management Directorate is an arm of the formal mechanisms for managing the NHS.

‘Q. What could they do to alert the Secretary of State that you could not?

‘A. If they had become aware of the problems, presumably they would have alerted other colleagues in the Department to the problem.

‘Q. Why could you not do that?

‘A. At this stage ...

‘Q. Not why did you not, but why could you not?

‘A. I could have done.

‘Q. So the Performance Management Directorate is a directorate which exists for the purposes you have mentioned. It had no more power – I think is what you are implying – than you did to act, the acting in circumstances where there is a failure of management control consisting of notifying other people who may be able to apply such pressure as they have at their disposal?

‘A. Their formal job within the responsibility of the Department was to look at the management of Trusts. Mine were very difficult responsibilities, to look at policy development in cardiac services. So they did have a formal requirement to look at the performance of Trusts.

‘Q. What was it about the problem as you understood it to be that made you think there may be a failure of management?

‘A. If the Trust failed to tackle a clear issue for which there was a clear mechanism for dealing with it and allowed that problem to go unresolved, that, in my book, is a failure of Trust management.’[90]

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[90] T67 p. 52–4 Dr Doyle

71 Dr Jane Ashwell, Senior Medical Officer, was asked about the role of the Performance Management Directorate:

> 'Q. You will have seen … the letter from Dr Doyle to Professor Angelini we looked at earlier, if I can look at it again. It is UBHT 0052 0287, the last paragraph on that page: "If there is a problem and for any reason, you are not able to reassure me that it has been resolved, the circumstances are such that I would be obliged to seek the help of colleagues in the Performance Management Directorate, who would doubtless raise the matter formally with the Trust. It is highly likely that some sort of formal inquiry would follow." You heard Dr Doyle explain what that directorate was and why it might have been an appropriate body to intervene. Do you agree with the evidence he gave about that?
>
> 'A. I do not think it was my opinion at the time that the Performance Management Directorate actually dealt with clinical practice. It would be much more concerned with financial management, corporate governance, those kinds of issues. That was my opinion.'[91]

The Clinical Outcomes Group

72 On 13 December 1993 Dr Ashwell wrote to Dr Stephen Bolsin, consultant anaesthetist, 'The CMO's committee … should address these sorts of issues [poor clinical performance]'. Dr Ashwell told the Inquiry:

> '… I think it was probably something to do with the Clinical Outcomes Group. That is the only thing I have actually managed to work out and that was a committee I was not on but I knew a little of, to do with looking at the development of medical audit, the sorts of issues I am referring to are dealing with outcome, audits and outcome … .'[92]

Changes since the period of the Inquiry's Terms of Reference

73 A number of changes in approach and view since 1995 were highlighted in evidence. Sir Graham Hart told the Inquiry:

> 'I think these days there is a greater interest at the centre in policy implementation and performance of the NHS than there was originally. That is an area where I think attitudes have changed somewhat, practice has changed somewhat, over the years.'[93]

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[91] T67 p. 183–4 Dr Ashwell

[92] T67 p. 183 Dr Ashwell

[93] T52 p. 4 Sir Graham Hart

74 As a result of the Bristol experience and other factors, the DoH[94] and government ministers are now more willing to intervene generally. Sir Alan Langlands thought that:

> '… current Ministers have no hesitation about intervening in areas where they feel, rightly in my view, responsible and where they feel they have to act. … So I think attitudes have been changing over time, and I think that really the point I want to get across here is a sort of evolutionary point: that through all of this, the relationship between the government medical profession and the public has been changing … issues of public accountability and self-regulation have to be in keeping with the current public mood. They cannot somehow be rooted in the past or in sort of romantic notions of clinical freedom in a bygone age. We are living in a different world.'[95]

75 Examples of where the willingness of the DoH to use its influence has changed UK clinical practice are heart transplants and the Kasai procedure for biliary atresia. Following a departmental press release, No 1999/0268 of 30 April 1999, Counsel to the Inquiry was able to tell the Inquiry that:

> 'We have heard what has recently happened with the Kasai procedure for biliary atresia, where we are given to understand that the Department has secured as a result of representations made to it that no more than three centres in England should conduct this particular form of procedure, the idea being, as we understand it, that otherwise the numbers of such operations would not be sufficient to ensure that any one team of clinicians had the sufficient expertise, quite apart from the necessary facilities.'[96]

76 Current interest in the supervision of poorly performing doctors by the DoH or its representatives is exemplified by an internal minute of 9 December 1996 from Dr Graham Winyard, Deputy CMO 1993–1998, to all Branch Heads and above in the NHS Executive, which advised staff who became aware of allegations about poorly performing doctors that they should report the matter to the appropriate Regional Director of Public Health.[97] The note adds, however, that:

> 'Simply notifying the Department of Health does not absolve people from taking local action within their own organisation, and they should be reminded of this.'[98]

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[94] T65 p. 79 Sir Alan Langlands

[95] T65 p. 105 Sir Alan Langlands

[96] T66 p. 28 Counsel to the Inquiry

[97] WIT 0335 0043 Sir Alan Langlands. The note 'Handling Reports of Service Problems Post Bristol' is at WIT 0335 0193

[98] WIT 0335 0193 Sir Alan Langlands

77 The introduction of new surgical techniques has, since 1996, been managed under the Safety and Efficacy Register of New Interventional Procedures (SERNIP). Professor Sir Kenneth Calman explained the operation of SERNIP:

> 'The principal safeguard [for ensuring that the introduction of new surgical techniques is managed safely] – beyond the work of local ethics committees – is the Safety and Efficacy Register of New Interventional Procedures (SERNIP). This voluntary system, which is independent of the Department of Health, was set up under the auspices of the Academy of Medical Royal Colleges in 1996 and continues to receive funding from the Department of Health.
>
> 'SERNIP is staffed by a part-time clinical director and a full-time administrator, and is supported by an Advisory Committee whose membership includes 11 representatives of the Medical Royal Colleges, and representatives from the Standing Group on Health Technology, the Medical Research Council and the Medical Devices Agency. The Department of Health has observer status on the Committee.
>
> 'A clinician when considering introducing an innovative procedure into his/her clinical practice is encouraged to contact the SERNIP office; alternatively, the enquiry may come from a Trust or commissioner. If the procedure in question is already on the register, the SERNIP office notifies which of four categories it has been assigned to. If it is not on the register, they arrange for an assessment of the intervention by a professional advisory committee, based on the published literature, to assign a category.
>
> 'In their current form the four categories are:
>
> - 'Safety and efficacy established: procedure may be used
> - 'Efficacy established. Further evaluation required to confirm safety: procedure can be used as part of a surveillance programme registered with SERNIP
> - 'Safety and efficacy not proven: should be used only as part of a primary research programme, using appropriate methodology and registered with SERNIP
> - 'Safety and/or efficacy shown to be unsatisfactory, should not be used.
>
> 'The Committee's advice is then notified to the clinician who raised the original enquiry. A summary of SERNIP's recommendations is also circulated to health authorities. SERNIP has so far categorised over 100 operations and procedures.
>
> 'If a surgical intervention involves the use of a *medical device*, the device is subject to statutory regulation under the terms of the two European Directives (a third directive covering in-vitro diagnostics will come into force in June 2000).

> Essentially, these provide safeguards about the safety and performance of the device, in particular that any risks associated with use of the device are acceptable when weighed against the benefits to patients. The Directives also establish procedures for post-market surveillance and reporting of adverse events. The competent authority in the UK for overseeing the application of the Directives is the Medical Devices Agency (MDA). …
>
> ‘The Department of Health and the Academy of Medical Royal Colleges are currently reviewing SERNIP. In particular they are considering the steps needed to ensure the participation of clinicians across all relevant specialties; detailed aspects of the process, including the possible need for a formal “appeals” procedure; and relations to the MDA and the National Institute for Clinical Excellence [NICE].’[99]

78 SERNIP was set up following problems with the introduction of laparoscopic surgery. The May 1994 report *‘Quality Assurance: The Role of Training, Certification, Audit and Continuing Professional Education in the Maintenance of the Highest Possible Standards of Surgical Practice’* of the Senate of The Royal Surgical Colleges of Great Britain and Ireland stated:

> ‘New techniques and procedures that are developed after an individual’s training has been completed will be dealt with by the continuing professional education programme (see Section 3). …
>
> ‘3. Continuing Professional Education
>
> ‘The profession believes that new techniques should be dealt with in the following manner:
>
> ‘a. New techniques must be detected, through literature, communication and conference reviews, when they are first made public.
>
> ‘b. If a technique is considered by the profession to be sufficiently novel as to require special training and assessment before being introduced into general clinical practice, its initial use should be controlled and limited to a number of specified centres for clinical trial. The Colleges are now devising the mechanisms for achieving such control. …
>
> ‘The problem for surgeons will be the definition of what is sufficiently new and different from existing practice to demand such control. Most technical developments are simply minor improvements on an existing technique.’[100]

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[99] WIT 0336 0021 – 0023 Professor Sir Kenneth Calman

[100] WIT 0048 0143 – 0145; *‘Quality Assurance: The Role of Training, Certification, Audit and Continuing Professional Education in the Maintenance of the Highest Possible Standards of Surgical Practice*’

79 Sir Barry Jackson, President of the Royal College of Surgeons, told the Inquiry:

> 'If you look in (b) [WIT 0048 0144] it says "the Colleges are now devising the mechanisms for achieving such control". They did this by setting up the Safety and Efficacy Register, New Interventional Procedures, SERNIP for short, which was developed in the 12 months after this document was published. It was actually formalised at the beginning of 1996, and widely publicised amongst purchasers, Trusts, clinicians, specialty associations and such like, whereby new techniques should be referred to this new body, SERNIP, for careful assessment as to whether or not this was a technique that could be recommended to Trusts and purchasers for widespread implementation, or whether it needed further refinement, proper controlled trial assessment, or whether it was found wanting. This body, SERNIP, has now been working for three years and has, by common consent, been reasonably – I say "reasonably" rather than "wholly" – successful in its aims and objectives. Only "reasonably", because it has not always had everything referred to it for assessment. It is a voluntary system of referral, and there have been one or two things that have just not been referred to it, but by and large, it has worked, I think, terribly well and its funding, which is Department of Health funding, has been extended for a further one year pending discussions with the new body, the National Institute of Clinical Excellence, and how it might interrelate with that new special authority, NICE.
>
> 'Q. So the mechanism set up in 1996 was SERNIP?
>
> 'A. Yes.
>
> 'Q. Prior to SERNIP, would it be the case that the identification of a new technique which raised ethical issues or issues of training would be reliant upon the surgeons concerned and that they might, if they needed advice, be reliant on local ethics committees or research committees to discuss the problems raised by new techniques?
>
> 'A. You would be right in that, yes.'[101]

80 SERNIP categorised procedures into four; however, Mr Julian Dussek, President of the Society of Cardiothoracic Surgeons, wrote:

> 'It [SERNIP] incorporates a method of identifying and registering new international procedures whose safety and efficacy have not been established and advising on how they may be evaluated in a controlled way. … Unfortunately, admirable as the system is, it does not deal with the actual problem of a surgeon learning a new operative technique.'[102]

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[101] T28 p. 104–6 Sir Barry Jackson

[102] SCS 0003 0002; Dussek, J. *'Avoiding the Learning Curve'* (13 September 1998)

81 The expert evidence on the issue of innovation in surgery is set out in Chapter 19.

82 In so far as the change in approach described by Sir Graham Hart relates to a greater willingness to be prescriptive about what services may be provided, Professor Sir Kenneth Calman explained that the DoH can prevent, on ethical grounds, a new technique from being introduced: '… government at that level has a fairly strong veto on the kind of things that can and cannot be done'.[103] He cited the example of xenotransplantation.

National regulatory and professional bodies

83 There is a multiplicity of regulatory, professional and specialist bodies and associations in medicine, nursing and the other healthcare professions. They may set, monitor and enforce standards and support practitioners. This overlap of bodies and of both functions and the responsibilities for these functions is addressed in the following paragraphs.

84 The evidence was that the proliferation of such bodies led to a degree of lack of co-ordination so far as regulation was concerned. Sir Donald Irvine, President of the GMC, told the Inquiry:

> 'Q. … if one were to look at the system of regulation as a system involving the GMC, the employer, that is the National Health Service or the Trust as may be the case, and the other regulatory bodies such as the Ombudsman, the court system and so on, would you describe the period from 1984 to 1995, at any rate, as one in which the system was co-ordinated in any way between those regulatory bodies?
>
> 'A. Co-ordinated up to a point, but I have expressed my opinion about this in public before. I do not believe the system was as well co-ordinated as it might have been, or should be.'[104]

Professional regulation – medicine: the GMC

85 The GMC is concerned with the practice of medicine; the United Kingdom Central Council (UKCC) with nursing. Both have a statutory basis. The Inquiry received evidence as to the GMC's statutory powers and duties from Mr Finlay Scott, Chief Executive and Registrar of the GMC, who also detailed the statutory rules relating to

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[103] T66 p. 69 Professor Sir Kenneth Calman

[104] T48 p. 20–1 Sir Donald Irvine

the GMC's procedures in respect of the conduct, health and performance of doctors.[105]

86 Sir Donald Irvine gave details of the GMC's statutory responsibilities, committee structure, and disciplinary procedure.[106] Mr Scott told the Inquiry:

> 'The GMC licenses doctors to practise medicine in the United Kingdom and has four main functions:
>
> 'a. Keeping up-to-date registers of qualified doctors.
>
> 'b. Fostering good medical practice.
>
> 'c. Promoting high standards of medical education.
>
> 'd. Dealing firmly and fairly with doctors whose fitness to practise is in doubt on grounds of conduct, health or performance.'[107]

87 Only since 1997 has the GMC had its specific power to deal with doctors whose fitness to practise is in doubt on the ground of performance.[108]

The approach of the GMC

88 Sir Donald took the view that the primary responsibility for the quality of clinical care rested with individual clinicians:

> 'I am saying, in this paragraph,[109] how vital it is to recognise that for the patient the quality of the consultation and all that flows from that in terms of diagnosis and treatment is immensely dependent on the integrity and the ability of the doctor to try and get things right. Most decisions in medicine – not just general practice – are still taken in relative privacy. It is that recognition of that very fundamental fact that leads us, or has led us in the GMC, to place such an emphasis on the culture. You cannot supervise the millions and millions and millions of independent individual decisions that are made about, "Is it this treatment rather than that?", "Is it this pill?", "Do I do this now or at another time?", et cetera. So the whole system I am putting here has to be geared to trying to make sure that doctors get it right first time as often as possible, and conduct themselves in a way that patients find helpful and which they expect.'[110]

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[105] WIT 0062 0002, 0016, 0018, 0020, 0021, 0022 Mr Scott. Mr Scott also includes a table of statutory amendments to the 1988 Procedure Rules: WIT 0062 0620

[106] For details of the GMC's processing of complaints and the disciplinary mechanisms, see T48 p. 110–21 Sir Donald Irvine

[107] WIT 0062 0001 – 0002 Mr Scott

[108] The General Medical Council (Professional Performance) Rules Order of Council 1997 (SI 1997 No 1529) came into force on 1 July 1997

[109] WIT 0051 0014 Sir Donald Irvine

[110] T48 p. 61–2 Sir Donald Irvine

89 A principle underpinning the statutory functions of the GMC is that of self-regulation by doctors of doctors. Sir Donald supported the concept:

> '… while I fully acknowledge that there is a demonstrable need for improvement, self-regulation does work. It is for the critics of self-regulation to convince – in sufficient detail, and on the basis of evidence not assertion – that an alternative would be more effective in protecting the public interest.'[111]

90 Earlier, he had written:

> 'Professional self-regulation is one element in the complicated relationship between the medical profession and society. For example, doctors working for the NHS are also accountable as employees and contractors. In a web of complex regulatory arrangements some tension is not only inevitable but healthy.'[112]

91 An important issue for the Inquiry is how the GMC conducted itself during the period of the Inquiry's Terms of Reference and of the respective responsibilities assumed by (and of) others, such as the Royal Colleges, the British Medical Association (BMA), and the employers of individual clinicians.

92 Throughout much of the period, according to Sir Donald, there had been

> '… growing public concern about the way the General Medical Council (GMC) and the Royal Colleges have operated professional self-regulation. To many, these institutions have reflected more general attitudes in the profession and have appeared unduly protective of doctors rather than patients. They have been accused of being inward-looking, self-interested, unaccountable, ineffective, and increasingly at odds with public interest.'[113]

93 During the period, the GMC has tried, Sir Donald said, to make itself more patient-centred. There has been a trend, since at least 1984, towards increased lay representation on the GMC and its committees.[114] However, throughout the period under review the general culture was said to be one centred on practitioners rather than on patients. Sir Donald wrote that one outstanding problem was that:

> 'The culture within medicine and medical regulation was predominantly doctor- rather than patient-oriented.'[115]

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[111] WIT 0051 0005 Sir Donald Irvine

[112] WIT 0051 0067 Sir Donald Irvine; 'The Performance of Doctors. I: Professionalism and Self-regulation in a Changing World', '*BMJ',* 1997; 314:1540–2.

[113] WIT 0051 0061 Sir Donald Irvine, '*Lancet',* 1999; 353:1174–7

[114] See WIT 0062 0003 Mr Scott for membership of GMC; WIT 0062 0007 – 0008 for membership of the Standards Committee; WIT 0062 0010 for membership of the Education Committee; WIT 0062 0016 for membership of the Preliminary Proceedings Committee (PPC); WIT 0062 0018 for membership of the Professional Conduct Committee (PCC); and WIT 0062 0021 for membership of the Health Committee. Since 1984 the proportion of lay representation in all these memberships has increased with each change in composition (with the exception of the PPC, in which lay membership was reduced in 1996)

[115] WIT 0051 0006 Sir Donald Irvine

94 Within this culture, the GMC's approach was to set standards by giving generic advice and stating principles, and to supervise the conduct of doctors in response to complaints.

95 So far as the former is concerned, it was the evidence of Mr Scott that:

> 'The Committee on Standards of Professional Conduct and on Medical Ethics (the Standards Committee) formulates generic advice on standards of professional conduct and on medical ethics. The Standards Committee defines the principles which underlie good professional practice; applies them to new situations as the circumstances of medical practice change; and where necessary, recommends revised guidance to the Council.'[116]

96 It does not, therefore, lay down specific clinical guidelines for the treatment of particular conditions. It expects such guidelines to be set by the Royal Colleges.

97 Moreover, there are also other areas of clinical practice that the GMC avoided: it gave limited guidance on consent and other areas that it regarded as the responsibility of the courts:

> 'Throughout the 1980s and early 1990s the Council saw a clear distinction between areas governed by law – both common law and legislation – and questions of conduct and ethics. The GMC gave no guidance on matters which it believed were covered principally by law and would be dealt with in the courts. This is still the policy, but not every subject falls neatly into one category or the other.' [117]

98 Nevertheless, the GMC dealt (and deals) with some cases involving 'consent' through its professional disciplinary procedures:

> '… the Standards Committee has from time to time thought about whether guidance could be appropriately given, but the difficulties of disentangling the professional and the legal matters seemed at the time to be too difficult to handle, but that did not stop the Professional Conduct Committee considering individual complaints in individual cases.'[118]

99 The main mechanism available to the GMC with which to supervise doctors, to ensure fitness to practise, is and was its disciplinary procedures. These may result in a doctor's name being removed from the register. This does not in theory prevent a doctor from practising medicine as such, but has much the same practical effect, since he may not represent himself as a registered medical practitioner.

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[116] WIT 0062 0007 Mr Scott

[117] WIT 0051 0076 Sir Donald Irvine

[118] T48 p. 122 Sir Donald Irvine

100 In the period covered by the Inquiry's Terms of Reference, a doctor could have his name removed from the register if found guilty, beyond a reasonable doubt, of 'serious professional misconduct', upon a complaint to the GMC.

101 The 'serious professional misconduct' standard is practitioner-centred; according to Sir Donald it may not accord with the patient's experience:

> '… from a patient's point of view, there is a greater difficulty. Most patients do not start asking themselves with a complaint "Is this likely to be serious professional misconduct or not?", they want to know what to do and where to go and have the thing taken forward.'[119]

102 Four features of this regime were explored more fully in evidence: the impact of the word 'serious' as qualifying 'professional misconduct'; the burden of proof; the focus on his conduct rather than poor performance; and the fact that any system operating by complaint may be reactive rather than proactive.

103 There is no statutory definition of serious professional misconduct. However, the Privy Council in a case on appeal from the General Dental Council in 1987 (*Doughty v GDC*)[120] gave the following definition (subsequently confirmed in 1995 as applying equally to doctors in *McCandless v GMC*):[121]

> 'Conduct connected with his profession in which (the dentist) concerned has fallen short, by omission or commission, of the standards of conduct expected among (dentists) and that such falling short as is established should be serious.'[122]

'Serious'

104 The use of the adjective 'serious' was accepted as too restrictive by Sir Donald.[123]

105 The impact of its use was explored in relation to a proposal for the future that contemplated replacing 'serious professional misconduct' with 'seriously deficient in performance'[124] or a 'recognisable deficiency of performance'.[125]. The latter would require two matters to be distinguished according to Sir Donald: (i) the degree of deviation from good clinical practice and the degree of culpability in such falling short; and (ii) the evidential standard of proof required. He said:

> 'I was trying to disentangle the two elements here: what is serious deficiency from the standard of proof, the evidence that might be required to get to that point.' [126]

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[119] T48 p. 22 Sir Donald Irvine

[120] [1988] AC 164; [1987] 3 WLR 769; [1987] 3 All ER 843 (PC)

[121] [1996] 7 Med LR 379 (PC)

[122] WIT 0062 0015 Mr Scott

[123] T48 p. 22 Sir Donald Irvine

[124] WIT 0051 0007 Sir Donald Irvine; T48 p. 74–5 Sir Donald Irvine

[125] T48 p. 75 Sir Donald Irvine

[126] T48 p. 76 Sir Donald Irvine

Burden of proof

106 Throughout the relevant period, the GMC not only had to be satisfied that the professional misconduct was 'serious' but also that it had been established as such, beyond reasonable doubt.

107 The standard of proof is the same as that applied by the UKCC in respect of nurses. Concern was expressed by one witness, a nurse, that in both the GMC and UKCC, the criminal standard of proof, persisting only because of the serious consequences to a practitioner of being struck off, might lead to a feeling that doctors had the significant benefit of the doubt in a situation where patients' safety was involved, and that protection of the public needed to be seen as more central to regulatory proceedings.[127]

Misconduct rather than poor performance

108 'Professional misconduct' has resulted in the GMC's disciplinary procedures and guidance traditionally being employed in relation to a few narrow areas, such as sexual relations with patients and advertising (maintaining the probity and reputation of doctors). There have been changes in emphasis over the relevant period, which may reflect changes in the perceived role of the GMC. (Such changes over the period are demonstrated in particular by the change in emphasis from a greater focus on 'disparagement' of a colleague to a recognition of the greater importance of the duty to notify others if a colleague's conduct is open to question. This change will be explored later in this chapter, once the evidence as to the analogous position of the UKCC in respect of discipline and standards has been reviewed.)

109 A consequence of the GMC's authority being limited to 'serious professional misconduct' which had to be proved beyond reasonable doubt, was that it left the public exposed, as this exchange between Leading Counsel to the Inquiry and Sir Donald revealed:

> 'Q. So misconduct aside, the poor performer has never, between 1984 and 1995, been erased from the register on the grounds of poor performance alone?
>
> 'A. A number of doctors have been erased from the register where their performance has been so unsatisfactory as to constitute serious professional misconduct in the GMC's eyes. But of course you touch on a fundamental weakness in the fitness to practise procedures, which we recognised in that period and set about a strengthening of the procedures by having the Medical Performance Act. It gave us the power to look at a doctor's pattern of practice over a period of time, but the basic fact of the matter is that we became aware that where a doctor's practice was manifestly unsatisfactory, it was nevertheless very difficult to bring a charge of serious professional misconduct and make it stick. This left the public exposed.'[128]

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[127] T33 p. 149–50 Ms Lavin and WIT 0052 0193; '*The Regulation of Nurses, Midwives and Health Visitors*', overview

[128] T48 p. 12–13 Sir Donald Irvine

Reactive rather than proactive

110 Sir Donald told the Inquiry that the GMC had been reactive rather than proactive:

> 'Q. … the points which I think you would accept in respect of the way in which the GMC had a place in the regulatory framework from 1984 to 1995 are these: that first it was punitive rather than preventative; you have already accepted that?
>
> 'A. Yes.
>
> 'Q. Secondly, it was – it may be the same thing – reactive rather than proactive?
>
> 'A. Yes.'[129]

111 However, Sir Donald later qualified his statement:

> 'I should add, by the way, just in relation to the fitness to practise arrangements, you asked me if I agreed with you this morning that they were essentially punitive, and I said yes, and I do not actually agree with that. There is a punitive element to them, but of course they are primarily about maintaining the public interest and the safety of patients. I am sure you know that from the various matters that have been published. I would not like to leave you with that wrong impression.'[130]

112 Sir Donald stated that an outstanding problem was that:

> 'The GMC's fitness to practise procedures were complaints-driven; they were not designed for prevention.'[131]

113 Sir Donald told the Inquiry: '… you simply cannot get at a preventative strategy if one relies on a complaints-driven system alone'[132] and that:

> '… my view is the more general one that I have put to you earlier – it is a personal one – that there is something inherently unsatisfactory in the way we are dependent on complaints for raising questions about poor practice.'[133]

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[129] T48 p. 33–4 Sir Donald Irvine

[130] T48 p. 81 Sir Donald Irvine

[131] WIT 0051 0006 Sir Donald Irvine

[132] T48 p. 24 Sir Donald Irvine

[133] T48 p. 116 Sir Donald Irvine

114 The GMC's complaints-driven system was not even working as efficiently as its inherent limitations allowed, as Sir Donald said:

> 'Q. Do you think that [the considerable time-lag expected between complaint to the GMC and resolution] has operated over the last 20 years as a fetter upon people making complaints to the GMC?
>
> 'A. It has certainly been one of the factors which has deterred people.'[134]

115 However, the GMC, according to Sir Donald, has recognised the need for change and sees revalidation as the way forward. One of the trends since 1984 that Sir Donald Irvine identified is 'a move from reactive to proactive regulation':[135]

> 'This seems to us to be the only sensible way of addressing the inherent weakness of any complaints-driven system, whether it is the GMC's or whether it is the NHS's arrangements, and that is actually of having a systematic on-going demonstration of fitness to practise.'[136]

Specific positive standards of professional conduct

116 As part of the trend from reactive to proactive, the GMC has changed the form of its standards from negative prohibitions to positive requirements.

117 The '*Blue Book*'[137] set, for the first time, positive standards that a doctor was required to adhere to:

> 'We have to go to the change in guidance in the 1985 Blue Book, page 10, and the reference there to "explicit clinical standards". That represented the first development of an explicit statement of expectation from a doctor, and as I referred to in an earlier response to you, that finds its way now into the current guidance. But it was more than that; it formed the basis against which charges of serious professional misconduct were framed and accounts for the substantial rise in the proportion of clinical cases which appeared before the Professional Conduct Committee'.[138]

118 Since 1995 the GMC has replaced the '*Blue Book*' with the package '*Duties of a Doctor*'[139] (consisting of '*Good Medical Practice*' and other booklets)[140] and '*Maintaining Good Medical Practice*'.[141]

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[134] T48 p. 113 Sir Donald Irvine

[135] WIT 0051 0002 Sir Donald Irvine

[136] T48 p. 78–9 Sir Donald Irvine

[137] The editions of the '*Blue Book*' current during the period of the Inquiry's Terms of Reference are at: WIT 0062 0127 (August 1983), WIT 0062 0145 (April 1985), WIT 0062 0165 (April 1987), WIT 0062 0183 (March 1989), WIT 0062 0201 (June 1990), WIT 0062 0220 (February 1991), WIT 0062 0239 (May 1992) and WIT 0062 0283 (December 1993)

[138] T48 p. 69–70 Sir Donald Irvine

[139] WIT 0062 0008 Mr Scott. '*Duties of a Doctor*' is at WIT 0062 0305

[140] WIT 0062 0009 Mr Scott. WIT 0051 0007 Sir Donald Irvine. '*Good Medical Practice*' is at WIT 0062 0309 (October 1995 edition) and WIT 0062 0374 (July 1998 edition)

[141] WIT 0062 0009 Mr Scott. '*Maintaining Good Medical Practice*' is at WIT 0062 0398

Implicit to explicit standards

119 A parallel to the move from negatively to positively expressed standards has been the trend since 1984 for 'a move from implicit to explicit professional and clinical standards'.[142]

120 Sir Donald told the Inquiry:

> 'Q. So far as the "thou wilt" part of it was concerned, standards tended to be unspoken rather than prescribed by the GMC, or for that matter by the Royal Colleges?
>
> 'A. That was the position in medicine as a whole, both in this country and elsewhere. Much of medicine, until the late 1980s, was based on implicit standards, the movement to explicit standards is relatively recent.'[143]

Content of standards regulated by the GMC

121 The change in form of standards from negative to positive also reflected a change in the content of the standards. Sir Donald identifies a principal philosophic change in the GMC's policies in 1984–1995 as not only:

> 'Adopting a role in fostering standards of good practice by defining the qualities and attributes of a good doctor rather than defining what would amount to serious professional misconduct'[144]

but also, parallel to that:

> 'a … move towards regulating doctors' standards of practice and performance rather than a narrow concentration upon doctors' conduct and probity'.[145]

122 Annex D of Sir Donald's statement *'The Development of GMC Policy on Professional Standards'* explains the expansion and change in nature of the standards with which the GMC concerned itself. Poor performance had been peripheral to its concerns:

> 'In the early 1980s the guidance in [the *"Blue Book"*] made clear … that the Council was not "ordinarily concerned with errors in diagnosis or treatment"'.[146]

123 The shift from a concentration on misconduct to include concerns with poor performance involved a shift in focus from isolated events to patterns of conduct:

> '… there was the separate category where you knew there was a pattern of repeated poor practice, but none of it at any point, any of those incidents, sufficient

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[142] WIT 0051 0002 Sir Donald Irvine

[143] T48 p. 34 Sir Donald Irvine

[144] WIT 0051 0007 Sir Donald Irvine

[145] WIT 0051 0002 Sir Donald Irvine

[146] WIT 0051 0074 Sir Donald Irvine

> that you could bring the conduct procedures to bear. That was the genesis of the performance procedures, to alter the evidential basis upon which one looked at a doctor's practice away from a single incident to a pattern of practice over time.'[147]

124 The new emphasis on performance required standards that were measurable, but an outstanding problem was that 'Measurable clinical standards were few and far between…'.[148]

125 More recently, developments have included the introduction of the GMC's performance procedures by the Medical (Professional Performance) Act 1995, from 1 July 1997,[149] and the establishment of the GMC's Fitness to Practise Policy Committee in 1997.[150]

Response to criticism: constraints imposed by statute

126 The response to criticism of the GMC for supposed inaction and its slowness to reform is that the GMC has been constrained by statute:

> 'The relevant legislation both imposes duties upon, and extends powers to, the GMC. As a corollary, the GMC cannot act beyond those duties and powers.'[151]

127 Sir Donald observed:

> 'I think that some of the criticisms stem from a misunderstanding or lack of understanding or appreciation of precisely what the functions of the GMC are, and the framework within which it works, what it can and cannot do. … That framework, then, we have to strictly adhere to. It gives us powers to act decisively in some areas, but it places considerable constraints particularly at the operational level where the Council's responsibilities do not run.'[152]

128 However, the approach of the UKCC may be contrasted with that of the GMC. It has adopted a more flexible and proactive approach to addressing day-to-day issues in trusts. Ms Mandie Lavin, Director of Professional Conduct, UKCC, told the Inquiry:

> 'I can think of many occasions where I have been directed to write to Directors of Nursing, most recently I think to a Chief Executive who wrote back to me and expressed his concern that the UKCC should have such a degree of interest in the day-to-day activities within his Trust. I assured him we were interested.'[153]

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[147] T48 p. 73 Sir Donald Irvine

[148] WIT 0051 0006 Sir Donald Irvine

[149] WIT 0062 0014 Mr Scott. The relevant statutory instrument (The General Medical Council (Professional Performance) Rules Order of Council 1997, SI 1997 No 1529) is at WIT 0062 0684 Mr Scott

[150] WIT 0062 0013 Mr Scott

[151] WIT 0051 0001 Sir Donald Irvine

[152] T48 p. 10 Sir Donald Irvine

[153] T33 p. 155 Ms Lavin

129 Sir Donald, however, told the Inquiry:

> 'You [the Trust] are the people who are employing the doctor, we [the GMC] are not, and it is not part of our statutory duty to do that monitoring.'[154]

130 He stressed:

> 'What I am saying is that, we have to operate within our framework. … Our framework did not include the management of doctors at work. The relevant framework is giving advice on standards of practice and promulgating those standards, seeking to inform the culture of practice, particularly through the education system and that part which we are specifically responsible for, and acting on the basis of complaint when things appear to have gone wrong.' [155]

131 Its statutory powers appear to have inhibited the GMC from initiating investigations itself:

> 'Its statutory position, of course, is as you describe: the GMC activates or acts on the basis of a complaint. It has not scanned the media, et cetera … that has not been part of the practice.'[156],[157]

132 Further, Sir Donald indicated that the GMC's previous response to its statutory framework had been more restrictive than it had to be:

> '… within the statutory framework that I have described, we have been undergoing a considerable change of outlook ourselves which began, again, in the early 1990s, and that was effectively to see how far within the framework, the statutory framework as it was, we could be as effective as possible.'[158]

133 Some of the GMC's reticence went beyond that required by statute:

> 'Q. … There would have been nothing, would there, in the statute to have stopped the GMC, had it wished to do so, having an individual who would write to the author of a media report saying, "You have said various critical things; do you wish to make a complaint?" Obviously you cannot act unless he does?
>
> 'A. That is absolutely true: there would have been nothing to stop that. The starting point for the Council is, was there a complaint? That is what the policy was and that is how it was operated.'[159]

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[154] T48 p. 84 Sir Donald Irvine

[155] T48 p. 28–9 Sir Donald Irvine

[156] T48 p. 115 Sir Donald Irvine

[157] T48 p. 132. Despite saying this, Sir Donald Irvine later said 'that the [General Medical] Council does in fact scan the press and pursues matters at the material time. However, it did not scan *"Private Eye"* as a matter of fact.'

[158] T48 p. 31 Sir Donald Irvine

[159] T48 p. 115–16 Sir Donald Irvine

134 The following exchange between Leading Counsel to the Inquiry and Sir Donald emphasises the point:

> ‘Q. I want to ask you about a suggestion from her [Marilyn Rosenthal’s] observation that the GMC was resisting enlargement of its own disciplinary responsibilities and would prefer to let the other mechanisms, that is the NHS authorities and the courts, deal particularly with medical malpractice and maloccurrence. As an historical [1987] snapshot, is it right or wrong?
>
> ‘A. I think it was probably an accurate historical snapshot … I think then that the translation from, as it were, one approach to a different approach took time.’[160]

135 Moreover, the view that the statutory framework in this area imposed a fetter on the activity of the GMC in this area may be contrasted with another area, in which the GMC interpreted its statutory powers more broadly:

> ‘Q. … The GMC inspects, does it, medical schools and those institutions where doctors are trained?
>
> ‘A. The definition of the Act is rather narrower than that. I do not have the right words in front of me, but the essence is the inspection of the final qualifying examinations. That is interpreted as generously as the Act actually allows, as an enquiry as to the sufficiency of what has gone before that leads to that final examination. But it is not a formal power of accreditation.’[161]

136 Moreover, since the end of the period with which the Inquiry is concerned, the GMC has requested increases in its disciplinary powers:

> ‘Orders for interim suspension or interim conditions may be made for up to six months but are renewable for up to three months at a time (until 1996, this power was limited to a single period of three months but, *at our request*, the power was increased).’[162]

137 Sir Donald circulated widely an explanation of the effects of The Medical Act 1983 (Amendment) Order 2000:

> ‘Both Houses of Parliament have now approved the legislation *we sought,* to widen our powers. The Privy Council approved our new rules on 12 July 2000. The effects will be:

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[160] T48 p. 71–2 Sir Donald Irvine

[161] T48 p. 105 Sir Donald Irvine

[162] WIT 0051 0134 Sir Donald Irvine; *‘Supplementary Evidence from the General Medical Council’* (emphasis added)

> 'To provide us with greater powers of interim suspension, and interim conditions on registration, exercised by a new Interim Orders Committee, on which there will be very strong lay representation.'[163]

Professional regulation – nursing: the UKCC

The statutory basis

138 The UKCC's role is broadly analogous to that of the GMC.[164] Ms Lavin gave evidence to the Inquiry about the legal foundations of the UKCC and its relationship to the National Boards:[165]

> '1. The UKCC, together with the four National Boards (in England, Scotland, Wales and Northern Ireland), regulates the education and practice of nurses, midwives and health visitors. The 1997 Act is a consolidation of the 1979 Act which established these bodies, and the 1992 Act which reformed their powers and composition.
>
> '2. The role of these statutory bodies is to define standards for the education, clinical practice, and professional conduct of nurses, midwives and health visitors; and to monitor the implementation and effectiveness of these standards. Broadly, the UKCC is responsible for standard setting and conduct procedures, including maintaining the register of professionals deemed fit to practice. The National Boards are responsible, within their respective countries, for oversight of the implementation of education standards and other related functions. The 1979 Act brought together all the statutory bodies concerned with regulating the professions at both pre- and post-registration levels and rationalised the regulatory structures across the UK.
>
> '3. A review of the organisation and functioning of the five statutory bodies in 1989 led to the 1992 Act and changes in legislation – the UKCC became the directly elected body and the National Boards became smaller, executive bodies appointed by the respective Secretaries of State (and, for Northern Ireland, the Head of the Department of Health and Social Services for Northern Ireland). All professional conduct functions were transferred to the Central Council.
>
> '4. Nurses have been regulated under statutory professional self-regulation since 1919; and midwives since 1902. Until 1979, health visitors were regulated through their nursing qualification, with other arrangements made under a separate body for their education and training as health visitors.'[166]

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[163] WIT 0051 0145; letter from Sir Donald Irvine, GMC President, to 'chief executives, NHS Executive in England, Wales, Scotland and Northern Ireland; regional chairs and directors, NHS; chairs of CHCs; local health councils and directors of public health authorities; health boards; health and social services boards; chief executives and medical directors of NHS trust and independent hospitals', dated 13 July 2000 (emphasis added) Sir Donald Irvine

[164] T33 p. 136 Ms Lavin

[165] The National Boards for England, Scotland, Wales and Northern Ireland

[166] WIT 0052 0001 – 0002 Ms Lavin

139 Ms Lavin[167] referred the Inquiry to the statutory provisions governing the professional conduct of nurses, midwives and health visitors: the Nurses, Midwives and Health Visitors Act 1997, the Nurses, Midwives and Health Visitors Rules Approval Order 1983,[168] the Nurses, Midwives and Health Visitors (Professional Conduct) Rules 1993 Approval Order 1993[169] and the Nurses, Midwives and Health Visitors (Professional Conduct) (Amendment) Rules 1998 Approval Order 1998.[170]

140 Ms Lavin explained the functions of the National Boards:

> 'The functions of the Boards are to:
>
> - 'approve institutions to provide courses of training
> - 'ensure that courses of training meet Central Council requirements as to their kind, content and standard
> - 'hold or arrange for others to hold such examinations as are necessary to satisfy requirements for registration or additional qualifications
> - 'collaborate with Council in promotion of improved training methods and
> - 'provide advice and guidance to Local Supervising Authorities for midwives.
>
> 'In addition the Boards are to carry out any other functions prescribed by the relevant Secretary of State.
>
> 'In addition to their primary function of the implementation and monitoring of Council standards for education, all the National Boards have additional functions. These are specified in the statutory instruments through which they were established in each country; any may differ from country to country. These functions include careers information, research into training methods, provision of courses of training and further training for nurse, midwifery and health visitor teachers and provision of a central applications system (Scotland). The constitution of the National Boards is prescribed in the [1997] Act and elaborated in statutory instruments.'[171]

141 The four UK Health Departments commissioned J M Consulting Ltd to:

> '... review the legislation which regulates the education and practice of nurses, midwives and health visitors and the five statutory bodies which operate it'.[172]

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[167] WIT 0052 0016, 0278 Ms Lavin
[168] SI 1983 No 873
[169] SI 1993 No 893
[170] SI 1998 No 1103
[171] WIT 0052 0004 – 0005 Ms Lavin
[172] WIT 0052 0188 Ms Lavin

142 J M Consulting Ltd is an independent, Bristol-based, company that specialises in conducting public sector reviews on commission from national agencies, particularly in the higher education and health sectors.

143 The review was announced in Parliament in July 1997.[173] At its conclusion, J M Consulting Ltd produced '*The Regulation of Nurses, Midwives and Health Visitors*'[174] which sets out the history and background to the Nurses, Midwives and Health Visitors Act 1997.[175]

144 One matter to emerge from the review was that the relationship between the UKCC and the National Boards could be improved[176] and indeed, the Government has accepted proposals to replace the UKCC and National Boards with a Nursing and Midwifery Council.[177]

Relative roles and responsibilities of the UKCC and the Royal College of Nursing

145 Although the UKCC's role is broadly analogous to that of the GMC, the relationship between the Royal College of Nursing (RCN) and the UKCC is different in nature from the relationship between the GMC, BMA and the Royal Colleges. The table of comparisons below helps to explain the respective roles of the RCN and the UKCC.

Table 1: Respective roles and responsibilities of the UKCC and the RCN

	RCN	**UKCC**
Founded	1916	'Nurses have been regulated under statutory professional self-regulation since 1919; and midwives since 1902. Until 1979, health visitors were regulated through their nursing qualification, with other arrangements made under a separate body for their education and training as health visitors.'[1] UKCC was established by the Nurses, Midwives and Health Visitors Act 1979
Constitution	Royal Charter granted 1928 It is a voluntary association It is a trade union – nurses may also belong to Unison, or another trade union which is open to membership from health professionals	Statutory: Nurses, Midwives and Health Visitors Acts 1997, Nurses, Midwives and Health Visitors Rules Approval Order 1983,[2] Nurses, Midwives and Health Visitors (Professional Conduct) Rules 1993 Approval Order 1993,[3] Nurses, Midwives and Health Visitors (Professional Conduct) (Amendment) Rules 1998 Approval Order 1998[4]
Charitable status	Registered charity	
Headquarters	London	London

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[173] WIT 0052 0216 Ms Lavin

[174] WIT 0052 0183 Ms Lavin; *'The Regulation of Nurses, Midwives and Health Visitors – Report on a Review of the Nurses, Midwives and Health Visitors Act 1997'*

[175] WIT 0052 0218 Ms Lavin

[176] T33 p. 141 Ms Lavin

[177] T33 p. 152 Ms Lavin; WIT 0052 0322; *'Review of the Nurses, Midwives and Health Visitors Act 1997 – Government Response to the Recommendations HSC 1999/030'*, p. 6 (dated 9 February 1999)

Table 1: Respective roles and responsibilities of the UKCC and the RCN (continued)

	RCN	UKCC
Responsible to whom?	'The College is accountable to Her Majesty the Queen in Privy Council'[5]	'The UKCC is an autonomous body … accountable to the public for their safety through Parliament (the Secretary of State), and accountable to registrants for the proper discharge of its functions on their behalf'[6]
Responsible for	Nurses	Nurses, midwives and health visitors
Aims	'To promote the science and art of nursing and the better education and training of nurses and their efficiency in the profession of nursing'[7] and other aims	'To establish and improve standards of training and professional conduct',[8] 'standard setting and conduct procedures, including maintaining the register of professionals deemed fit to practice'[9]
Number of members	318,000	634,229[10]
Sources of funding	Membership subscriptions, gifts[11]	'UKCC is … funded principally by registrants'[12]
Basic membership		
Higher membership	No higher categories of membership	UKCC's register has 15 parts
Fellowship	No higher categories of membership	
Is membership a requirement for employment?	No	Yes. Registration is compulsory for nurses, midwives and health visitors who want to practice[13]
Training post approval	No	Approval of institutions to provide courses of training; the quality of such courses is the responsibility of the National Boards[14]
Standard setting	'The RCN is a leading player in the development of nursing practice and standards of care.'[15] 'The RCN offers its members a wide range of services including: development of nursing practice and standards of care';[16] 'the Dynamic Quality Improvement Programme has focused on development work, including … developing specialist guidelines and standards';[17] 'an initial programme of work to develop national standards for particular speciality areas was undertaken in the late 1980s and early 1990s. This resulted in the production of standards for a whole range of specialist subjects'[18]	See aims above
Current President	Christine Watson (General Secretary: Christine Hancock)[19]	Alison Norman
Discipline of members	'The RCN can remove members from membership, although this power has never been used'[20]	As the professional regulatory body, it has sanctions for misconduct and ill health

Table 1: Respective roles and responsibilities of the UKCC and the RCN (continued)

	RCN	UKCC
Continuing Professional Development (CPD)/ Continuing Medical Education (CME)	'The RCN offers its members a wide range of services including: … education and professional development activities.' RCN has a continuing education points (CEP) system [21]	Compulsory post-registration education and practice (PREP).[22] 'CPD is a requirement for all nurses and midwives and evidence of appropriate activity will be a condition of renewed registration'[23]
Historic links to other colleges	'The RCN has a good track record in working with other organisations in order to improve health care'[24]	

1. WIT 0052 0002 Ms Lavin
2. SI 1983 No 873
3. SI 1993 No 893
4. SI 1998 No 1103
5. WIT 0042 0003 Miss Hancock
6. WIT 0052 0007 Ms Lavin
7. WIT 0042 0004 Miss Hancock
8. Nurses, Midwives and Health Visitors Act 1997, section 2(1)
9. WIT 0052 0001 Ms Lavin
10. UKCC 0001 0001 total number of registrants 1998/1999
11. WIT 0042 0004 Miss Hancock
12. WIT 0052 0007 Ms Lavin
13. Nurses, Midwives and Health Visitors Act 1997, section 13
14. WIT 0052 0004; WIT 0052 0223 Ms Lavin; T33 p. 136–8 Ms Lavin
15. WIT 0042 0003 Miss Hancock
16. WIT 0042 0003 Miss Hancock
17. WIT 0042 0005 Miss Hancock
18. WIT 0042 0005 Miss Hancock
19. Until May 2001
20. WIT 0042 0003 Miss Hancock
21. T34 p. 124–5 Mrs Jenkins; WIT 0042 0003 Miss Hancock
22. See *'PREP and You'*, UKCC, October 1997; WIT 0052 0089
23. WIT 0052 0203 *'The Regulation of Nurses, Midwives and Health Visitors; Report on a Review of the Nurses, Midwives and Health Visitors Act 1997'*
24. WIT 0042 0025 Miss Hancock

Fitness to practise: nurses

146 The statutory definition of 'misconduct' for nurses: 'conduct unworthy of a registered nurse…'[178] is broadly similar to the GMC's 'serious professional misconduct', and has been described as vague and unhelpful.[179] A charge of 'misconduct' cannot be brought simply by citing a breach of a provision of the '*Code of Professional Conduct*', although the *'The Regulation of Nurses, Midwives and Health Visitors'* proposes such a change.

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[178] WIT 0052 0055; Nurses, Midwives and Health Visitors (Professional Conduct) Rules 1993 Approval Order 1993, Rule 1(2)(k)

[179] WIT 0052 0205, 0249 Ms Lavin; *'The Regulation of Nurses, Midwives and Health Visitors'*

147 Charges of misconduct against nurses, as with doctors, must be proved beyond a reasonable doubt. However, when the UKCC does not pursue a case to a hearing because the evidence is not strong enough to meet this threshold, or it is dropped for another reason, there is other action that the UKCC can take. The UKCC has a practice of writing to practitioners:

> '… indicating areas where they might want to reflect on practice, for instance, in relation to the administration of medicines or in relation to guidance on records and record-keeping'.[180]

Limits of disciplinary powers

148 The statutory powers of the UKCC, like those of the GMC, appear to be restricted.[181] It has no power, for instance, to impose a life ban on nurses (i.e. removal from the Register with no right to reapply for registration).[182] J M Consulting Ltd in its review did not support the introduction of this power.[183] The GMC similarly does not currently have the power to impose a life ban but has requested the Government for such a power. The Government has indicated its willingness to enact the necessary legislation.

Alternative sanctions and interventions

149 The Government supports the proposal to give the UKCC's successor Council the power to impose sanctions other than removal from the Register, for instance the power to remove the registered marks of a nurse's higher level qualifications or specialism without going so far as to remove the nurse's basic registration.[184]

150 Although the UKCC is complaints-oriented,[185] and thus reactive like the GMC, it has been more punitive in its approach than the GMC. Differential treatment of Doctors and nurses is reflected in the different rates of their being removed from the Register.

151 The UKCC advised the Inquiry of the number of nurses, midwives and health visitors registered with the UKCC and the number removed by the Professional Conduct Committee (PCC), for 1995/96–1999/2000. The following table sets out the figures:[186]

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[180] T33 p. 155 Ms Lavin

[181] WIT 0052 0190; *'The Regulation of Nurses, Midwives and Health Visitors'*, overview para 12(g); WIT 0052 0251 Ms Lavin

[182] WIT 0052 0015 Ms Lavin

[183] WIT 0052 0251; *'The Regulation of Nurses, Midwives and Health Visitors'*

[184] WIT 0052 0326 'The new register will include marks against registrant's [*sic*] entries to indicate enrolled nurse status, specialisms (within nursing) and higher level qualifications. A further level of public protection can be afforded by making it possible for these marks to be removed (for example, on the grounds of unfitness to practise or failure to meet periodic re-registration conditions) without the practitioner being removed from the register.' *'Review of the Nurses, Midwives and Health Visitors Act 1997 – Government Response to the Recommendations HSC 1999/030'*

[185] WIT 0052 0009 Ms Lavin

[186] UKCC 0001 0001; letter from Rebecca Blease to Peter Whitehurst, 15 September 2000

Table 2: Number of nurses, midwives and health visitors registered with the UKCC and the number removed by the Professional Conduct Committee (PCC)

	1999/2000	1998/99	1997/98	1996/97	1995/96
Total registrants	634,529	634,229	637,449	648,240	645,001
Removed by PCC	96	93	84	96	73
Number of registrants for each one removed	6,610	6,820	7,589	6,753	8,836

152 The reporting period for each year covers 1 April to 31 March. In addition, the UKCC's Health Committee removed and suspended a number of registrants on health grounds.

153 By comparison, there are about 100,000 doctors practising in the UK[187] but only a few are erased from the medical register each year, as is indicated by the figures in the next two paragraphs.

154 The GMC provided the Inquiry with statistics for each year of the period of the Inquiry's Terms of Reference relating to the progress of complaints to various stages of the GMC disciplinary procedures. The number of cases referred to the PCC were:[188]

Table 3: The number of cases referred to the PCC

	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
No of cases	52	42	49	53	33	35	51	31	35	59	83	117

155 The number of erasures (with immediate suspension) relating to clinical performance (in the sense of disregard of professional responsibilities and irresponsible prescribing only) were:[189]

Table 4: The number of erasures from the UKCC Register

	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
No of cases	5	6(2)	4(2)	3(1)	2(1)	5(1R)	3(1R) (1)	4(2)	1(1R) (1)	13 (1R) (11)	6(1R) (2)	6(3)

156 The UKCC feels it is currently constrained as regards the flexibility of its response to those facing disciplinary action by its limited repertoire of responses:

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[187] T48 p. 18 Sir Donald Irvine. 'Of the total doctors on the Medical Register, the ball-park would be around 180,000. But of those, around 100,000 practise in the National Health Service. Many of our registrants are overseas or retired. The operating figure for this country is effectively 100,000.'

[188] WIT 0051 0136 Mr Hamilton. 'Figures have been taken from [GMC] Annual Reports for 1984–1994 and from the Report to Council of the work of the PPC in 1995.'

[189] WIT 0051 0137 Mr Hamilton. 'Figures taken from [GMC] Annual Reports 1984–1995. Figures in brackets and marked (R) denote the number of cases which were resumed from an earlier hearing in a previous year. Figures in brackets and not marked (R) are the number of cases in which an order for the immediate suspension of the doctor's registration was also made.'

> 'The difficulty we have at the moment is, we have nothing in between no action and a caution,[190] which remains on the register for five years. That is a pretty big gap in terms of flexibility of response to cases.'[191]

Issues common to regulation of doctors and nurses (and others)

Disparagement and the duty to inform others if a colleague's conduct is in question

157 The change in emphasis since 1984 from a prohibition on disparagement of a colleague to a duty to inform others can be traced through evidence given to the Inquiry of GMC publications and of clinicians' attitudes over time. The change was felt necessary,[192] was made in response to particular cases[193] and reflected changes in attitudes.

Clinicians' traditional attitudes

158 Professor Leo Strunin, President of the RCA, told the Inquiry:

> 'Q. You are emphasising there, I think, two things: firstly, the development of a team or corporate identity and, secondly, more self-consciousness about professional standards and the need to keep abreast of those. Is that fair comment?
>
> 'A. I think that is true. I do not think it is true in anaesthesia, although anaesthetists are better in some respects. They work in departments with some other specialties because of the nature of the work we do, but I think *it was fairly common back ten years when people thought, "Well, as long as I am doing a good job it is not actually my problem what is occurring around me"*, whereas now that has changed and people believe there is a corporate structure and they are responsible for everybody. That is obviously in line with what the General Medical Council now recommends to doctors, that we are not only responsible for our own activities but for those of others around us.'[194]

159 Sir Donald Irvine told the Inquiry:

> 'A. The notion that clinicians and team members might have some collective responsibility, an explicit notion, I think was not in the mind then [1984].
>
> 'Q. So responsibility for one's fellows, if one's fellow was guilty, if I can use that word, of shoddy practice, was not necessarily something which a clinician saw himself as having any duty in 1984 to report upon?
>
> 'A. I think that was a very common attitude.'[195]

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[190] T33 p. 156 Ms Lavin. '… a caution can only be given by the Preliminary Proceedings Committee in circumstances where a practitioner admits the facts of a case and admits misconduct. It is to deal with one-off deviances…'

[191] T33 p. 156 Ms Lavin

[192] T48 p. 98 Sir Donald Irvine

[193] Principally, the cases of Dr Frempong (see para 164), Dr Dunn (see para 173)

[194] T14 p. 4–5 Professor Strunin (emphasis added)

[195] T48 p. 89 Sir Donald Irvine

Movement in attitudes and published guidance

160 Sir Donald traced the series of amendments in consecutive editions of the '*Blue Book*'[196] which indicate the trend away from disparagement towards a duty to inform others.

161 The August 1983 '*Blue Book*' stated:

> **'Depreciation of other doctors** …
>
> 'The Council also regards as capable of amounting to serious professional misconduct:
>
> '(i) the depreciation by a doctor of the professional skill, knowledge, qualifications or services of another doctor or doctors …'[197]

162 The April 1985 *'Blue Book'* included an identically worded section. Although this advice in the *'Blue Book'* was unqualified, Sir Donald felt that disparagement required a malicious motive:

> 'Q. If one honestly reported poor practice but was wrong, that would be disparagement, would it not?
>
> 'A. I am not sure that that would be disparagement; I mean, it comes back to the motive behind it. Disparagement was about reporting with malice.'[198]

163 The GMC's guidance on disparagement was perceived to discourage doctors from expressing legitimate concerns. Dr Ernest Armstrong, Secretary of the BMA, said:

> 'Q. So one consequence … of the doctor whistle-blowing the colleague would be that it might be said that he was actually acting in breach of his own contract?
>
> 'A. Not in breach of his own contract, but certainly in breach of his own codes of professional conduct as set out by the GMC.
>
> 'Q. And those are those codes of conduct to be expected explicitly under his contract?
>
> 'A. Correct.

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[196] The editions of the *'Blue Book'* current during the Inquiry's period are at: WIT 0062 0127 (August 1983), WIT 0062 0145 (April 1985), WIT 0062 0165 (April 1987), WIT 0062 0183 (March 1989), WIT 0062 0201 (June 1990), WIT 0062 0220 (February 1991), WIT 0062 0239 (May 1992) and WIT 0062 0283 (December 1993)

[197] WIT 0062 0136 Mr Scott

[198] T48 p. 90 Sir Donald Irvine

> 'Q. Because they are the only standards there are under his contract?
>
> 'A. That is correct.'[199]
>
> 'Q. So one had the rather Alice in Wonderland, topsy-turvy position that the doctor who might very well be incompetent in particular areas could not be dealt with for that in any realistic way, other than through the Regional Medical Officer as you have described, the informal mechanisms, whereas another doctor complaining about him would, at least until the early 1990s, until the culture began to change, himself be transgressing in a clear and objective way the standards to be expected of him?
>
> 'A. That, sadly, is a very neat encapsulation of the doctor's dilemma.'[200]

164 In March 1984 Dr Frempong's case before the Professional Conduct Committee (PCC) raised the question why doctors had not reported a colleague whom they knew to be a danger to patients. Some doctors said they did not do so because they feared falling foul of the GMC's guidance on disparagement. In response, the Council made clear in its next Annual Report that:

> '… there may be circumstances in which it would be the responsibility of doctors to report to the Council evidence which may raise a question of serious professional misconduct'.[201]

165 Thus it was that Sir Donald could say there was a policy change between April 1985 and April 1987 that:

> '… came about because of an increasing awareness inside the Council that reporting poor practice — that there was a problem here that had to be addressed, and it was articulated by both lay and medical members who took this matter very seriously, but it was also illustrated by the case of Dr [Frempong] in March 1984, and I think it was Esther Rantzen who made a film about this particular situation in which, in this case, there were clearly circumstances in which colleagues had known about the doctor's quite wrong practice and had done nothing about it, so that created the debate which led to this change of policy.'[202]

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[199] T20 p. 30 Dr Armstrong

[200] T20 p. 34–5 Dr Armstrong

[201] WIT 0051 0075 Sir Donald Irvine

[202] T48 p. 91–2 Sir Donald Irvine

166 As a result, the April 1987 '*Blue Book'* incorporated the first explicit duty to inform others about a colleague who was apparently guilty of serious professional misconduct or experiencing serious ill health.[203] Sir Donald said:

> 'This change was highlighted in the Annual Report (1987) which went to all doctors on the Medical Register.'[204]
>
> '"Disparagement of professional colleagues
>
> '"65. It is improper for a doctor to disparage, whether directly or by implication, the professional skill, knowledge, qualifications or services of any other doctor, irrespective of whether this may result in his own professional advantage, and such disparagement may raise a question of serious professional misconduct.
>
> '"66. It is however entirely proper for a doctor, having carefully considered the advice and treatment offered to a patient by a colleague, in good faith to express a different opinion and to advise and assist the patient to seek an alternative source of medical care. The doctor must however always be able to justify such action as being in the patient's best medical interests.
>
> '"67. Furthermore, a doctor has a duty, where the circumstances so warrant, to inform an appropriate body about a professional colleague whose behaviour may have raised a question of serious professional misconduct, or whose fitness to practise may be seriously impaired by reason of a physical or mental condition. Similarly, a doctor may also comment on the professional performance of a colleague in respect of whom he acts as a referee."'[205]

167 The June 1990 '*Blue Book'* included an identically worded section.[206]

168 The April 1987 and June 1990 editions of the '*Blue Book'* contained no guidance on the meaning of the qualifying phrase 'where the circumstances so warrant'[207] which was open to individual interpretation by individual doctors.[208] Sir Donald said: '… we [the GMC] also acknowledged the difficulty inherent for the doctor in that guidance, because it then changed'.[209]

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[203] T48 p. 93 Sir Donald Irvine
[204] WIT 0051 0075 Sir Donald Irvine
[205] WIT 0062 0175 Mr Scott
[206] WIT 0062 0210 – 0211 Mr Scott
[207] T48 p. 93 Sir Donald Irvine
[208] T48 p. 94 Sir Donald Irvine
[209] T48 p. 95 Sir Donald Irvine

169 Coupled with the series of 'clarifications' and 'refinements' of the duty to inform, the GMC tried to publicise the duty as widely as possible within the medical profession:[210]

> 'In 1990, the Council – in public session – considered whether to remove the guidance on disparagement from the *"Blue Book"* altogether, but concluded that it was not right to do so. However, it was agreed that the focus of the guidance should be on reporting colleagues, with questions of disparagement – defined as "gratuitous and unsustainable comment" – being raised as a subsidiary matter. All doctors were told of the importance of this in the 1990 Annual Report.'[211]

170 The February 1991 '*Blue Book'* stated:

> 'Comment about professional colleagues
>
> '62. Doctors are frequently called upon to express a view about a colleague's professional practice. This may, for example, happen in the course of a medical audit or peer review procedure, or when a doctor is asked to give a reference about a colleague. It may also occur in a less direct and explicit way when a patient seeks a second opinion, specialist advice or an alternative form of treatment. Honest comment is entirely acceptable in such circumstances, provided that it is carefully considered and can be justified, that it is offered in good faith and that it is intended to promote the best interests of patients.
>
> '63. Further, it is any doctor's duty, where the circumstances so warrant, to inform an appropriate person or body about a colleague whose professional conduct or fitness to practice may be called in question or whose professional performance appears to be in some way deficient. Arrangements exist to deal with such problems, and they must be used in order to ensure that high standards of medical practice are maintained.
>
> '64. However, gratuitous and unsustainable comment which, whether directly or by implication, sets out to undermine trust in a professional colleague's knowledge or skills is unethical.'[212]

171 For the first time 'honest comment' was explicitly acceptable in relation to doctors called upon to express a view (para 62),[213] but the duty to inform was still qualified by the phrase 'where the circumstances so warrant' (para 63), so that the difficulties of its interpretation remained.[214] The words 'arrangements exist to deal with such problems', it was said, '… referred to the local arrangements such as the informal procedures which local medical committees operated in general practice, or the "three wise men" procedures in hospitals.'[215]

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[210] T48 p. 98–9 Sir Donald Irvine
[211] WIT 0051 0075 Sir Donald Irvine
[212] WIT 0062 0230 Mr Scott
[213] T48 p. 96 Sir Donald Irvine
[214] T48 p. 96–7 Sir Donald Irvine
[215] T48 p. 96 Sir Donald Irvine

172 Identically worded sections were included in the '*Blue Book'* editions of May 1992[216] and December 1992.[217]

The Dunn case and *'Good Medical Practice'*[218]

173 The first edition of *'Good Medical Practice'*, published in October 1995,[219] contained the first unqualified statement of a duty to inform others about a colleague.[220] It arose from the case of Dr Dunn, a clinical director who had known of a locum consultant's deficient practice and had done nothing about it.[221]

> '8. The Dunn case in March 1994 marked a further step in making clear the GMC's policy on the importance of reporting poor practice. The case against Dr Dunn arose from that of Dr B S Irani, an anaesthetist who was erased following a PCC [Professional Conduct Committee] hearing in July 1993. The case involved a patient left with permanent brain damage after anaesthesia. Dr Dunn was Chairman of his hospital anaesthetics division during the time that Dr Irani was employed there as a locum consultant. Serious concerns had been expressed to him about Dr Irani's competence and conduct, but he failed to take appropriate action.
>
> '9. Dr Dunn was found guilty of serious professional misconduct. In its determination, the PCC drew on the draft guidance being prepared for *"Good Medical Practice"* in stating:
>
> '"Doctors who have reason to believe that a colleague's conduct or professional performance pose a danger to patients must act to ensure patient safety. … This Committee has already drawn attention to the existence of appropriate procedures for response to the reports of evident, and dangerous, incompetence. Doctors have a duty to activate these procedures promptly, where such cases arise. At all times patient safety must take precedence over all other concerns, including understandable reticence to bring a colleague's career into question."[222]
>
> '10. The Dunn case was well publicised by the GMC because of the central importance of patient safety. The GMC took the unusual step of issuing a press release giving details of the case to all national and medical press editors on 18 March 1994. Furthermore, the Annual Report for 1994 alerted all registered doctors to the forthcoming publication of "*Good Medical Practice"* and reminded them of their duty to protect patients from colleagues whose health or professional conduct poses a danger. "The Dunn case" was highlighted in the same report and

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[216] WIT 0062 0250 Mr Scott

[217] WIT 0062 0294 Mr Scott

[218] *'Good Medical Practice'* is at WIT 0062 0309 Mr Scott (October 1995 edition) and WIT 0062 0374 Mr Scott (July 1998 edition)

[219] WIT 0062 0309 Mr Scott

[220] T48 p. 97–8 Sir Donald Irvine

[221] T48 p. 97–8 Sir Donald Irvine

[222] GMC Annual Report 1994, p. 20

part of the judgement was reprinted, repeating once again that patient safety must take precedence over all other concerns.

> '11. While developing *Good Medical Practice*, as well as strengthening the guidance on the duty to protect patients, the GMC also reviewed the need for guidance on disparagement. The GMC concluded that such guidance should be retained, but its scope should be restricted to cases where patients were affected – "You must not make patients doubt a colleague's knowledge or skills …" – and not apply to cases which concerned only the reputation of a colleague or the profession. It was agreed that this guidance should appear in the booklet separately from the guidance on reporting colleagues whose fitness to practise is in doubt, in order that the advice on disparagement should not be seen as qualifying the duty to report dangerous colleagues.'[223]

174 The Dunn case and the change in emphasis are reflected in the wording of *'Good Medical Practice'*.

175 In October 1995 the GMC issued the package of guidance '*Duties of a Doctor'*.[224] '*Duties of a Doctor'* concerns 'The duties of a doctor registered with the General Medical Council'. It states 'In particular as a doctor you must…', followed by a list of 14 particular duties, including the duty to 'act quickly to protect patients from risk if you have good reason to believe that you or a colleague may not be fit to practice'.[225] The list is repeated on the inside front cover of the leaflets in the pack, '*Good Medical Practice'*,[226] '*Confidentiality'*,[227] '*HIV and AIDS: The Ethical Considerations'*[228] and *'Advertising'*.[229]

176 *'Good Medical Practice'* (October 1995 edition) states:

> **'Maintaining trust**
>
> *'Professional relationships with patients*
>
> '11. Successful relationships between doctors and patients depend on trust. To establish and maintain that trust you must:[230]
>
> '… respect the right of patients to a second opinion. …'[231]

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[223] WIT 0051 0075 – 0076 Sir Donald Irvine
[224] WIT 0062 0305 Mr Scott
[225] WIT 0062 0307 Mr Scott
[226] WIT 0062 0310 Mr Scott
[227] WIT 0062 0343 Mr Scott
[228] WIT 0062 0360 Mr Scott
[229] WIT 0062 0328 Mr Scott
[230] WIT 0062 0314 Mr Scott
[231] WIT 0062 0315 Mr Scott

It adds:

> *'Your duty to protect all patients*
>
> '18. You must protect patients when you believe that a colleague's conduct, performance or health is a threat to them,[232]
>
> '19. Before taking action, you should do your best to find out the facts. Then, if necessary, you must tell someone from the employing authority or from a regulatory body. Your comments about colleagues must be honest. If you are not sure what to do, ask an experienced colleague. The safety of patients must come first at all times.'[233]

And continues:

> *'Working with colleagues…*
>
> '24. You must not make any patient doubt a colleague's knowledge or skills by making unnecessary or unsustainable comments about them.'

And again:

> *'Working in teams …*
>
> '27. If you disagree with your team's decision, you may be able to persuade other team members to change their minds. If not, and you believe that the decision would harm the patient, tell someone who can take action. As a last resort, take action yourself to protect the patient's safety or health.'[234]

177 Although outside the time frame of the Terms of Reference of the Inquiry, it should be noted that the July 1998 edition of '*Good Medical Practice'* contained amendments making explicit a doctor's duty to inform on colleagues who were not doctors and to give more advice on whom doctors should approach with concerns. In the following extracts additions to the October 1995 edition are in **bold**, deletions in ~~strikethrough~~.

> *'Your duty to protect all patients*
>
> '23. You must protect patients when you believe that a **doctor's or other colleague's** health, conduct, or performance is a threat to them.
>
> '24. Before taking action, you should do your best to find out the facts. Then, if necessary, you must **follow your employer's procedures or** tell ~~someone~~ **an appropriate person** from the employing authority, **such as the director of public**

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[232] WIT 0062 0316 Mr Scott

[233] WIT 0062 0317 Mr Scott

[234] WIT 0062 0318 Mr Scott

> **health, medical director, nursing director or chief executive, or an officer of your local medical committee**, or ~~from~~ a regulatory body. Your comments about colleagues must be honest. If you are not sure what to do, ask an experienced colleague **or contact the GMC for advice**. The safety of patients must come first at all times.'[235]

178 Since the Bristol case has been widely publicised there have been many other publications (including '*Maintaining Good Medical Practice*'[236]) that have explained the doctor's duty to inform others about colleagues, the appropriate channels for expressing concern and mechanisms for rectifying problems.

179 The changes in guidance on informing others about colleagues should be understood in the context of the shift in regulatory emphasis from conduct to performance, as explained above: there is not only greater encouragement of doctors to inform others, but also a change in the nature of that about which they should be concerned.

Disparagement and the duty to inform others if a colleague's conduct is in question – (nurses)

180 The evidence emphasised that a nurse has always been required to be the 'patients' advocate'. It was accepted that this might bring a nurse into conflict with another health professional.

181 The UKCC's '*Code of Professional Conduct*' of 1992[237] stated:

> 'As a registered nurse, midwife or health visitor, you are personally accountable for your practice and, in the exercise of your professional accountability, must …
>
> '11 report to an appropriate person or authority, having regard to the physical, psychological and social effects on patients and clients, any circumstances in the environment of care which could jeopardise standards of practice;
>
> '12 report to an appropriate person or authority any circumstances in which safe and appropriate care for patients and clients cannot be provided;
>
> '13 report to an appropriate person or authority where it appears that the health or safety of colleagues is at risk, as such circumstances may compromise standards of practice and care.'[238]

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[235] WIT 0062 0384 Mr Scott

[236] WIT 0062 0398 Mr Scott; '*Maintaining Good Medical Practice*'

[237] 3rd edition, June 1992

[238] WIT 0052 0142 Ms Lavin

182 Although the 1996 guidance gives 'inadequate resources to maintain standards of care',[239] amongst the examples of situations in which it is required that a nurse should report, the obligation on nurses to report applied and applies regardless of whether the substandard circumstances involve another nurse.[240] Thus, further examples include colleagues suffering ill health,[241] and colleagues' 'inappropriate behaviour'[242] (which has overtones of misconduct and abuse of patients). There is no specific mention of colleagues underperforming, but there is an obligation to report 'circumstances in the environment which could jeopardise standards of practice'.[243]

Changes since 1995

183 The Inquiry was told that since 1995 nurses have become more likely to express their concerns. It may be inferred, therefore, that the position in the period with which the Inquiry is concerned was less propitious for them to do so. Ms Lavin said:

> 'I think we are getting better at it. I think people are far more likely to express concerns and be the patients' advocates in circumstances where they have worries about individual practitioners across the board, not just doctors.'[244]
>
> 'Q. You talked about the changing situation of nurses now being perhaps more willing to challenge or complain about or comment on the conduct of doctors than they were in the past. Is that a change that has taken place since or during the period that the Inquiry is concerned with?
>
> 'A. Yes, I would say so.
>
> 'Q. So in the mid-1980s, the culture would be other than that that you have described as being the one that is developing now?
>
> 'A. I qualified as a nurse in 1987 and at that time I think the change was starting to happen.'[245]

184 Ms Lavin explained the possible reasons for nurses being more likely now to express concerns:

> 'A. I think there have been a number of reasons for it. I think that many people would say the changes in nursing education have resulted in practitioners who

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[239] WIT 0052 0341 Ms Lavin; 'Employers have a duty to provide the resources needed for patient and client care, but the numerous requests to the UKCC for advice on this subject indicate that the environment in which care is provided is not always adequate. You may find yourself unable to provide good care because of a lack of adequate resources'. WIT 0052 0341 – 0342 Ms Lavin; 'This [advice] will help to make sure that those who manage resources and staff have all the information they need to provide an adequate and appropriate standard of care. You must not be deterred from reporting your concerns, even if you believe that resources are not available … this [communication] may require senior managers to justify their actions if inadequate resources are seen to affect the situation.'

[240] T33 p. 109–10 Ms Lavin

[241] WIT 0052 0142 Ms Lavin

[242] WIT 0052 0341 Ms Lavin; 'You may also have concerns over inappropriate behaviour by a colleague and feel it necessary to make your concerns known.'

[243] WIT 0052 0342 Ms Lavin

[244] T33 p. 111 Ms Lavin

[245] T33 p. 113 Ms Lavin

> perhaps have got better skills in terms of expressing concerns and feeling able to do so. I am not sure I entirely concur with that view.
>
> 'Q. May it be that now that nursing is more of a university-orientated, educational environment than it was before, that nurses are taken more seriously by doctors than they were before?
>
> 'A. Again, I am not sure about that. I certainly have been in a position as a fairly junior nurse in challenging a doctor about not telling a patient the truth, and in latter years, as a Hospital Manager holding a nursing registration, tackling a consultant about not telling a patient the truth and in fact suggesting I was going to go and tell the patient the true state of affairs myself if he was not willing to do so. I think much depends on the individuals and the dynamics and the relationships between people in the organisation as to how seriously and how credible nursing is viewed.[246]
>
> 'I think that there are some areas of nursing where nurses still see themselves in a very subordinate role to doctors, but again, I think that is changing. Nurses are extending the boundaries of their competence and knowledge; they are taking on many tasks that I think traditionally might have been associated certainly with a junior doctor's role.'[247]

Duty to inform – whistleblowing: healthcare staff in general

185 There was concern, following the introduction of trusts, that healthcare staff, in some trusts, might be in breach of their contract of employment if they were to speak out about issues relating to healthcare in the trust. It was thought that this might be a breach of the duty of confidentiality an employee owes to an employer in respect of information that might be commercially sensitive. Sir Alan Langlands noted that:

> '… the rights and responsibilities of all NHS staff when raising concern about health care issues were set out in guidance to the NHS in 1993.[248] It is the NHS Executive's policy that there should not be confidentiality clauses in contracts.'[249]

Recent developments

186 The Public Interest Disclosure Act (PIDA) 1998 [250] inserts additional sections into the Employment Rights Act (ERA) 1996.

187 In effect, they provide that any provision in a contract which purports to preclude a worker from making a 'protected disclosure' is void; that an employee may not lawfully be subjected to any detriment by any act or deliberate failure to act by his employer, done to him because he has made a 'protected disclosure', nor may he be

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[246] T33 p. 113–14 Ms Lavin

[247] T33 p. 111 Ms Lavin

[248] Guidance to staff on relations with the public and media; EL(93)51 GMC 0006 0017

[249] WIT 0335 0016 Sir Alan Langlands

[250] Enacted 2 July 1998

dismissed, or selected for redundancy on that basis. If detriment, dismissal, or unfair selection for redundancy is proved, the employee is entitled to compensation, in respect of which there is no limit.

188 All depends upon the meaning of 'protected disclosure'. Under the Act, it is a 'qualifying disclosure' [251] meaning:

> '… any disclosure of information which, in the reasonable belief of the worker making the disclosure, tends to show one or more of the following —
>
> '(a) that a criminal offence has been committed, is being committed or is likely to be committed,
>
> '(b) that a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject,
>
> '(c) that a miscarriage of justice has occurred, is occurring or is likely to occur,
>
> '(d) that the health or safety of any individual has been, is being or is likely to be endangered,
>
> '(e) that the environment has been, is being or is likely to be damaged, or
>
> '(f) that information tending to show any matter falling within any one of the preceding paragraphs has been, is being or is likely to be deliberately concealed.'

189 To be protected, a qualifying disclosure must not only be of information in one of those categories, but also must be made:

> '… in good faith —
>
> '(a) to his employer, or
>
> '(b) where the worker reasonably believes that the relevant failure relates solely or mainly to –
>
> '(i) the conduct of a person other than his employer, or
>
> '(ii) any other matter for which a person other than his employer has legal responsibility, to that other person.'

190 Thus, the disclosure is protected only if it is made to the employer, or to someone in an analogous position — or (perhaps oddly) to the person whose failing is criticised.

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[251] Section 42A, ERA 1996; defined in Section 43B

191 However, it is also a 'protected disclosure' if made to a legal advisor in the course of obtaining legal advice,[252] to a Minister of the Crown,[253] to any person prescribed in an Order made by the Secretary of State for the purposes of the section [254] and otherwise (by Section 43G) if:

> '(a) the worker makes the disclosure in good faith,
>
> '(b) he reasonably believes that the information disclosed, and any allegation contained[255] in it, are substantially true,
>
> '(c) he does not make the disclosure for the purposes of personal gain,
>
> '(d) any of the conditions in sub-section (2) is met, and
>
> '(e) in all the circumstances of the case, it is reasonable for him to make the disclosure.'

192 By sub-section (2), the conditions referred to in sub-section (1)(d) are:

> '(a) that, at the time he makes the disclosure the worker *reasonably believes* [256] that he will be subjected to a detriment by his employer if he makes a disclosure to his employer …
>
> '(b) that, in a case where no person is prescribed for the purposes of Section 43F in relation to the relevant failure the worker reasonably believes that it is likely that evidence relating to the relevant failure will be concealed or destroyed if he makes a disclosure to his employer, or
>
> '(c) that the worker has previously made a disclosure of substantially the same information —
>
> '(i) to his employer, or
>
> '(ii) in accordance with Section 43F.'

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[252] Section 43D ERA

[253] In the case of the NHS: see Section 43E ERA

[254] HSE, for example: as at September 1999 no specific person had been proscribed in respect of the NHS (Section 43F ERA)

[255] See Section 43G ERA

[256] (Emphasis added)

193 In determining whether it is reasonable for the worker to make the disclosure, regard is to be had in particular to: [257]

> '(a) the identity of the person to whom the disclosure is made,
>
> '(b) the seriousness of the relevant failure,
>
> '(c) whether the relevant failure is continuing or is likely to occur in the future,
>
> '(d) whether the disclosure is made in breach of a duty of confidentiality owed by the employer to any other person,
>
> '(e) in a case falling within sub-section (2)(c)(i) or (ii), any action which the employer or the person to whom the previous disclosure in accordance with Section 43F was made has taken or might reasonably be expected to have taken as a result of the previous disclosure, and
>
> '(f) in a case falling within sub-section (2)(c)(i), whether in making the disclosure to the employer the worker complied with any procedure whose use by him was authorised by the employer.'

194 It follows that, under the PIDA, disclosure must be made in the first place to the employer, or to a Minister of State or to a prescribed official. It may not be made to any other person, and still retain the quality of a 'protected disclosure', unless the conditions in Section 43G are met. They speak for themselves, but it needs to be emphasised that the provision that the disclosure should be made 'in good faith' means (as the requirement of good faith always does in a statute) 'in the absence of bad faith'. Thus where a worker has mixed motives for making a disclosure (personal pique, pursuance of a political objective, or mischief-making) the disclosure may not qualify. Mixed motives may be very easy to attribute to any potential whistleblower, and would prevent protection under this section.

195 Moreover, the belief must be 'reasonable'. That implies an objective standard in addition to the subjective belief as to the truth of the information. Applying this analysis of the recent developments in the law to the events in Bristol, it is not clear whether any disclosures would have been protected even under the newly enacted law.

Healthcare professionals in management

196 Doctor-managers remain subject to the GMC's jurisdiction, even while acting in a managerial or administrative capacity. The view of the GMC in this regard was upheld by the Privy Council in *Roylance v General Medical Council.*[258]

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[257] Section 43G(3) ERA

[258] 1999 *'Lloyd's Law Reports'* 139–52, PC

197 Nurse-managers similarly remain bound by their professional code of conduct:

> 'They [managers] are absolutely bound by the code whilst they maintain their [UKCC] professional registration.'[259]

And, similarly:

> '… we [UKCC] see cases where we have managers who also hold nursing registration who are reported to us for failing to act on concerns that have been made known to them.'[260]

198 The Privy Council rejected the view of Dr Roylance, which is, perhaps, exemplified by the following exchange:

> 'Q. Did you, being a doctor, have any responsibility, as you saw it, for the best interests of the patient?
>
> 'A. I had a responsibility, but I had no ability to determine what was in the best interests of the patient.'[261]

Team-based standards

199 One trend in professional standards has been the move from standards based on individual responsibility to team-based standards. According to Sir Donald Irvine, as has been seen:

> 'The concept of collective responsibility in clinical teams did not sit easily with such individualism' which '… flowed from, and was reinforced by … the concept – in most doctors' minds – of accountability primarily to the patient and peers.'[262]

200 Sir Donald identified 'The move towards more clinical teamwork and the concept of collective as well as personal responsibility'[263] as a trend since 1984. By contrast, the recent[264] report *'The Regulation of Nurses, Midwives and Health Visitors'*[265] suggests that collective responsibility was the norm, but is being built upon:

> 'Nursing is going through a period of significant change and professional development. Changes in nursing roles and practice include … nurses becoming individually accountable for their practice'.[266]

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[259] T33 p. 108 Ms Lavin

[260] T33 p. 111–12 Ms Lavin

[261] T89 p. 62–3 Dr Roylance

[262] WIT 0051 0003 Sir Donald Irvine

[263] WIT 0051 0002 Sir Donald Irvine

[264] WIT 0052 0275 Ms Lavin; the exact date of the report is uncertain but it is after January 1998

[265] WIT 0052 0183 Ms Lavin; conducted by J M Consulting Ltd for the UK Health Departments

[266] WIT 0052 0220 Ms Lavin

201 However, Ms Lavin qualified that statement:

> 'Individual accountability has always been there. I think nurses are becoming more aware of what it means in practice … .'[267]

202 The GMC essentially regulates individual doctors (it maintains a register of individuals) not clinical teams (such as units). It nonetheless now promulgates standards for teams, but:

> '… [responsibility for] the implementation of this [guidance for collective responsibility] is not with us, it is with employers and this is where the overlap with institutions comes.'[268]

203 In addition, clinical teams are often multidisciplinary and responsibility is shared with managers (who might not belong to one of the healthcare professions):

> '… the regulating bodies, be it for nursing, for medicine, have their prescribed responsibilities for the fitness to practise of the individual practitioner. But managers have always had a duty of care, responsible managers have always seen themselves as having a duty of care for those who come to their hospital or their practice for a service.'[269]

Nursing – National Boards for Nursing, Midwifery and Health Visiting: statutory basis and functions

204 There are National Boards for Nursing, Midwifery and Health Visiting in each of the four countries of the United Kingdom.[270] Their constitution and functions are set out in the Nurses, Midwives and Health Visitors Act 1997, sections 5 and 6.[271] Mr Anthony Smith, the English National Board (ENB) Chief Executive, set out ENB's aims, structure and funding in his witness statement.[272]

205 In 1993 the ENB was streamlined to become a purely professional quality assurance organisation, without a role in administering the management of training courses.[273] The ENB has been concerned with matters such as the standards of training courses,[274] and the quality of student nurse clinical experience,[275] but not directly with standards of nursing care itself.

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[267] T33 p. 135 Ms Lavin

[268] T48 p. 134 Sir Donald Irvine

[269] T48 p. 136 Sir Donald Irvine

[270] English National Board for Nursing, Midwifery and Health Visiting (ENB), National Board for Nursing, Midwifery and Health Visiting for Scotland (NBS), Welsh National Board for Nursing, Midwifery and Health Visiting (WNB), National Board for Nursing, Midwifery and Health Visiting for Northern Ireland (NBNI)

[271] WIT 0052 0025 – 0027 Ms Lavin

[272] WIT 0063 0001 – 0006 Mr Smith

[273] T9 p. 52–3, 136 Mrs Le Var and Mrs Marr

[274] T9 p. 97–8 Mrs Le Var and Mrs Marr; WIT 0063 0010, 0738 Mr Smith. Such as the requirement in children's wards that student nurses be supervised by Registered Sick Children's Nurse at all times: 1988 ENB Circular 1988/53/RMHLV

[275] Mr Smith devotes much of the main part of his witness statement to describing courses, both pre-registration (WIT 0063 0009 – 0016) and post-registration (WIT 0063 0009 – 0022). Mrs Le Var and Mrs Marr address ENB's scrutiny of course quality at T9 p. 89 and T9 p. 93–6

206 The main sanction available to National Boards was the de-recognition of wards or units for training purposes if they did not have sufficient appropriate staff to supervise nurses in training.[276] This is similar to the Royal Colleges' only sanction of de-recognition of medical training posts. The emphasis was on ensuring the quality of training rather than clinical quality itself.

207 The implicit assumption in the focus of the ENB on training is that training will lead to better care. So far as paediatric services are concerned, however, the theory that 'attaining levels of qualifications of children's nurses actually makes a difference to the outcomes in terms of care' is based on only anecdotal evidence.[277]

208 Although the National Boards set standards for training, they do not regard themselves as responsible for compliance with them. Professor Jarman asked Mrs Le Var:

> 'Q. … my general impression is that the ENB is in favour of units where children are nursed, the nurses having children-training. … who actually is responsible for getting what you consider to be a better situation? Whose ultimate responsibility is it? Is it the ENB or the Department of Health, the RCN, or is it nobody? I just want you to give me your general impressions.
>
> 'A. It is a Health Service responsibility, so the Board does not have the power to have that responsibility; the Board can influence and the Board can certainly have responsibility in relation to the areas which are approved for training, but that is where it stops. The general availability of children's nurses is determined by the NHS Executive …
>
> 'Q. So although it is your opinion that it should be a high proportion, it is not actually your responsibility; it is the Health Service, I think you said. You mean who, the NHS Executive or the Department of Health?
>
> 'A. The broad Department of Health, and then specifically within the Department of Health and the NHS Executive …'[278]

209 Although the UKCC, unlike the GMC, is a registered charity,[279] the National Boards are funded by the respective Departments of Health.[280]

210 The Royal Colleges' role in medical education has similarities to the role of the National Boards in nursing education. [281] It is, however, not precisely analogous,

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[276] T9 p. 66 Mrs Le Var and Mrs Marr

[277] T9 p. 126 Mrs Le Var and Mrs Marr

[278] T9 p. 131–3 Mrs Le Var

[279] T33 p. 138 Ms Lavin

[280] WIT 0052 0007, T33 p. 138–9 Ms Lavin. '*The Regulation of Nurses, Midwives and Health Visitors*', para 2.42 (WIT 0052 0225). The proportion of ENB's funding derived from government grant has changed over the years. It has been 98% (1984 onwards), 83% (after the 1992/93 financial year); 70% (for the 1994/95 financial year); and 77% (since 1995) (WIT 0063 0003 – 0006). See Mrs Le Var's explanation of the figures at T9 p. 137

[281] T33 p. 136–8 Ms Lavin

in that the Royal Colleges have a role to play particularly in the attainment of post-registration qualifications, whereas the National Boards focus upon the attainment of an 'entry' qualification.

Royal Colleges

211 There are Royal Colleges for each of the principal hospital-based clinical specialties. They are established by Royal Charter (e.g. the Royal College of Surgeons of England (RCSE) was established in 1800; and the Royal College of Physicians of London[282] (RCP) in 1518).

212 The objectives of each vary, but have a broad similarity in encouraging education and knowledge ('science') in their respective fields. Royal Colleges typically have charitable status. The Inquiry took evidence from the RCSE, the RCP, the RCA, the Royal College of Paediatrics and Child Health (RCPCH) and other Royal Colleges. The first table of comparisons (Table 5) below sets out comparisons between four Royal Colleges of hospital-based clinical specialties in respect of such matters as constitution, membership, fellowship, discipline and funding.

213 There are also Royal Colleges relating to non-hospital-based medical specialties, such as the Royal College of General Practitioners (RCGP). In the second table of comparisons (Table 6), the RCGP is contrasted with the British Paediatric Cardiac Association (BPCA), one of very many other, ad hoc, associations of healthcare specialists. The other specialist associations that have given evidence to the Inquiry include: the British Cardiac Society (BCS), the Paediatric Intensive Care Society (PICS), the Intensive Care Society (ICS), the Society of Cardiothoracic Surgeons of Great Britain and Ireland (SCS), the Association of Paediatric Anaesthetists of Great Britain and Ireland (APA) and the Society for Cardiological Science and Technology. The details of the RCGP in the second table of comparisons (Table 6) may also be compared with those of the four hospital-based specialties in the first table of comparisons.

214 There are also Royal Colleges for healthcare professionals other than doctors, such as the Royal College of Nursing of the United Kingdom (RCN) and the Royal College of Midwives (RCM). In practice, the RCN has functions like that of a trade union, in addition to having a Royal Charter. Miss Christine Hancock, General Secretary, RCN, told the Inquiry:

> 'The RCN is a professional union, responsible for addressing its members' employment and welfare needs, as well as the realisation of their professional goals. In addition, unlike most other accredited trades unions within the health service, it is governed by its Royal Charter to promote the science and art of nursing.'[283]

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[282] There are other Royal Colleges of Physicians, including the Royal College of Physicians of Edinburgh and the Royal College of Physicians of Glasgow

[283] WIT 0042 0004 Miss Hancock

215 The third table of comparisons (Table 7) sets out the similarities and differences between the RCN and the RCM.

Table 5: First table of comparisons

	College			
	RCSE	**RCP**	**RCA**	**RCPCH**
Founded	1800	1518	1992	23 August 1996
Constitution	Royal Charter granted 1800	Royal Charter granted 1518, endorsed by statute 1523. RCP's role and responsibilities altered over time, notably due to the founding of the GMC and the Medical Acts of 1858, 1860, 1886 and 1960	Faculty of Anaesthetists established within RCSE 1948, became College of Anaesthetists in 1988. Royal Charter granted and become Independent Royal College 1992	RCPCH was formerly the British Paediatric Association (BPA) with no statutory authority or duties. Royal Charter granted 17 October 1996
Charitable status	Yes	Yes	Yes	Yes
Headquarters	London	London	London	London
Responsible to whom?	Independent	Responsible to the Privy Council	Independent	Independent
Responsible for	Surgical specialties	Medical specialties, general internal medicine	Anaesthesia	Full range of general and specialist paediatricians (but not paediatric cardiologists)
Aims	Art and science of surgery	To set the standards and to influence the quality of medical practice in hospitals[1]	Education, training, research and promotion of anaesthesia	Art and science of paediatrics, raising standards, education of practitioners and public
Number of members	Fellows and members: 6,000 (UK) and 2,000 (overseas)	9,000 fellows worldwide and 7,000 active collegiate members	10,728 fellows, 962 members and 1,965 trainees	Just over 5,000
Sources of funding	Courses (16%), investments (16%), membership subscriptions (15%), rents, charges and sales (11%), examinations (9%), grants (9%), legacies (8%), residential and conference (8%), donations (8%)	Membership subscriptions, examination fees, DoH grants in aid, investments, room hire	Fellows' subscriptions (45%), examination fees (21%), course fees (13%), DoH grants (6%), investment income (6%), other income (9%)[2]	Members' subscriptions, annual meeting, research unit, profits from archives, trading subsidiary, sales of publications, donations, surveillance unit, training grants[3]

Table 5: First table of comparisons (continued)

	College			
	RCSE	**RCP**	**RCA**	**RCPCH**
Basic membership	LRCS (primary qualifying diploma)	Membership is obtained through passing an examination (MRCP(UK)) and payment of a diploma fee	Membership (paying College subscriptions and participating in College activities) voluntary	Ordinary members have passed College membership examination – MRCPCH (parts 1 and 2). Junior members have commenced training but not passed exam. Administers Diploma in Child Health (DCH)
Higher membership	MRCS (postgraduate diploma – basic surgical training)	Associate membership; MRCP(UK) qualification[4]	Fellowship: FRCA (following traditional surgical model)	Associate members are paediatricians in non-consultant career grade posts and medical practitioners from other specialties with an interest in child health
Fellowship	FRCS (intercollegiate examination toward end of specialist training)	FRCP	See above	Fellows are selected by Council from members on Specialist Register
Is membership a requirement for employment?	No, but widely looked for	Membership and Fellowship are not compulsory for employment in relevant posts, though generally recognised	Membership has no legal relationship to the continued practice of the specialty	
Training post approval	Role in the Joint Committee on Higher Surgical Training and the Specialist Advisory Committees	Approves senior house officer (SHO) posts and rotations for training. Central to the Joint Committee on Higher Medical Training's approval and supervision of training posts and programmes	Programmes of inspection of hospital posts for approval of training of anaesthetists: 'a powerful tool … through the ultimate sanction of removal of training posts'.[5] Provides an Advisory Appointments Committee assessor on consultant and non-consultant career grade appointment committees	Higher Specialist Training: monitors trainees, publishes syllabus and recommends Certificates of Completion of Specialist Training. General Professional Training: inspecting and approving SHO posts. Advising committees appointing consultant paediatricians

Table 5: First table of comparisons (continued)

	College			
	RCSE	**RCP**	**RCA**	**RCPCH**
Standard-setting	Has published many documents, including *'The Surgeon's Duty of Care'*. No statutory powers	Ad hoc reports and guidelines are recommendations as to good practice. Some statutory powers: providing representatives on advisory appointment committees; also delegated powers with respect to specialist training from specialist training authority	Sets educational and training standards for entrants and good practice and conduct for continuing members	
Current President[6]	Sir Barry Jackson	Prof Sir George Alberti	Dr Peter Hutton (Professor Cedric Prys-Roberts was President from June 1994 for 3 years)	Prof David Hall
Discipline of members	'The College's disciplinary powers over members are limited. … It cannot … of itself, initiate disciplinary action against individuals in relation to their standards of professional practice'[7]	If member 'has been guilty of any great crime or public immorality, or has acted in any respect in a dishonourable or unprofessional manner.'[8] Participation in Joint Cardiology Committee 'intermediate procedure' review	Grounds for termination of membership include fraudulent application for membership, criminal conviction, GMC erasure, bankruptcy (not yet used). The Joint Liaison Committee responds to requests for help in dealing with the poor performance of anaesthetists and with system failures	'The College has the ability (rarely exercised) to expel a member for misconduct.'[9] Scope for expansion with CME and reaccreditation. 'The College sets professional standards: the GMC enforces them'[10]
Continuing Professional Development/ Continuing Medical Education (CME)	Involved in Senate of Surgery publications promoting CME	Co-ordinates and monitors for consultant and non-consultant career grade physicians	Likely in future to be a requirement of membership. Wants statutory role in CME linked to revalidation	

Table 5: First table of comparisons (continued)

	College			
	RCSE	**RCP**	**RCA**	**RCPCH**
Historic links to other colleges	RCSE keeps pre-1992 archives of RCA	Historic links with many other Colleges. Before formation of RCPCH, paediatricians were represented on own board within RCP. RCP retained responsibility for paediatric cardiology. Joint CME programme with the Royal Colleges of Physicians of Edinburgh and Glasgow	RCSE keeps pre-1992 archives of RCA. Mutual recognition of Fellowship of College of Anaesthetists and Royal College of Surgeons in Ireland	RCP retained responsibility for paediatric cardiology

1. WIT 0032 0001 Professor Sir George Alberti. The College has, since the period covered by the Inquiry, developed a new statement of purpose – see further WIT 0032 0002
2. WIT 0065 0117; RCA annual report 1997/98 Professor Strunin
3. WIT 0036 0151; annual report 1997/98 Professor Baum
4. WIT 0032 0003 – 0004 Professor Sir George Alberti
5. WIT 0065 0007 Professor Strunin
6. As at January 2001
7. WIT 0048 0003 Sir Barry Jackson
8. WIT 0032 0017 Professor Sir George Alberti; chapter 34, bye-law 168 'Of Penalties'
9. WIT 0036 0009 Professor Baum
10. WIT 0036 0010 Professor Baum

Table 6: Second table of comparisons

	College	
	RCGP	**BPCA**
Founded	1952	1991
Constitution	1952 (unincorporated association), 'Royal' prefix 1967, Royal Charter granted 1972	1991. Non-statutory body[1]
Charitable status	Yes	A non-profit-making organisation
Headquarters	London	No headquarters building
Responsible to whom?	Independent	Independent, but affiliated to the British Cardiac Society
Responsible for	General practitioners	Paediatric cardiologists and paediatric cardiac surgeons

Table 6: Second table of comparisons (continued)

	College	
	RCGP	**BPCA**
Aims	'To encourage, foster and maintain the highest possible standards in general medical practice'[2]	'To promote the study and care of infants and children with heart diseases … to promote and distribute study data pertaining to these problems and their prevention; to help those engaged in this work … to promote communication and co-operation between these workers.'[3]
Number of members	18,400	270
Sources of funding	Annual membership fees, examination fees, sale of publications, grants for specific research and particular projects and activities	Members' subscriptions
Basic membership	MRCGP	–
Higher membership	–	No higher membership
Fellowship	FRCGP	No fellowship
Is membership a requirement for employment?	'Membership of the College is voluntary.'[4] 'The College in 1994 stated that all new principals in general practice should normally possess the MRCGP.'[5]	No
Training post approval	'The College plays no direct role in the regulation of entry to the profession nor continued membership of it. The Competent Authority which regulates entry to general practice is the Joint Committee on Postgraduate Training for General Practice (JCPTGP)'[6]	'The Association plays a major role in training but the statutory control of this rests with the Specialist Advisory Committee (SAC) of Paediatric Cardiology of the Joint Committee on Higher Medical Training of the Medical Royal Colleges and of the SAC in Cardiothoracic Surgery of the Joint Committee on Higher Surgical Training of the Royal Colleges of Surgery.'[7]
Standard-setting	'In 1993 the Royal College of General Practitioners, in conjunction with the British Paediatric Association, produced guidelines on the paediatric component of vocational training for general practice'[8]	'It has attempted to advance professional standards and good inter-disciplinary practice.'[9]
Current President[10]	Dame Lesley Southgate	Dr Michael Godman
Discipline of members	'The College has limited regulatory control over its members in the sense of their right to practise. The College's disciplinary powers are generally confined to striking them from the list of members if they fail to renew their subscriptions or when they are struck off the Medical Register by the General Medical Council (GMC)'[11]	'The British Paediatric Cardiac Association at present is not a regulatory body…'[12]

Table 6: Second table of comparisons (continued)

	College	
	RCGP	**BPCA**
Continuing Professional Development/Continuing Medical Education (CME)	Introduction of Accreditation of Professional Development (APD) planned	The BPCA appoints a Council Member to regulate and assess programmes of Continuing Medical Education in Paediatric Cardiology. This responsibility has been devolved to the Association from the Royal Colleges[13]
Historic links to other colleges	None	Affiliated to the British Cardiac Society, and thereby to other similarly affiliated associations[14]

1. WIT 0047 0014
2. WIT 0059 0020 Royal Warrant
3. WIT 0047 0014 Dr Godman
4. WIT 0059 0003 Dr Reith
5. WIT 0059 0006 Dr Reith
6. WIT 0059 0003 Dr Reith
7. WIT 0047 0004 Dr Godman
8. WIT 0059 0005 Dr Reith
9. WIT 0047 0003 Dr Godman
10. As at January 2001
11. WIT 0059 0005 Dr Reith
12. WIT 0047 0004 Dr Godman
13. WIT 0047 0003 Dr Godman
14. WIT 0066 0002 Dr Howard Swanton

Table 7: Third table of comparisons

	College	
	RCN	**Royal College of Midwives[1]**
Founded	1916	1881: Midwives Institute founded under the patronage of Queen Victoria 1889: Incorporated under the Companies Acts 1942: Name changed to The College of Midwives 1947: Name changed to The Royal College of Midwives 1971: The Royal College of Midwives was included on the Special Register of trade unions established under the Industrial Relations Act 1971
Constitution	Royal Charter granted 1928	The last modifications to the Memorandum and Articles of Association were made on 20 April 1999
Charitable status	Yes	The College does not have charitable status. A sister college (The Royal College of Midwives Trust) is registered as a charity
Headquarters	London	London

Table 7: Third table of comparisons (continued)

	College	
	RCN	**Royal College of Midwives**[1]
Responsible to whom?	'The College is accountable to Her Majesty the Queen in Privy Council'[2]	Independent
Responsible for	Nurses	Midwives
Aims	'To promote the science and art of nursing and the better education and training of nurses and their efficiency in the profession of nursing'[3] and other aims	'To promote and advance the art and science of midwifery, to promote the effectiveness of and protect the interests of midwives'[4]
Number of members	318,000	Approximately 35,000
Sources of funding	Membership subscriptions, gifts[5]	Membership subscriptions: 95% Net income from courses: 2% Dividends and interest: 2% Other: 1%
Basic membership	Full membership is open to all nurses on any part of the UKCC Register. In addition there are Newly Qualified, Joint, Career Break and Associate memberships, depending on circumstances	Full membership and Overseas membership are available to practising midwives. Associate, Retired and Honorary memberships are available for those no longer practising, depending on eligibility
Higher membership	No higher categories of membership	No higher categories of membership
Fellowship	No higher categories of membership	No higher categories of membership
Is membership a requirement for employment?	No	Membership is not required or even recommended for practice as a midwife
Training post approval	No	The College does not inspect or approve midwifery training posts
Standard-setting	'The RCN is a leading player in the development of nursing practice and standards of care.'[6] 'The RCN offers its members a wide range of services including: development of nursing practice and standards of care'.[7] 'The Dynamic Quality Improvement Programme has focused on developing work, including … developing specialist guidelines and standards.'[8] 'An initial programme of work to develop national standards for particular specialty areas was undertaken during the late 1980s and early 1990s. This resulted in the production of standards for a whole range of specialist subjects'[9]	The College plays only an advisory role to its members and the five statutory bodies (the UKCC and the four National Boards)
Current President	Mrs Roswyn Hakesley-Brown (General Secretary: Christine Hancock)[10]	Dame Lorna Muirhead (General Secretary: Karlene Davis)[11]

Table 7: Third table of comparisons (continued)

	College	
	RCN	**Royal College of Midwives[1]**
Discipline of members	'The RCN can remove members from membership, although this power has never been used'[12]	The College regulates the conduct of its members only in relation to the Code of Conduct for Council members as directors of the company and trustees of a charity
Continuing Professional Development/Continuing Medical Education	'The RCN offers its members a wide range of services including: education and professional development activities'[13]	The RCM currently runs courses, study days, workshops and conferences
Historic links to other colleges	'The RCN has a good track record in working with other organisations in order to improve health care.'[14]	Links with other Royal Colleges are informal and depend upon mutual co-operation

1. Information in WIT 0576 0001; letter from Louise Silverton, Deputy General Secretary, Royal College of Midwives to Inquiry, dated 6 October 2000
2. WIT 0042 0003 Miss Hancock
3. WIT 0042 0004 Miss Hancock
4. WIT 0576 0016; Memorandum of Association of The Royal College of Midwives
5. WIT 0042 0004 Miss Hancock
6. WIT 0042 0003 Miss Hancock
7. WIT 0042 0003 Miss Hancock
8. WIT 0042 0005 Miss Hancock
9. WIT 0042 0005 Miss Hancock
10. As at January 2001
11. As at January 2001
12. WIT 0042 0003 Miss Hancock
13. WIT 0042 0003 Miss Hancock
14. WIT 0042 0025 Miss Hancock

216 As 'independent' bodies, the Royal Colleges are not accountable to anyone other than their own members for achieving their respective objectives, save to the extent that some are responsible to the Privy Council (see Tables above). Much evidence was received as to the role of the Royal Colleges in the maintenance of standards, both in relation to clinical practice and to professional education.

Educational and training standards

217 The GMC has the statutory function of promoting high standards of medical education, but traditionally, the Royal Colleges and specialist associations have set standards for higher and specialist training:

> 'Responsibility for the form and specific content of training programmes, and for overseeing the assessment of trainees, rests with the appropriate training body – usually a Royal College, Faculty or joint higher training committee.'[284]

218 Over the period 1984–1995, the Colleges (including the RCSE) awarded Certificates of Accreditation to those who satisfactorily completed specialist training, as a mark of a fully trained surgeon ready for a consultant appointment and independent practice.

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[284] WIT 0062 0012 Mr Scott

This certificate was not a mandatory requirement for appointment.[285] However, such accreditation gradually became more generally recognised and was more likely to be required by consultant appointment committees.[286]

> 'The College [RCSE] … ensures that the required standards of training are provided by regular inspection and approval of training posts and recognition of individual consultant surgeons as trainers. It can act, and has done so, to de-recognise a training programme or trainer where it considers the required standards of provision or supervision not being met. These arrangements have been in place for many years, applied during the period 1984–95, and continue to operate.'[287]

219 A Regional Medical Postgraduate Dean is appointed by a university; there is, for example, one appointed by the University of Bristol. Postgraduate Deans were mentioned infrequently in evidence to the Inquiry about standards and quality of care, despite the extensive machinery for postgraduate training in every region. Sir Barry Jackson told the Inquiry about the role of the Postgraduate Dean in dealing with recognition of trainers and training posts in relation to surgery:

> 'The Postgraduate Dean is responsible for ensuring that the educational function of a higher surgical training post is actually carried out, the educational side.'[288]

220 Professor David Baum, the then President of the RCPCH, told the Inquiry that part of the career progress of a paediatrician is:

> '… higher training … in which there is … an annual appraisal with the Regional Adviser of the College and the Postgraduate Dean'.[289]

221 Whilst a College could point out an institution's deficiencies, de-recognition as a training institution was the only sanction it could apply to it:

> '… no Royal College or comparable professional body had statutory powers to impose professional and quality standards on hospitals or individual consultants.'[290]

> 'If at the end of that inspection and the interviews that take place, the committee is dissatisfied with any aspect of the training, what would normally happen – and I stress "normally" – would be that they would make it clear in a written statement to the Trust concerned that there were deficiencies and that they would not approve that post for training for the next quinquennium, but they would wish to reinspect,

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[285] WIT 0048 0003 Sir Barry Jackson. Sir Barry Jackson's statement continues, however, 'With the introduction of the European Specialist Medical Qualifications Order (1995), it became mandatory from 1 January 1997 for an individual seeking appointment as a consultant to be entered on the new Specialist Register of the General Medical Council'

[286] T28 p. 3–5 Sir Barry Jackson

[287] WIT 0048 0004 Sir Barry Jackson

[288] T28 p. 24 Sir Barry Jackson

[289] T18 p. 55 Professor Baum

[290] WIT 0047 0027 – 0028 Royal College of Surgeons

> reassess the situation within a given period of time, usually 6 months, sometimes a year, after the perceived deficiencies have been corrected and they would then go back and see the post again to check that the deficiencies that they have noted have been rectified. In almost every case – not all, but in almost every case – those deficiencies are rapidly corrected by the hospital concerned, by the trainers concerned, because they do not wish to lose training status. Occasionally, it turns out that those corrections have not been put into place, in which case, in the case of the SAC, they would recommend to the JCST, the Joint Committee, that training, the recognition be removed and in the case of the Hospital Recognition Committee, they would recommend to their parent committee in the College, the Training Board, that recognition should be removed. Very rarely, a committee may come across such a situation which would merit instant de-recognition.'[291]

Educational and training standards – with particular reference to surgery

222 Higher surgical training is controlled and administered by the Joint Committee on Higher Surgical Training (JCHST). It is 'joint' in the sense that it represents not only the four surgical Royal Colleges in the United Kingdom and Ireland, but also the relevant specialist associations and the university professors of surgery.

223 So far as basic medical and surgical training is concerned,[292] the Hospital Recognition Committees (HRCs) discharge the functions of the Royal Colleges.

224 The JCHST's '*A Manual of Higher Surgical Training in the United Kingdom and Ireland*' sets out the scheme of higher surgical training:

> 'The Scheme of Higher Surgical Training is controlled and administered by the JCHST representing the four surgical Royal Colleges in Great Britain and Ireland, the relevant Specialist Associations and the University Professors of Surgery. The JCHST is the advisory body to the surgical Royal Colleges with regard to Higher Surgical Training and award of the Certificate of Completion of Specialist Training, supported for the day to day management of the scheme by the Specialist Advisory Committees (SACs). The JCHST and the SACs are administered by a secretariat at the Royal College of Surgeons of England.'[293]

225 Sir Barry Jackson described the respective roles of the JCHST, SAC and HRC:

> 'A. The Hospital Recognition Committee is run solely by the Royal College of Surgeons, but part of its complement would include invited members representing a range of specialties. It is responsible for monitoring similar to the Joint Committee on higher surgical training, the training and the posts for what is known now as basic surgical training. That is the training that all trainees receive in the generality of surgery, sometimes called "common trunk training", before embarking on a

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[291] T28 p. 10–11 Sir Barry Jackson

[292] 'The Hospital Recognition Committee was strictly under the aegis of the Royal College of Surgeons in England looking at training in England and Wales alone.' Sir Barry Jackson T17 p. 57, but other Royal Colleges (including the Royal College of General Practitioners) have an HRC

[293] JCHST, '*A Manual of Higher Surgical Training in the United Kingdom and Ireland*', p. 1 (May 1996); WIT 0048 0038 Mr Jackson

> specialist training in one of the nine recognised surgical specialties such as orthopaedic surgery, cardiothoracic surgery and such like. It has a very similar role at basic surgical training level as the JCHST you have referred to has at higher surgical training level, and it is responsible also for ensuring that the training the basic surgical trainee obtains is suitable and appropriate for them to be eligible to sit an examination in the generality of surgery, which used to be called the FRCS [Fellowship of the Royal College of Surgeons] and is now called the MRCS [Membership of the Royal College of Surgeons].
>
> 'Q. So if one were looking at the accreditation of teaching posts and teaching positions within Bristol, one would be looking firstly at the role of the Hospital Recognition Committee for basic surgical training, and then at the specialist level, looking within the field of cardiothoracic surgery, it would be the specialist advisory committee with particular responsibility for that field which would be responsible for the appropriate accreditation?
>
> 'A. That is absolutely correct, yes.'[294]

226 The main means by which the Royal Colleges regulate medical education is through the SAC's inspection of training posts. Sir Barry Jackson described the system in relation to cardiothoracic surgery thus:

> 'Cardiothoracic surgery is a relatively small specialty and therefore the SAC itself acts as the training committee and interviews all higher surgical trainees at least once during the course of their training. The SAC also arranges regular inspections, normally every 5 years, or more frequently where necessary, of programmes and posts where training is carried out. At all such inspections trainees have confidential interviews with the visitors at which time they can comment on the quality of the training post and their trainers. All trainees are subject to annual assessment by their trainers and all trainees are required to complete training post assessment forms so that the relevant training committee and the SAC gets feedback from the trainees.'[295]

227 The reporting process further explains the relationship between the bodies:

> '… the report of each SAC inspection would be reported to the parent Specialist Advisory Committee in full session, which in turn would report to the Joint Committee on higher surgical training … .'[296]

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[294] T28 p. 7–8 Sir Barry Jackson

[295] WIT 0048 0012 Sir Barry Jackson

[296] T28 p. 15 Sir Barry Jackson

228 A limitation on Royal Colleges' inspections (SAC and HRC) is simply that they were not designed to monitor the clinical quality as such of the training clinician or institution:

> 'Q. Would you say that the inspections are mainly designed to make sure that trainees have adequate clinical experience and supervision, or would you say they were designed to examine the quality of the care in the hospital?
>
> 'A. The former.'[297]

229 To a question about the regard paid by SAC visitors to the quality of surgery performed by a consultant involved in training, Sir Terence English, past President of the RCSE, said:

> 'A. It was not a requirement as such. It was perhaps something — well, it certainly did not receive as much attention as the quality of the training which the individual was receiving.
>
> 'Q. Quality of training was the whole purpose of the visit?
>
> 'A. Correct.
>
> 'Q. So inevitably, quality of outcome would not, could not, receive as much consideration as that, but I think what you are telling me – I want to be sure I am right about it – is that whether formally or informally, it was the expectation of all concerned that those visiting the unit would ask about quality of outcome, or quality of surgery?
>
> 'A. I think the reality of it was that generally, throughout surgery, it was not regarded – it was not common to enquire specifically about mortality at SAC visits. I am not sure about that, but as a generalisation, I think that is true.'[298]

230 The quality and effectiveness of visits at Bristol in respect of cardiothoracic surgery were evidenced by what was said about two visits within a week of each other, the first on behalf of the SAC by Mr David Hamilton and Mr Julian Dussek (8 July 1994) and the second on behalf of the HRC (therefore dealing with more junior doctors in training) by Miss Leela Kapila and Mr P May (13 July 1994). The detailed evidence is set out later, to the effect that obvious features of the layout and facilities were mis-stated in the former report, which also bore such similarity to the report five years earlier, to bear the inference that the text had merely been copied, without there being any fresh consideration of its contents. Such was the difference between the factual circumstances recorded in the two reports, that the co-ordinating of information between them was called into question.

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[297] T28 p. 140 Sir Barry Jackson

[298] T17 p. 27 Sir Terence English

231 Sir Terence told the Inquiry about the difficulty of co-ordinating training visits:

> ‘Q. And so far as giving a complete picture of the service, not only the more important, as you describe it, senior trainees, but also the less important junior trainees, who in the Royal College would, as it were, look at or be likely to look at the 2 reports, put them side by side and say, “Well, we have a problem here which has to be sorted”, or something to that effect?
>
> ‘A. That, to my knowledge, did not happen. The SAC, as I explained earlier, was very much an intercollegiate committee. The Hospital Recognition Committee was strictly under the aegis of the Royal College of Surgeons in England looking at training in England and Wales alone. And the whole question of which units should be recognised for training, which should be warned if they were falling down in their training, was dealt with very separately. That may be an error, but that is the way it was. I think it would have been difficult to try and co-ordinate the two. Having said that, if there was a problem in a particular unit that was brought to the attention of the College, then I would hope that both reports would be looked at critically.
>
> ‘Q. What I think you are telling me – please confirm if it is the case – is that any cross-referencing between the reports would occur by accident rather than design, except if there were a particular query about a particular unit?
>
> ‘A. In essence, I think that is correct.’[299]

232 The lack of co-ordination in visits from Royal Colleges was recognised by Professor Strunin as a drawback of the system:

> ‘This is one of the criticisms of the College visits, of course: there is no co-ordination. I have to say now, if we encounter serious anaesthetic problems, our visitors are instructed to ask the Medical Director whether they have had a visit from any other College recently, because often there are problems in other specialties. The Medical Director does not always wish to tell us that, of course, which is a problem. There is no co-ordination at the moment. That is about to change as well, because it is obvious that visit after visit is unsatisfactory, and there are moves to see whether these can be brought together… .’[300]

Educational training standards – proposals for change

233 Sir Barry Jackson emphasised that ‘the [Royal] Colleges and the specialist associations are reconsidering all aspects of inspection, [and] training processes’.[301]

234 Amongst ideas being considered is that there should greater co-ordination between HRC and SAC visits and between visits of different SACs, or that visits should be

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[299] T17 p. 57–8 Sir Terence English

[300] T14 p. 132–3 Professor Strunin

[301] T28 p. 60 Sir Barry Jackson

broader in what they look for and to whom they speak. Professor Strunin was questioned on this:

> 'Q. … do you think some formal method of co-ordination could be helpful and practical?
>
> 'A. I think it would be helpful. The practicalities of it are not quite as straightforward as might be. There is also of course the role of post-graduate dean, and some of the things we look at in visits we are going to devolve to the post-graduate deans. Our college, and I suspect others will do the same, would wish to reserve the right to visit anyway, because of course the post-graduate deans may also find themselves compromised on occasional issues and we would wish to come as an outside body and look at that specifically.'[302]

The Colleges' role and responsibility for setting and monitoring standards of care

235 There were differing views as to which organisation it was that laid down standards relating to the outcome of care in the period of the Inquiry's Terms of Reference. Professor Sir Kenneth Calman said that it was the medical profession as a whole, rather than the DoH or any particular Royal College:

> 'Q. In terms of laying down standards [relating to the outcome of care], who would do it? The Royal Colleges? The Department of Health? Would it depend on the area?
>
> 'A. It would generally be the profession, and I say that rather than the Royal Colleges, because there may be a number of areas which do not neatly fall into a particular Royal College.'[303]

236 In the specific context of supra regional services Dr Norman Halliday, the Medical Secretary of the SRSAG, by contrast, took the view that he was reliant upon the Royal Colleges for such matters, to the exclusion of a role for the SRSAG.

237 Professor Gareth Crompton (former CMO, Wales), speaking of cardiac services, said that:

> 'Welsh policy was heavily reliant on the best available authoritative advice, notably from … Joint Cardiac Committee of the Royal College of Physicians of London and the Royal College of Surgeons of England.'[304]

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[302] T14 p. 132–3 Professor Strunin

[303] T66 p. 17 Professor Sir Kenneth Calman

[304] WIT 0070 0001 Professor Crompton

238 Dr Roylance relied heavily on the Royal Colleges to maintain clinical standards:

> ‘A. … The whole purpose of a Royal College of Radiologists is to oversee standards in radiology, and they do that in a whole variety of ways. If they are not maintaining standards in radiology, I do not know what they are doing.
>
> ‘Q. So you depended a lot on them?
>
> ‘A. The expertise in whether the clinical work was up to standard lay within the profession and the profession was concentrated and represented and overseen by the Royal College.’[305]

239 Dr Roylance stated:

> ‘I also considered that the Royal Colleges had an overall responsibility for the maintenance of standards and that if concerns about such issues were made known to them and a solution could not be found through their own good offices, they would notify me that appropriate management action was required.’[306]

240 Dr Roylance thus indicated a belief that maintenance of clinical standards was primarily the Royal Colleges’ responsibility rather than that of local management. For their part, the Royal Colleges regarded problems with local services as the responsibility of local management:

> ‘Q. What would you conceptually regard as being the role of management in such a situation as I started off by positing, when there are some concerns being expressed about the performance or outcomes of a particular service within a hospital?
>
> ‘A. Conceptually, I think if management was aware of that it would be up to management to discuss that with the clinicians concerned to try and resolve the matter, quite clearly.’[307]

241 Management faced difficulty in knowing what precisely to expect of doctors clinically, as the evidence of Sir Donald Irvine suggests:

> ‘Q. So was it one of the problems in bringing the bad doctor to book that the non-medical management did not necessarily know what to expect of a good doctor?
>
> ‘A. Yes.’[308]

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[305] T26 p. 4–5 Dr Roylance

[306] WIT 0108 0020 Dr Roylance

[307] T28 p. 129–30 Sir Barry Jackson

[308] T48 p. 83 Sir Donald Irvine

242 Sir Barry Jackson told the Inquiry that part of RCSE's role in more recent years had been the preparation and dissemination of clinical guidelines for the surgical management of certain conditions.[309] However:

> '… in the production of clinical guidelines, the College has no statutory power to ensure that these are followed by individual surgeons but these are again published on the assumption that they will be adopted by surgeons. The College's powers in this area and in other areas of professional regulation of consultant and other career-grade surgeons may be extended with the introduction of re-validation as a basis of continuing registration to practice, but this concept is still at an early stage of development.'[310]

243 This was echoed in respect of the RCP by its President, Professor Sir George Alberti:

> '… I would also hope that we can ensure that all consultants in the country, in all specialties, continued to maintain and improve their standards, their practice and their knowledge, throughout their working career, which, in most professions, was a tacit assumption but without any obligation in the past.'[311]

244 Sir George agreed that the RCP had in the past been reactive rather than proactive:

> 'A. I think now we would be much more interventionist on the grounds of safety, particularly, and quality.
>
> 'Q. What you are telling me is that in those particular years, at any rate, the Royal College of Physicians would hesitate to interfere or influence the exercise of clinical freedom upon the grounds that it perceived generally that the public interest lay in an opposite direction?
>
> 'A. I think that, first of all, if we were not informed that there were problems, we would not have any ability to interfere, other than informally.
>
> 'Q. So it would be reactive rather than proactive?
>
> 'A. Correct.'[312]

245 Sir Barry Jackson told the Inquiry that:

> 'The College's [RCSE's] disciplinary power over members are limited. …
> It cannot … , of itself, initiate disciplinary action against individuals in relation to their standards of professional practice. The College will not remove the status of fellow or member from individual members unless they have been found guilty of

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[309] WIT 0048 0004 – 0005 Sir Barry Jackson

[310] WIT 0048 0005 Sir Barry Jackson

[311] T9 p. 3 Professor Sir George Alberti

[312] T9 p. 41–2 Professor Sir George Alberti

serious professional misconduct by the GMC, have been convicted of a significant criminal offence or fail to pay their subscriptions to the College.'[313]

246 Professor Strunin discussed the relative roles of the GMC, Royal Colleges and trusts:

> 'Q. The question I was asking was the balance of responsibility or involvement between, firstly, the General Medical Council; secondly, the Hospital Trust; and, thirdly, the Royal College of Anaesthetists or other Colleges in, as it were, regulating, to use that word in its loosest sense, the competence and performance of individual practitioners?
>
> 'A. I understand the question. The reality is this. If you take the General Medical Council first, they have the ultimate sanction in that they control the register, but they have no power to go and visit anywhere, they have to wait for a complaint, and under the law that operates it has to be a serious complaint. Up to 1st July 1997 they could only look at specific cases. They can now look at patterns of performance, but, nevertheless, they are, I think, at the end of the line, because it would take a while before something comes to them. The College, again, for an individual practitioner, would have to wait for a report, although we could pick up problems in a department when we do a training visit. But, as I indicated, that is for training specifically, it is presumably training, and not to look at the clinical service per se. The Trust is the right place. That is where the work is carried out; that is where it should be done, and they have mechanisms to deal with that. They can prevent a practitioner from practising, they can suspend a practitioner, they can report him to the General Medical Council if they wish, they can go down the procedures laid down by the Department of Health for suspension, and so forth. And I would say, as the prime group who look at quality clinical practice day by day, that has to be locally within the hospital, and as far as an anaesthetic department is concerned, that is a prime responsibility of the Clinical Director.
>
> 'Q. So you are saying that the Trust represents what you might call the "front line" of quality, or scrutiny of the quality, of clinical practice?
>
> 'A. I think they have to, because there is no means of anybody externally knowing about that until there is a serious problem. We are based in London. It is unlikely we will know what is going on anywhere else in the land until somebody tells us about it, whereas that is an absolute responsibility. Now, with the clinical governance, of course, it starts with the Chief Executive, but it has always been, in my view, an absolute responsibility of the Clinical Director of the service to make sure it is properly delivered and, if there are problems, to address them.
>
> 'Q. You describe the GMC as representing what you might call the "end of the line" in terms of acting upon complaints. It is right, I think, that your statutes require you to follow the judgment of the GMC in striking off any practitioner, or removing

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[313] WIT 0048 0003 Sir Barry Jackson

> from membership any practitioner, who has failed to meet proper professional standards. If we look at page 7 of your statement[314] where, at paragraph 5.1 you summarise the position, it follows that you do not have power, as I understand it, under your ordinances, to discipline for clinical incompetence without the prior decision of the GMC; is that right?
>
> 'A. That is correct.
>
> 'Q. The corollary of that seems to be that in fact you have never actually had to exert that power; is that right?
>
> 'A. That is also correct.'[315]

247 The only formal sanction over consultants who do not follow clinical guidelines is to remove the trainer status of those who are college trainers. Sir Barry Jackson told the Inquiry:

> '… we had no statutory way in which we could maintain standards at consultant level at that time, or even now we have no statutory method of doing it, other than by removing trainer status.'[316]

Sir Barry Jackson's evidence included this exchange:

> 'A. … any College guideline that comes out, such as the one you have on the screen at the present moment,[317] is a recommendation by the College to its fellows and others, but it is not mandatory upon our fellows and others to follow those guidelines or those recommendations.
>
> 'Q. No, we understand from your evidence that the College may set standards, but it has very limited powers, indeed, in terms of enforcement?
>
> 'A. Sadly, that is true.'[318]

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[314] WIT 0065 0007 Professor Strunin

[315] T14 p. 13–15 Professor Strunin

[316] T28 p. 141 Sir Barry Jackson

[317] RCSE 0001 0009; *'How Doctors Explain Risks To Patients*'

[318] T28 p. 120–1 Sir Barry Jackson

248 The Royal Colleges had no power to enforce compliance with its standards for those already in post other than the indirect one of the threat of de-recognition of training posts.[319] This does not, of course, affect surgeons who have finished training, namely consultants: 'The Royal College of Surgeons of England has no formal or statutory role in identifying or enforcing retraining obligations for consultant surgeons.'[320] The greatest sanction that a Royal College can apply to an individual consultant is limited and indirect: if the consultant is a trainer or examiner for a College, the College can withdraw that recognition.[321]

249 If the Royal Colleges' powers over its members are limited, their ability to persuade their members to adopt new practices is also limited. Dr Kieran Walsh, Senior Research Fellow, University of Birmingham, indicated (at least in relation to the introduction of audit) that professionals at the grass roots were less than enthusiastic about following the lead of Royal Colleges:

> 'I would distinguish though, between the reaction of the professional bodies, the Royal Colleges and others and the great and the good, and the profession on the ground. I think your paper cites a study that suggested that on the ground the profession was perhaps less enamoured, less convinced, than professional bodies and organisations. That is reflected in some of the papers recruited from individual clinicians, saying "Whilst we sign up to the aims of this, we are not sure it is really going to work and deliver improvement" or whatever.'[322]

250 It is not possible for the DoH or professional bodies to implement a policy without consensus agreement, as Professor Sir Kenneth Calman agreed:

> 'Q. You need a very firm consensus view to carry a whole profession with a particular policy?
>
> 'A. Yes.'[323]

251 Sir Donald Irvine stated that an outstanding problem was that: 'The Royal Colleges had no power to impose on individual members the professional standards they developed and were refining: they could only require an entrance examination.'[324]

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[319] Although Sir Donald Irvine and Professor Liam Donaldson state: 'In Britain, the accreditation of training schemes for doctors in hospital, general practice or public health medicine has led to the setting of standards and their enforcement by the Royal Colleges.' Irvine D, Donaldson L. 'Quality and Standards in Health Care'. *'Proceedings of the Royal Society of Edinburgh'* (1993); 101 B: 1–30 at p. 22; WIT 0051 0051 Sir Donald Irvine

[320] WIT 0048 0012 – 0013 Sir Barry Jackson

[321] WIT 0048 0013 Sir Barry Jackson: 'Since 1996 the Colleges have been implementing a structured system of continuing medical education in which all practising surgeons were expected to participate as a professional obligation. The Senate has more recently expressed the view that it is mandatory for all practising surgeons to participate but the only sanction the Colleges currently have against individuals who fail to participate would be to withdraw recognition as a trainer or examiner for the College. It should be recognised that not all surgeons are necessarily trainers or examiners'

[322] T62 p. 18 Dr Walsh

[323] T66 p. 35 Professor Sir Kenneth Calman

[324] WIT 0051 0006 Sir Donald Irvine

252 Dr Halliday's view appears to be that the Royal Colleges assist upholding standards, but are not responsible for the upholding of those standards:

> '… we are very fortunate in the way that our Royal Colleges assist us, because they are not formally part of the National Health Service. They have no responsibility for the provision of services. Their role is educational and the training of doctors. Yet despite that, they are only too happy to contribute their time, and sometimes money, to look at the things we want them to address. So I think we are very lucky in that sense.'[325]

253 Dr Halliday's description suggested that the Royal Colleges worked by exerting peer pressure on a colleague who was not adhering to the promulgated standard.

254 Sir Alan Langlands confirmed that the Royal Colleges had provided assistance to SRSAG:

> 'Both groups [SRSAG and NSCAG] have regularly sought advice from the Medical Royal Colleges and other professional bodies on such matters as the services to be designated and the best units to provide these services.' [326]

Relationship between the Royal Colleges and the GMC

255 Sir Donald stated that an outstanding problem was that:

> 'Co-ordination between the various professional bodies with regulating functions was limited and accountability often unclear.'[327]

256 A principal change of philosophy in the GMC's policies during the period 1984–1995, he said, was that of 'regarding poor or unsafe clinical performance as within the GMC's scope rather than as the sole responsibility of others'.[328] This did not, however, imply that the GMC would review Royal Colleges' training reports. The reason for declining to do so is given in the following exchange:

> 'Q. Did the GMC have any function in reviewing the reports by Royal Colleges for the purposes of their accreditation of their specialist training?
>
> 'A. No, it is not empowered to do so under the Act.'[329]

257 It should be noted that a College such as the Royal College of Paediatrics and Child Health (RCPCH) now takes a firm line on the enforcement of standards. Professor Baum, Former President, RCPCH, said it would 'hold our College Fellows responsible, if knowingly they were not alerting us to a failing in standards'. [330]

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[325] T13 p. 121 Dr Halliday

[326] WIT 0335 0020 Sir Alan Langlands

[327] WIT 0051 0006 Sir Alan Langlands

[328] WIT 0051 0007 Sir Donald Irvine

[329] T48 p. 110 Sir Donald Irvine

[330] T18 p. 64 Professor Baum

However, reference may be made to the tables of comparisons for the limited extent to which any disciplinary power has been exercised by the College (or, indeed, any of the Colleges).

258 The primary approach is thus working with a colleague to remedy a problem . If this is not possible, RCPCH's sanction is to report the clinician to the GMC:

> '… if it was outwith that kind of corrective programme, then we would openly say "This is a matter we must refer to the General Medical Council".'[331]

Proposed reforms of the Colleges

259 The Royal Colleges would wish to have similar powers to maintain the standards of performance of consultant as they currently have for doctors in training:

> '… I would wish very much indeed that the Medical Royal Colleges could be given statutory powers to maintain standards at consultant level, just as they now have statutory powers of maintaining standards for trainees in ensuring that any consultant appointed is appropriately qualified and trained and competent to carry out the responsibility of a consultant. That statutory responsibility has only been given to them in the last two years through the medium of the specialist training authority and the College's participation in the specialist training authority. I would like to see that extended to consultant level, and I think that that would strengthen medicine throughout this country enormously. And I hope very much it happens.'[332]

260 Similarly, Professor Sir George Alberti told the Inquiry:

> '… it is evident that continuing lifelong education is essential for all consultants, and that this should be assessed at regular intervals'.[333]

Specialist associations

261 Specialist associations are groups of healthcare professionals. They have no power over their members. They set standards but cannot enforce any of them.

262 Sir Barry Jackson told the Inquiry about the origin of specialist associations and their relationship to the Royal Colleges:

> 'Q. Can I just ask you a little bit more about the specialist associations and their relationship with the Royal College of Surgeons? Generally, can I ask, how would specialist associations come into being in the first instance? Would that be anything

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[331] T18 p. 65 Professor Baum
[332] T28 p. 141–2 Sir Barry Jackson
[333] T9 p. 47 Professor Sir George Alberti

to do with the initiative of the Royal College, or would that be purely a professionally led evolution?

‘A. The latter; it would be professionally led. The College would have no part in the gestation of a specialist association.

‘Q. We have seen, for instance, that some have a very long history; that from a statement provided to the Inquiry by the President of the Society of Cardiothoracic Surgeons, that Society, for instance, was established in 1933, would that be typical, too, of some other specialist associations?

‘A. The specialty association representing general surgery antedates that quite considerably. That was founded in 1917, I believe.

‘Q. So there is no formal relationship between the Royal College of Surgeons and specialist associations?

‘A. No formal relationship, although informally there are very close links indeed, to the extent that on the Council of the College of Surgeons, we have invited representatives from each of the nine specialist associations representing the nine SAC specialties and within the college buildings, we have the offices of each of the specialist associations.

‘Q. Do you have any formal supervisory or monitoring role within the work of the specialist associations?

‘A. No.’[334]

263 Dr Michael Godman, President of the BPCA, a specialist association, told the Inquiry:

‘The British Paediatric Association at present is not a regulatory body but … it attempts to publicise its work as widely as possible … The Association plays a major role in training but the statutory control of this rests with the Specialty Advisory Committee of Paediatric Cardiology of the Joint Committee on Higher Medical Training of the Medical Royal Colleges and of the SAC in Cardiothoracic Surgery of the Joint Committee on Higher Surgical Training of the Royal Colleges of Surgery.’[335]

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[334] T28 p. 11–13 Sir Barry Jackson

[335] WIT 0047 0004 Dr Godman

Trade unions of healthcare professionals

264 The principal trade unions are the BMA, for doctors, and the RCN and Unison, for nurses. Unison covers other healthcare workers and other public sector workers: its nursing membership in teaching hospitals such as the BRI tends to be low. There are also a number of other professional associations that are entitled to qualify as trade unions under the ERA 1996.

British Medical Association (BMA)

265 The BMA sees itself as more than a trade union: 'The BMA is a professional body and a trade union …'.[336] Membership is voluntary and some 80% of practising doctors are members:[337]

> 'The principal objective for which the BMA was established in 1832 was "to promote the medical and allied sciences and to maintain the honour and interest of the medical profession". This remains its principal aim and abiding concern.'[338]

BMA – role

266 The professional aspect of the BMA is exemplified by the BMA's Medical Ethics Committee (MEC) which '… publishes ethical guidance on a very wide range of subjects and its secretariat advises individual doctors'.[339] It does not, however, set educational or training standards as such.[340]

267 The trade union aspect was referred to by Dr Ernest Armstrong, Secretary of the BMA. It has 'heavy involvement in negotiations and consultation concerning virtually all aspects of doctors' professional working lives, including in particular their contractual arrangements'.[341]

BMA – responsibilities

268 The BMA has no authority to require anyone to do anything:

> 'The BMA plays no role in regulating entry to or regulation of membership of the medical profession. It has a limited [virtually non-existent] disciplinary power over its members …'[342]

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[336] WIT 0037 0005 Dr Armstrong
[337] WIT 0037 0004 Dr Armstrong
[338] WIT 0037 0004 Dr Armstrong
[339] WIT 0037 0005 Dr Armstrong
[340] WIT 0037 0005 Dr Armstrong
[341] WIT 0037 0005 Dr Armstrong
[342] WIT 0037 0004 Dr Armstrong

269 Nonetheless, it voluntarily accepts a responsibility for patients' safety, and rejects the notion that it is an entirely self-serving body of doctors:

> '… notwithstanding our duty to stand by a member in terms of the rights and privileges that he has under his membership … we must be aware that if, in the course of our work, we find or unearth a problem which gives rise to a serious concern about patient safety, then we do not have the option of doing nothing; … doctors, including myself, have to have regard to our own duty to protect patients at all times.'[343]

270 Dr Armstrong expressed the views of the BMA on many issues in healthcare, such as doctors' pay and conditions, the NHS reforms of 1991, the NHS internal market, employment contracts for hospital consultants, revalidation, and disparagement/ whistleblowing.

271 There are also medical defence organisations such as the Medical Defence Union (MDU) and the Medical Protection Society (MPS) that represent members, in particular where they may be exposed to liability or discipline in respect of their practice, but they have no powers to regulate their members.

Employment contracts

272 There is a distinction to be drawn between an employee (employed under a contract of service) and an independent contractor (employed under a contract for services).[344]

273 Employment has, as a distinguishing feature, control over the employee by the employer.[345] Although this should not be overstated – e.g. an airline pilot is employed, but his employer may not know how to fly – it gives rise to a power to direct where, when, in what circumstances, and, in particular, what an employee should do, subject only to any contractual agreement between employer and employee to the contrary.

Medical contracts – terms

274 The National Health Service Act 1946 set up the NHS. It provided that:[346]

> 'All officers employed for the purposes of any hospital providing hospital and specialist services, other than a teaching hospital, shall be officers of the Regional Hospital Board for the area in which the hospital is situated … and the remuneration and conditions of service of all such officers shall, subject to regulations, be determined by the Regional Hospital Board …'

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[343] T20 p. 39–40 Dr Armstrong

[344] For example, the chauffeur, employed by a company, is an employee, employed under a contract of service; the taxi driver, hailed for a one-off journey, is an independent contractor

[345] See Cooke, J, in *Market Investigations Limited v Minister of Social Security* [1969] 2 Q. B. 173 p. 184–5

[346] Section 14(1) National Health Service Act 1946

275 The effect of this provision was considered by the courts in the case of *Barber v Manchester Regional Hospital Board* [1958] 1 WLR.

276 The judgment treated the plaintiff as an employee, subject to the terms and conditions which had been promulgated by the Minister of Health. In doing so, the court had held that someone in the position of Mr Barber, though a consultant, and in that sense an officer of the Hospital Board, was, in law, an employee.

277 In later cases, hospital consultants working in the public sector have also been held to be employees.[347]

278 Any consultant to whom the Barber principle might have applied, prior to the creation of NHS Trusts under the National Health Service and Community Care Act 1990, would have had his contract of employment transferred automatically from the Health Authority to the new Trust.[348]

279 Thus, with effect in Bristol from April 1991, and with effect in other parts of the country depending upon the date that the relevant trust came into being, consultants ceased to be employees of the regional health authority, and became employees of the relevant NHS trust. As such, they were no longer under the (theoretical) control of the Region, possibly seen as distant from the unit where they worked, but were from then on under the more direct control of the employing unit.

Junior hospital doctors

280 Junior doctors, either career grade or in training, will in general also be employees. For instance in *Johnstone v Bloomsbury Health Authority* [1992] QB 333 a senior house officer (SHO) was regarded as engaged under a contract of employment (in 1988/89, when the events which gave rise to his claim arose).

Nurses

281 A nurse will also usually be an employee. Thus in *R v East Berkshire Health Authority ex parte Walsh* [1985] QB 152 a senior nursing officer was regarded as an employee; and similarly a charge nurse[349] and a nurse[350] have been treated as employees of, respectively, the district health authority and the NHS trust.

282 However, it is open to a hospital authority to contract for services to be provided by an individual health professional. It is thus, theoretically, possible for a consultant (e.g. a locum) to be an independent contractor, rather than employee; and nurses are frequently engaged through a nursing ‘bank’ (agency). In *Clarke v Oxfordshire Health*

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[347] *Bliss v South-East Thames Regional Health Authority* [1987] ICR 700, CA ; *Porter* [1993] IRLR 486, QBD; and *Mishriki* (EAT, Morison J, 10 May 1999)

[348] Section 6, National Health Service and Community Care Act 1990, in relation to ‘any person who, immediately before an NHS Trust’s operational date – (a) is employed by a health authority to work solely at, or for the purposes of, a hospital … which is to become the responsibility of the Trust …’ and Section 6(3): ‘… the contract of employment … shall have effect from the operational date as if originally made between him and the NHS Trust’

[349] *Paul v East Surrey District Health Authority* [1995] IRLR 305

[350] *Gale v Northern General Hospital NHS Trust* [1994] IRLR 292, CA

Authority [1998] IRLR 125 it was held that a staff nurse who was offered and accepted employment, where it was available, at any of the Health Authority's hospitals and was paid hourly on the applicable scale, but who received no payment during periods when she was not supplying her services and had no contractual entitlement to sick pay or holiday pay, and whose contract stipulated that she had no entitlement to guaranteed or continuous work, was not an employee of the Health Authority, at least at times between engagements. There was no 'overriding' or 'umbrella' contract of employment to which her work for the Health Authority and its hospitals was subject. However, this is short of saying that each time she actually worked as a nurse she was *not* an employee – and, of course, each and every time she worked her work was regulated by a contract. In *Mensah v West Middlesex University Hospital* [351] the Court of Appeal accepted a similar analysis in the case of a midwife who worked as a bank nurse.

Professions Allied to Medicine

283 Similar considerations apply to Professions Allied to Medicine (PAMs); those working in these professions are likely, particularly if engaged full-time, to be employees. If employed sporadically, under a succession of contracts of short duration, they are likely to be employees whilst performing the contract, but not otherwise. They *can* theoretically be independent contractors, though most are likely to be treated as employees by any court or tribunal. The tendency, generally, of the law is to treat anyone who could be an employee as being an employee.[352]

Chief executives, hospital managers and administrators

284 These are almost all likely to be employees.

General practitioners

285 By contrast, GPs are rarely employees. They are, in general, the equivalent of sole traders, or partners in an enterprise, who provide their services to their patients. The fact that their remuneration comes from central funding does not essentially alter their status as independent contractors. That this is so is recognised in statute. When the PIDA 1998 came into force on 2 July 1999, the ERA 1996 was amended to provide that for the purposes of provisions protecting employees against victimisation and adverse treatment because they had 'blown the whistle', the definition of 'worker' for the purposes of the Act would be taken to include a person who:

> '… works or worked as a person providing general medical services, general dental services, general ophthalmic services or pharmaceutical services in accordance with arrangements made –

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[351] 22 October 1998, CA, unreported

[352] *'Harvey on Industrial Relations and Employment Law'*, para 51; Butterworths

> ‘(i) by a Health Authority under Section 29, 35, 38 or 41 of the National Health Service Act 1977…’[353]

Terms of employment

286 Some of the terms and conditions of employment of health care professionals are standard terms, decided in national collective bargaining agreements such as those derived from the Whitley Councils.[354] For many years pay and other terms and conditions of employment were determined centrally for the whole of the NHS by the Whitley Councils and Review Bodies that has evolved over many years. Each occupational group tended to have a separate system of negotiation and consequently there was a multiplicity of different terms and conditions. Collective negotiation over several decades resulted in a large number of different allowances and special payments including complex rules on such things as annual sick leave and acting-up.

Once the trusts were in place there was a widespread move away from centrally agreed negotiated terms. Many Trusts have negotiated local recognition agreements with the principal trade unions and have devised their own terms and conditions. Key features were a reduction in the multiplicity of bargaining groups and the elimination or reduction of special allowances combined with an obligation on the employees to work more flexibly. Added impetus to these developments has been given by the 1995 national pay awards, where some national increases have been limited in order to give scope for local pay awards.

287 Mr Graham Nix, Finance Director, UBHT, told the Inquiry about the UBHT’s use of Whitley terms regarding pay:

> ‘Q. … “Staffing flexibility. The changed status will allow the Trust to reward excellence and ensure that it retains staff” [WIT 0106 0017]. What was the mechanism for that anticipated to be, when you drew up this document with your colleagues?
>
> ‘A. Centrally, Trusts were told that you could change the way you pay staff. Prior to this you had to stick to Whitley Council payments, terms and conditions of service, and under trust status you could move away from that and pay people locally.
> In reality, UBHT are stuck to Whitley all the way through, but other trusts did use other mechanisms.

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[353] Section 29 of the NHS Act 1977 provides that the Family Practitioner Committee should arrange with medical practitioners to provide personal medical services for all persons in the locality wishing those services, and for the making of regulations providing for payment at predetermined rates for the provision of those services; Section 35 does the same for dentists, Sections 38 and 41 for ophthalmic practitioners and pharmacists

[354] DOH 0015 0471; Whitley Councils for the Health Services (Great Britain) Main Constitution (revised 1 January 1984)

> ‘Q. The plan at this stage [1990], obviously, for those drawing up this document [UBH/T’s application for trust status], of which you were one, was to reward excellence, presumably in financial terms. Was there a corollary of that, of an intention, at least a willingness, to penalise the opposite of excellence, where that was found?
>
> ‘A. No, absolutely not. This was really saying that, as Trust status, you had this flexibility to achieve this end. In reality, we have not used it the way other trusts have done, because we felt that Whitley Council terms and conditions have been created over many years of experience, and we should stick with that.’[355]

288 Mr Hugh Ross, Chief Executive, UBHT from 1995 to date, told the Inquiry about UBHT’s use of Whitley terms regarding internal complaints:

> ‘Q. So far as the formalised structures [to deal with internal complaints] are concerned, do you know whether they existed in individual contracts of employment prior to your becoming a Chief Executive?
>
> ‘A. Yes. Those policies would have been standard in NHS Trusts.’[356]

289 Leading Counsel to the Inquiry raised with Dr Roylance the issue of the UBHT’s use of Whitley provisions in non-health disciplinary cases. [357] The health circular put to Dr Roylance states:

> ‘The recommended procedure (above) [the “three wise men” procedure] is intended to deal with cases where disability (including addiction to drugs or alcohol) is suspected in a member of medical or dental staff which might, if not remedied, lead to harm or danger to patients. It is not intended to replace or detract from the procedures set out in HM(61)112 and Section XXXIV of the General Whitley Council Conditions of Service. However, it may be appropriate to use the procedure recommended above in cases where it is possible that disciplinary action could arise but where there is reason to suspect disability.’[358]

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[355] T22 p. 171–2 Mr Nix

[356] T19 p. 76 Mr Ross

[357] T25 p. 8–9 Dr Roylance

[358] UBHT 0061 0268; *‘Prevention of Harm to Patients Resulting from Physical or Mental Disability of Hospital or Community Medical or Dental Staff’,* para 15 (July 1982), HC (82) 13

Summary of respective roles of bodies concerned with standards and their implementation

290 This section attempts to summarise the shared and divided responsibilities for setting and implementing standards borne by the various bodies described above.

291 A distinction has to be made between general and specialist standards and between setting and implementing standards once set.

292 Dr Graham Winyard said that prior to the publication in 1989 of *'Working for Patients':*

> 'General standards were set by the GMC and the Medical Royal Colleges, through general and specialist examinations, the inspection of training posts and involvement in consultant appointment committees. However the prime responsibility for a doctor's ongoing standard of professional practice lay with that individual and was seen very much as a matter for him or her. General peer pressure was undoubtedly important in maintaining overall standards but could prove much less effective when an individual was, for whatever reason, resistant to criticism.'[359]

293 Of the period of concern to the Inquiry, Sir Donald Irvine and Professor Liam Donaldson, CMO for England and Wales, referred to Black's *'Quality Assurance of Medical Care'*, which comments:

> 'In the 1990s, developing standards of good care is increasingly likely to fall to national expert groups such as the medical Royal Colleges, partly because they are most likely to have the resources necessary to assemble the scientific, clinical and medical ethical expertise needed to construct guidelines which are competent and widely acceptable, and partly because of the sheer complexity, time and expense involved in achieving such guidelines. The implementation of standards, on the other hand, may be a more local matter in the form of protocols which can be attained within specified but manageable deadlines by practitioners operating under widely differing circumstances.'[360]

294 In practice, responsibility for setting general and specific standards was divided, as was their implementation.

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[359] WIT 0331 0002 Dr Winyard

[360] Cited by Irvine D and Donaldson L. 'Quality and Standards in Health Care'. *'Proceedings of the Royal Society of Edinburgh'* (1993); 101 B: 1-30 at p. 16 (WIT 0051 0045). The full Black 1990 reference is: Black N. 1990. 'Quality assurance of medical care'. *'Journal of Public Health Medicine',* 12, 97–104 (cited at WIT 0051 0055)

295 The GMC advised and advises on generic professional standards. It did not and does not set clinical standards for particular specialties (such as paediatric cardiac surgery).[361] Such specific standards were and are set primarily by the Royal Colleges. The GMC's view was that:

> 'The Royal Colleges and specialist associations were primarily responsible for detailed, condition-specific clinical standards … The GMC offered no specific advice on audit during the 1980s and early 1990s.'[362]

This view was mirrored by that of the RCSE, which had published guidance on child surgery but '… has not published any guidance specifically referring to the competence or conduct of paediatric cardiac surgeons'.[363]

296 Furthermore, the GMC only enforced or implemented the standards it established. It has no jurisdiction to enforce the specialist standards laid down by the Royal Colleges.

297 The DoH meanwhile looks to the Royal Colleges and the GMC together to maintain standards. Dr Halliday told the Inquiry:

> 'The Secretary of State is not responsible for the way medicine is practised. He has no duty to Parliament for that. The responsibility of how clinical medicine is practised is a matter for the General Medical Council. The Secretary of State is obviously concerned about the way that service is provided and he looks to the Colleges and to the GMC to ensure that that is the situation.'[364]

298 The crux of the split between setting standards and implementing them is that the bodies that set specialist standards (the Royal College) have no direct power to enforce them, and the body (GMC) charged with enforcing general standards is unable to enforce specialist standards, not least because they cannot assess compliance with them. Leading Counsel to the Inquiry asked Sir Donald Irvine:

> 'So far as standards then were concerned during 1984 to 1995, standards of good practice, we have heard from the evidence given to us by the Royal Colleges that they would promulgate the standards in their own particular specialisms. Much of the evidence that we have heard suggests that there was a vacuum when it came to the enforcement of those standards. Is that how you would have seen the years 1984 to 1995, or not?

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[361] WIT 0062 0026 Mr Scott

[362] WIT 0051 0009 Sir Donald Irvine

[363] WIT 0048 0013 Sir Barry Jackson. However, 'In 1995 the SAC in Cardiothoracic Surgery approved a programme for advanced training for those wishing to specialise in paediatric cardiac surgery …' (WIT 0048 0011). The document is: *'Suggested Paediatric Cardiac Surgical Training Programmes'* (WIT 0048 0018). *'Training for Paediatric Cardiac Surgery'* (J Stark's document presented to the SAC 1995) (WIT 0048 0016) and *'Training Curriculum in Paediatric Cardiothoracic Surgery'* (WIT 0048 0021) are '… the specific curriculum document for training in paediatric cardiac surgery that is used at Birmingham and Great Ormond Street to follow through the training of individuals on the rotation between these [two] hospitals' (WIT 0048 0011)

[364] T13 p. 80 Dr Halliday

> ‘A. The enforcement by the Royal Colleges, do you mean?
>
> ‘Q. Enforcement generally.
>
> ‘A. In general terms, yes.’ [365]

299 Sir Donald was subsequently asked:

> ‘Q. So in terms of standards throughout the period we are looking at, the Royal Colleges would set the standards of performance generally speaking for doctors and their specialties, would they?
>
> ‘A. Yes. They would indicate in their various ways what standards would be expected for their individual specialties.
>
> ‘Q. But there was no sanction from the GMC for a failure to meet those performance standards until 1997, I think?
>
> ‘A. Until ... ?
>
> ‘Q. 1997, was it? The change was brought in in 1995, but that was the first year for “seriously deficient professional performance”?
>
> ‘A. I am sorry, yes.
>
> ‘Q. So the only sanction for the failure to meet a Royal College standard would either be up to the Royal Colleges themselves or to the local employer?
>
> ‘A. Yes.’[366]

300 The evidence of the GMC was that it set professional, but not clinical, standards; that it adopted but did not enforce clinical standards, and that it expected employers (with the assistance of the Royal Colleges) to enforce those clinical standards.

301 The evidence of the Royal Colleges was that they lacked any means to enforce clinical standards, and relied upon the GMC to ensure professionalism.

302 The evidence of the DoH was that it relied on both the Royal Colleges and the GMC to set standards and to enforce them, but declined any direct responsibility itself for doing so. Responsibility for clinical treatment was that of the individual clinician (or, at least, consultant). The role of the DoH was, in part, to set the framework within which standards might be set and implemented, but its focus was split until 1995 as between management and policy, and its emphasis was on financial rather than clinical performance.

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[365] T48 p. 26–7 Sir Donald Irvine

[366] T48 p. 108–9 Sir Donald Irvine

303 The individual doctor was required to satisfy the GMC of basic medical competence, and the Royal Colleges of specialist competence, but only at the outset of a career, as a one-off qualification.

304 This last point has been addressed by Continuing Medical Education (CME)/Continuing Professional Development (CPD), to the evidence on which we now turn.

Continuing professional development (CPD)

305 'CPD' is an equivalent term to 'CME', used in various professions and replacing CME as the predominant term used.

306 The development and acceptance of 'CPD' was stimulated by problems in the introduction of minimal access (or 'keyhole') surgery. As Sir Barry Jackson said:

> '… discussions and debate had been taking place about these general issues relating to audit, to CME, in the 1980s, but were stimulated and perhaps minds focused quite sharply by the introduction of minimal access surgery in the 1990s in this country, 1991, I think.[367]
>
> '… the introduction of minimal access surgery played a part in focusing the mind quite acutely. This was "keyhole surgery" by want of another name, because as is well known, when keyhole surgery in the field of gallbladder surgery was introduced in this country in the early 1990s, there was unfortunately a spate of complications resulting from the introduction of that particular technique which focused the mind very acutely.'[368]
>
> 'There was a recognition, and there had been over some years before, that these matters of audit, continuing medical education, ensuring that individual practitioners participated, was an area that needed more formal adoption than had previously been the case.'[369]

307 CPD includes training for new techniques such as minimal access surgery, but is broader. It includes keeping up to date with improvements to existing techniques,[370] and requires post-qualification training.[371]

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[367] T28 p. 75 Sir Barry Jackson

[368] T28 p. 30 Sir Barry Jackson

[369] T28 p. 76 Sir Barry Jackson

[370] WIT 0048 0145 Sir Barry Jackson; 'Most technical developments are simply minor improvements on an existing technique.'

[371] The relationship of CPD to the 'learning curve' is dealt with in Chapter 14

308 In addition to what was described to the Inquiry as the 'furore'[372] over minimal access surgery, medical litigation added to the pressure for making CME and training, generally, more rigorous:

> 'I think one of the factors might have been the increasing rate of medical litigation, of alleged under-performance by medical practitioners. Certainly, it is a fact that the number of cases brought to the solicitors have increased almost exponentially over the last 15 years, and I think it became clear that the proportion of these cases where there was alleged under-performance, there might have been some justification for the allegations that were made; certainly not all, but some.'[373]

CPD as a professional obligation

309 During the period of the Inquiry's Terms of Reference, there was very little enforcement of CPD. It was left to the individual as a moral obligation, as Sir Barry Jackson explained:

> '… the question of continuing medical education or continuing professional development, during the period of our terms of reference again, I think it is accurate to say there were no formal obligations placed upon a Fellow of The Royal College of Surgeons or a Member of the Royal College of Surgeons to take part in such an exercise?
>
> 'A. That is correct.
>
> 'Q. So what would the nature of the obligation to keep oneself up to date as a matter of professional competence be?
>
> 'A. It was a moral obligation. That is the short answer.
>
> 'Q. A moral obligation possibly backed up by the Code of Practice of the GMC?
>
> 'A. The answer is yes, although I have to say that I cannot remember the dates when successive GMC documents were published, but certainly, the GMC did not figure high in the minds of most surgeons throughout the time in question, the Inquiry time.
>
> 'Q. So the prime concern would be the individual moral or ethical responsibility?
>
> 'A. Yes.

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[372] 'This document [WIT 0048 0140], came out to some extent in response to the furore over the complications arising from the introduction of minimal access surgery', Sir Barry Jackson T28 p. 75–6

[373] T28 p. 79 Sir Barry Jackson

> ‘Q. Would contracts of employment or job descriptions of consultants be likely to have contained during this period any requirements to engage in continuing medical education?
>
> ‘A. I think it most unlikely, but I cannot state authoritatively that that was the case, particularly towards the end of the terms of your Inquiry. Certainly, in the 1980s, that would not have been in job descriptions; it may have started creeping in in the early to mid-1990s.[374]
>
> ‘Q. I appreciate it is difficult for you to answer because no doubt the practices would have varied locally from Trust to Trust, at least to some extent, but is it fair to conclude from the earlier part of your answer that even if they did, the real pressure that would be felt by consultants is likely to be the moral and ethical one, rather than whatever the job description might have said on the subject?
>
> ‘A. Yes.’[375]

310 Similarly, in relation to new procedures, it was left to the individual doctor to decide what training he felt he needed to do before embarking on the procedure:

> ‘Q. … what would be the expectations as to the practical steps that had to be taken before a person could be confident or reasonably confident that actually they would not be harming their patient if they embarked on something relatively new?
>
> ‘A. There was nothing laid down about this. It was not formalised. It was up to an individual surgeon to take what steps they considered necessary to enable them to carry out that operation with a clear conscience.’[376]

311 The Inquiry has received little evidence on what proportion of hospital doctors actually felt obliged to undertake CPD and what proportion of doctors actually did undertake CPD as recommended. Such information is available for general practice, through data on Post Graduation Education Allowance payments, but otherwise it may be impossible to find out, as no one monitored compliance with what recommendations there were:

> ‘Q. … what assessment would the College make of the extent to which consultants were already participating in CME prior to the introduction of a formal accreditation programme?
>
> ‘A. None, formally.

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[374] The standard form of contract for a hospital consultant contained a clause relating to study leave, which both authorised and encouraged it

[375] T28 p. 72–3 Sir Barry Jackson

[376] T28 p. 112 Sir Barry Jackson

> ‘Q. Nobody was formally engaged in it in so far as nobody was required to formally notify their engagement in it, but to what extent did the College believe it was all chugging along nicely with everybody doing what was expected of them, or to what extent did they regard there might be a problem in this field?
>
> ‘A. I do not think the College as such took a formal position in the early 1990s that continuing medical education had to be carried out by all their fellows.[377]
>
> ‘Q. … prior to the early 1990s there was very limited awareness of the extent to which consultants were keeping themselves up to date?
>
> ‘A. Yes. I think the answer to that is probably yes; there was a limited awareness. I mean, it was, as I said before, a moral obligation that consultants did keep themselves up to date and did continue to practice appropriately … .’[378]

312 Further, there was no systematic assessment of trainers providing CPD:

> ‘Q. … Did I understand you previously to say that there was no systematic assessment of the trainer?
>
> ‘A. I do not think I said it in those terms, but your derivation, the implication of what I said was exactly as you suggest.’ [379]

GMC

313 The GMC has now become more involved in periodic review of clinicians’ performance than it used to be.[380]

Royal Colleges

314 The Royal Colleges have been active in promoting CPD, with publications including: *‘Quality Assurance: The Role of Training, Certification, Audit and Continuing Professional Education in the Maintenance of the Highest Possible Standards of Surgical Practice’* (The Senate of Surgery of Great Britain and Ireland, London, 1994)[381] and *‘Handbook on Continuing Medical Education for Surgeons’* (The Senate of Surgery of Great Britain and Ireland, London, 1995).[382]

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[377] T28 p. 77–8 Sir Barry Jackson
[378] T28 p. 80 Sir Barry Jackson
[379] T28 p. 70 Sir Barry Jackson
[380] T52 p. 45 Sir Graham Hart
[381] Listed in ‘Further Reading’ section RCSE 0001 0137
[382] Listed in ‘Further Reading’ section RCSE 0001 0137

315 The RCSE recommends the explicit incorporation of standards (such as training and CPD) into contracts of employment:

> 'Q. Do I take it from that that the College would in fact support the inclusion in terms of contracts of employment, contractual terms which required consultants to maintain CPD, CME, according to terms of the Royal Colleges' schemes?
>
> 'A. The College would support that 100 per cent.'[383]

Revalidation

316 CPD may be related to revalidation. The aim of revalidation is the maintenance of doctors' fitness to practise. The mechanism envisaged is continued entitlement to registration. The Inquiry has received evidence giving some indication of the standards sought to be upheld and the procedures involved:

> 'Hitherto, doctors have remained registered without any continuing assessment of their fitness to practise. In February 1999, the Council [GMC] decided that all doctors must be able to demonstrate on a regular basis that they are keeping themselves up to date and remain fit to practise in their chosen field.
>
> 'Revalidation of fitness to practise will be linked with registration.'[384]

317 Sir Donald told the Inquiry:

> '… we have taken the decision to change the basis of registration so that doctors in future have to be able to demonstrate on an ongoing basis their fitness to practise …'[385]
>
> 'For all established doctors, the principles of '*Good Medical Practice'* – interpreted for each specialty by the Colleges – will provide the template against which doctors' continuing registration will be regularly revalidated in future.'[386]

318 And again:

> 'The GMC's fitness to practise procedures, especially the performance procedures, will be used to underpin revalidation when it is introduced. They will be the instrument through which the GMC will assess the performance of doctors who fail to meet the criteria for revalidation, and through which it will decide whether to act on a doctor's registration.'[387]

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[383] T28 p. 83 Sir Barry Jackson
[384] WIT 0062 0006 – 0007 Mr Scott
[385] T48 p. 78 Sir Donald Irvine
[386] WIT 0051 0010 Sir Donald Irvine
[387] WIT 0051 0013 Sir Donald Irvine

319 The revalidation is 'revalidation of registration'.[388] It could apply both to basic and other registrations, such as higher level nursing registrations.[389]

320 The principle of revalidation (or re-accreditation) is widely supported by general practitioners:

> 'In 1992 the General Practitioners' Committee of the BMA ran a very large opinion survey … to which 25,000 GPs replied. … One of the questions was: did doctors believe that re-accreditation, regular re-accreditation, would improve standards of care. Two-thirds said yes.'[390]

Mechanics of revalidation

321 The mechanics of revalidation are still being discussed. The GMC's view was given to the Inquiry by Sir Donald:

> '… many of these problems that have arisen in the United States and elsewhere arise because of a reliance or seeking to rely on the assessment itself, and, you know, the questions arise as to what the appeal would be against, et cetera. The difference with the proposals that we have in mind – this is already adopted as policy – is that against the screen, effectively, which is what revalidation will be, if questions about performance, fitness to practise arise, then they will be investigated further and in all the appropriate detail within the GMC's fitness to practise procedures, almost certainly the performance framework. In that, it will bring the questions into an established statutory framework in which patients and doctors have their respective rights and all is settled and all agreed. So there is no need at that earlier stage to be concerned, be revalidated or not. It is not at that point that the decision would be taken. It would be taken by the GMC within that statutory framework. That is settled.'[391]

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[388] WIT 0051 0014 Sir Donald Irvine

[389] WIT 0052 0326 Ms Lavin; *'Review of the Nurses, Midwives and Health Visitors Act 1997 – Government Response to the Recommendations'*, p. 10, HSC 1999/030

[390] T20 p. 35–6 Dr Armstrong

[391] T48 p. 142 Sir Donald Irvine

Chapter 5 – Regional, District and Trust Management

Scope of this chapter

1 This chapter aims to give a factual description of the history of both the regional and district health authorities and their management structures throughout the period in question, and of how their respective rights and obligations were distributed and changed or were transferred over time.

2 Although the account is given of the evidence as to the position nationally, it focuses on the regional and district framework most relevant to Bristol, in particular that relating to paediatric cardiac services (PCS).

Brief chronology of the main events

1 April 1974	South Western Regional Health Authority (SWRHA) established Avon Area Health Authority (Teaching) established Bristol Health District (Teaching) established Weston Health District established
1 April 1982	Bristol & Weston District Health Authority (B&WDHA) established
1 February 1985	B&WDHA appointed its first District General Manager, replacing the District Administrator
1 April 1991	United Bristol Healthcare NHS Trust (UBHT) and Weston Area NHS Trust became operational
1 October 1991	Bristol & District Health Authority (B&DHA) established
1 April 1992	Frenchay Healthcare Trust operational Southmead Healthcare Trust operational NHS Executive regional outposts established
1 April 1994	Boundaries of SWRHA enlarged and name changed to South & West Regional Health Authority (S&WRHA)
1 October 1994	Avon Health Commission established
1 April 1996	NHS Executive South & West established

(S&WRHA abolished)

Avon Health Authority (Avon HA) established

Statutory framework

Introduction

3 The relevant statutes governing the matters described in this chapter are:

- National Health Service Act 1946 (the 1946 Act)
- National Health Service Reorganisation Act 1973 (the 1973 Act)
- National Health Service Act 1977 (the 1977 Act)
- Health Service Act 1980 (the 1980 Act)
- National Health Service Community Care Act 1990 (the 1990 Act)
- Medical (Professional Performances) Act 1995 (the 1995 Act).

4 The 1973 Act revised the structure of the NHS and introduced regional and area levels of management in England (but not Wales)[1] by providing for the establishment of regional health authorities (RHAs), area health authorities (AHAs) and area health authorities (teaching).

5 Under the 1977 Act 'It is the Secretary of State's duty to continue the promotion in England and Wales of a comprehensive health service designed to secure improvement –

> '(a) in the physical and mental health of people in those countries, and
>
> '(b) in the prevention, diagnosis and treatment of illness, and for this purpose to provide or secure the effective provision of services in accordance with this Act.'[2]

6 The 1977 Act confers a wide discretion on the Secretary of State, in deciding what services ought reasonably to be provided. It provides that, 'It is the Secretary of State's

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[1] Sections 5 and 5(1) (b), 1973 Act

[2] Section 1(1), 1977 Act

duty to provide throughout England and Wales, to such an extent as he considers it necessary to meet all reasonable requirements –

> ‘(a) hospital accommodation;
>
> ‘(b) other accommodation for the purpose of any service provided under this Act;
>
> ‘(c) medical, dental, nursing and ambulance services;
>
> ‘(d) such other facilities for the care of expectant and nursing mothers and young children as he considers are appropriate as part of the health service;
>
> ‘(e) such facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service;
>
> ‘(f) such other services as are required for the diagnosis and treatment of illness.’[3]

Establishment of regional and district health authorities

7 The 1977 Act required the Secretary of State to establish health authorities for the regions.[4]

8 Fourteen RHAs were set up under the 1973 Act.[5] In 1993 the decision was taken to abolish all 14 RHAs and to replace them with 8 regional offices of the NHS Executive, performing fewer functions than the authorities they replaced. It was recognised in 1993 that, given the many responsibilities of RHAs, it would take some time to bring this change into effect. Thus, in 1994, as a step towards eventual abolition, the number of RHAs was reduced to 8, and the regional offices of the NHS Executive were set up to run in parallel. The change was fully implemented in April 1996 when the RHAs ceased to exist.[6]

9 The 1980 Act[7] gave the Secretary of State power to establish district health authorities (DHAs) in place of AHAs. On 1 April 1982 AHAs ceased to exist and 192 new DHAs took their place.[8] DHAs became the main operational authorities.

10 By the Health Authorities Act 1995, RHAs and DHAs were abolished with effect from 1 April 1996, and the Secretary of State was under a duty to establish ‘health authorities’. These new health authorities were created from the merger of the old DHAs and family health service authorities (FHSAs).

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[3] Section 3(1) (a)–(f), 1977 Act

[4] Section 8, 1977 Act

[5] Regional health authorities established by the NHS (Determination of Regions) Order 1981, SI 1981/1836: Northern, Yorkshire, Trent, East Anglia, North East Thames, South East Thames, North West Thames, South West Thames, Wessex, Oxford, South Western, West Midlands, Mersey, and North Western

[6] The eight regional offices are: Eastern, London, North West, Northern & Yorkshire, South East, South & West, Trent and West Midlands

[7] Section 1, 1980 Act

[8] DHAs established by the NHS (Determination) Order 1981, SI 1981/1837, Reg. 3

The regional health authority

11 The region was established in 1973.[9] 'Regional Authority as respects its region … shall exercise on behalf of the Secretary of State his functions relating to the health service under the enactments … [set out in Schedule 1 of these regulations]'.[10] The relevant duties delegated to the RHA included those under Section 3(1) (a)–(f) of the 1977 Act.

12 The 1977 Act provided that the Secretary of State may direct an RHA to '... exercise on his behalf such of his functions relating to the health service as are specified in the directions'.[11] The RHA could in turn direct DHAs within its region to exercise those functions.[12]

13 Statutory Instrument (SI) No 1989/51 delegated functions to the RHAs (including all of those under Section 3 of the 1977 Act) and obliged the RHA in turn to delegate certain matters to its DHAs.

14 The DHA had to act in accordance with limitations or directions set by the Secretary of State or the RHA (provided that these latter directions, from the RHA, were not in conflict with those from the Secretary of State).[13]

15 The sequence of maps below show the extent of the RHA from 1981–1996 and the boundaries of the Avon Health Authority created in 1996

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[9] NHS (Determination of Regions) Order 1973

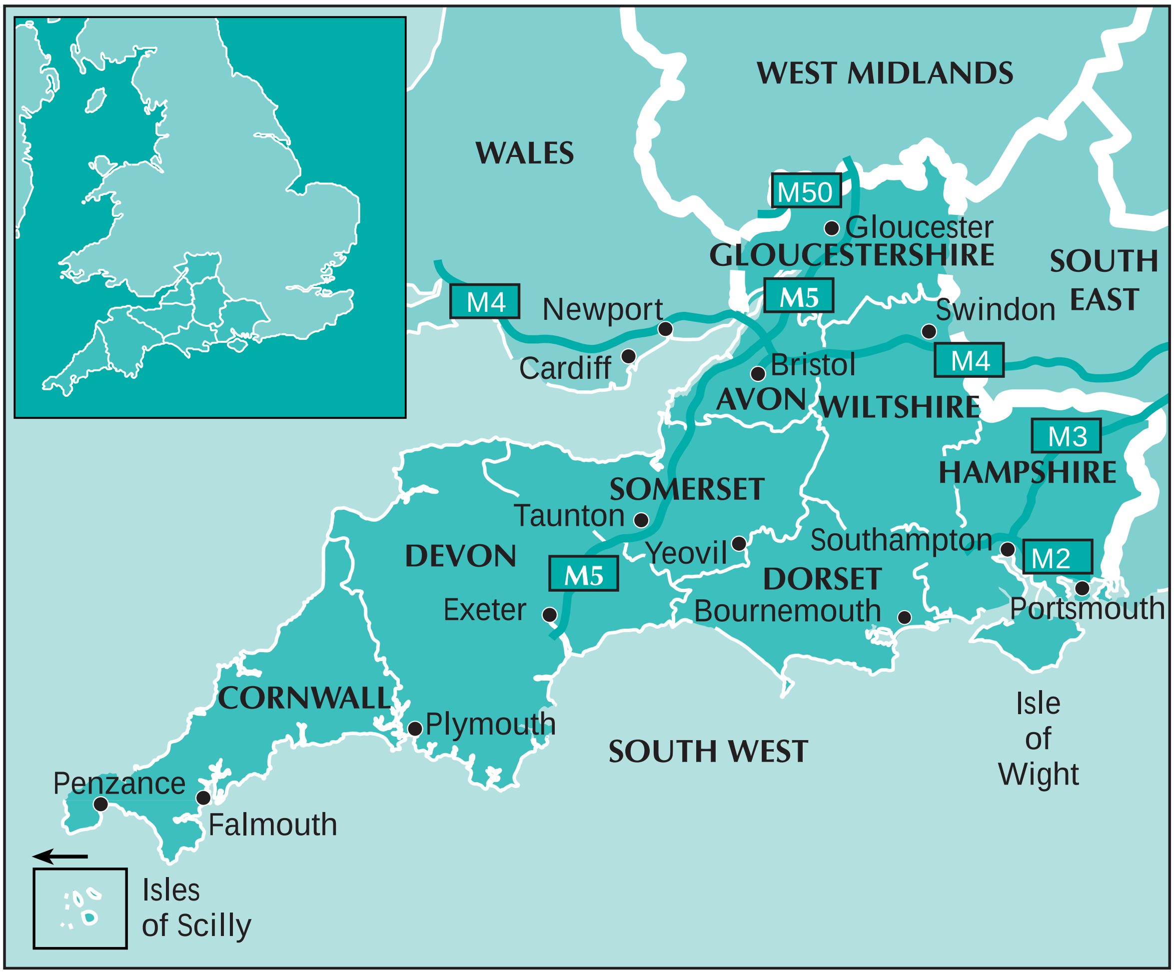
[10] Regulations consolidating the NHS Functions (Directions to Authorities and Administration Arrangements) Regulations 1982, SI 1989/51 regulation 3

[11] Section 13(1), 1977 Act

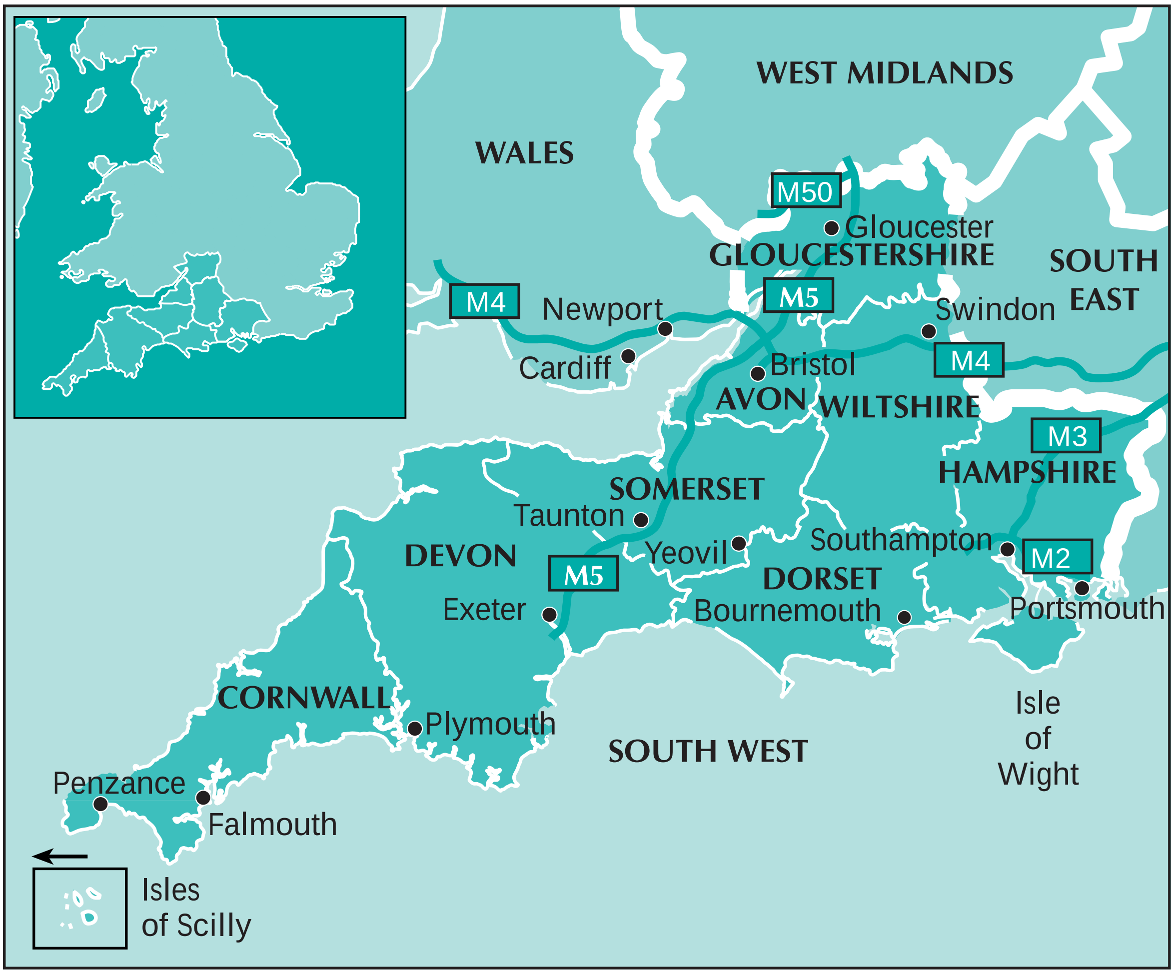
[12] Section 14(1), 1977 Act

[13] Regulation 6

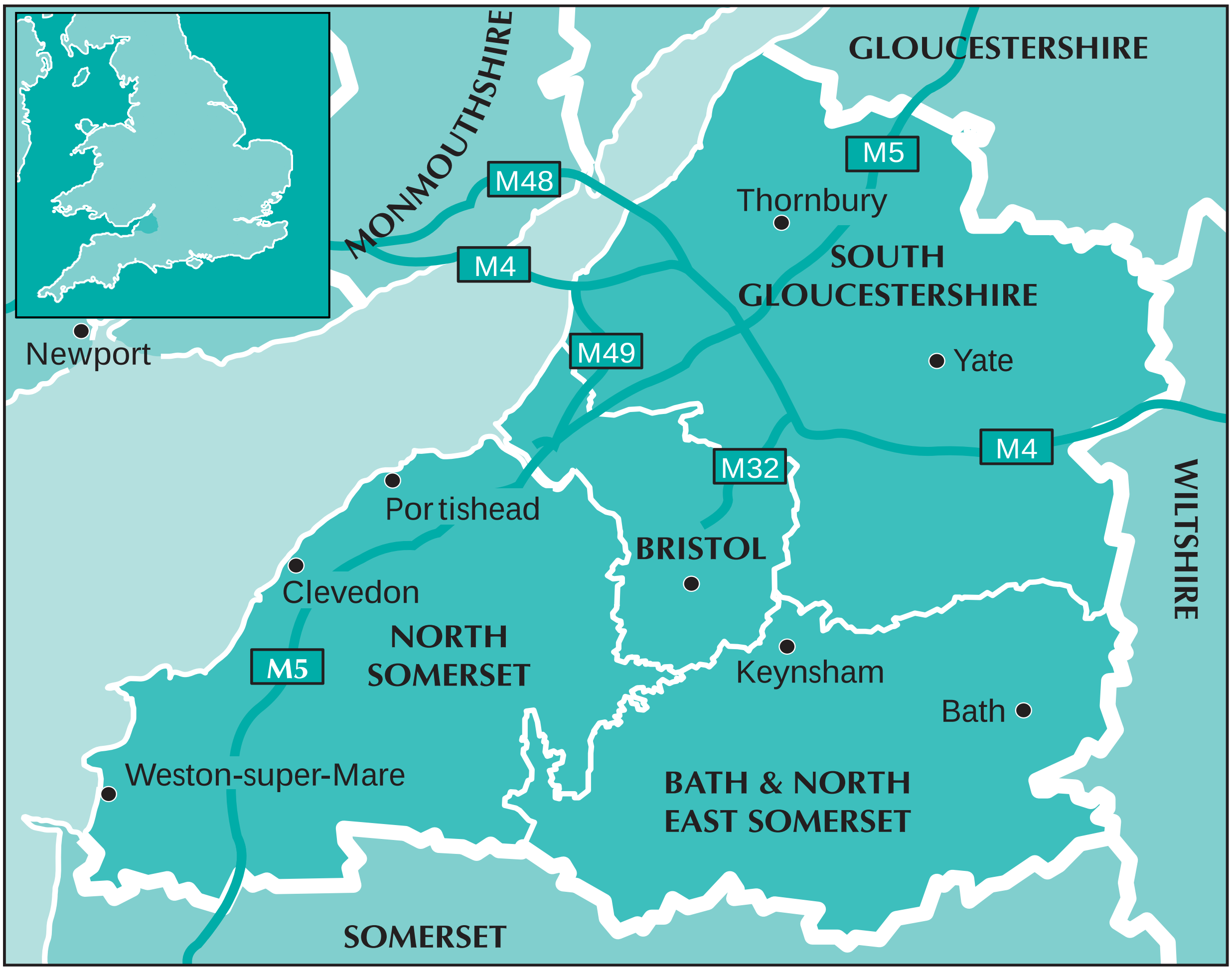
South Western Regional Health Authority 1981 – 31/03/1994



South & West Regional Health Authority – 01/04/1994 – 31/03/1996



Avon Health Authority 01/04/1996



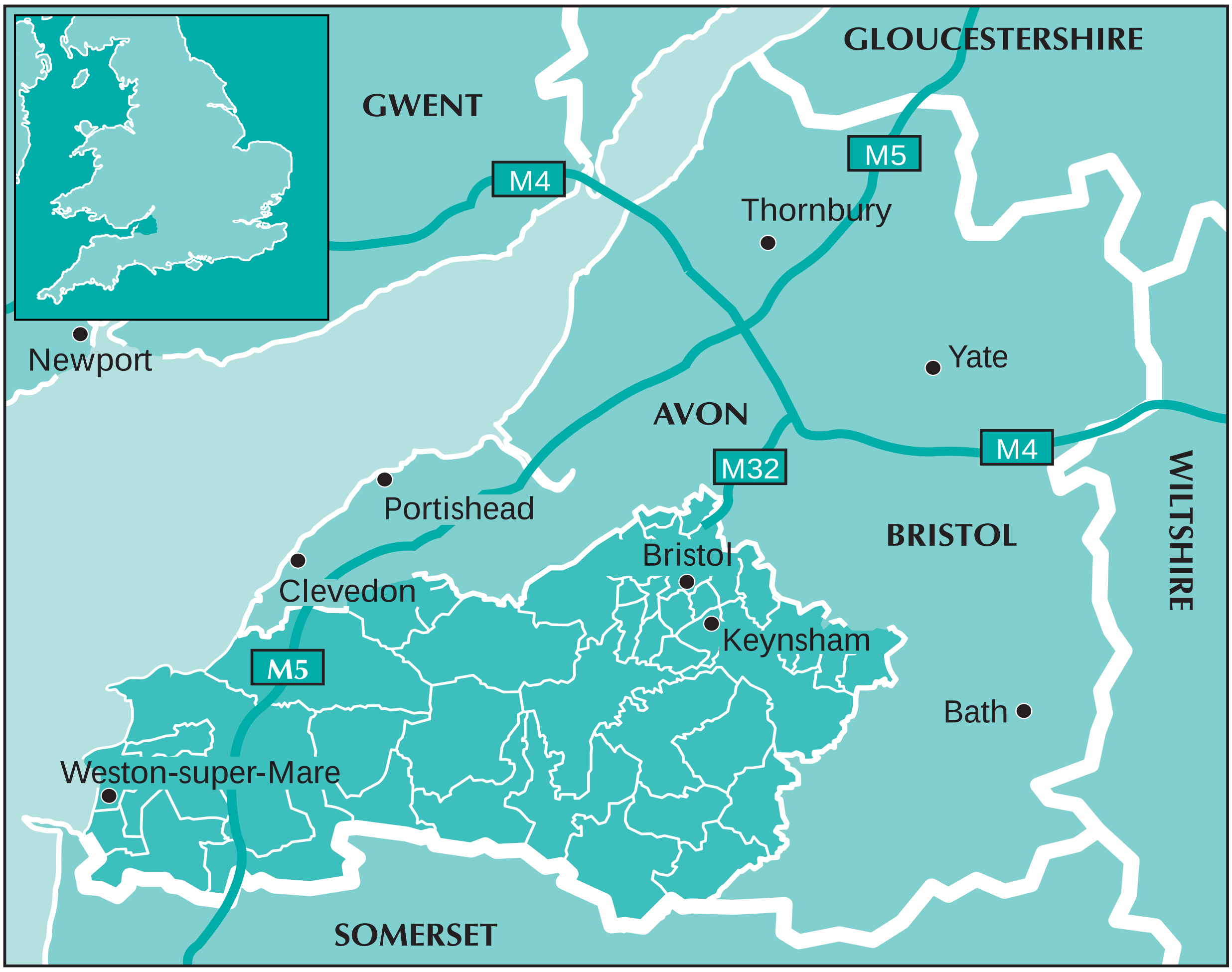
The district health authority

16 The district was established by the NHS (Determination of Districts) Order 1981.[14] The districts were largely constituted out of the old AHAs, and took over most of their staff. In Bristol, the constitution of the district was varied in 1991 by SI 1991/2039, which created the B&DHA.

17 The Secretary of State allocated funds to DHAs and could direct how these funds were to be applied.[15]

18 The following sequence of maps below show the extend of the DHA over time.

Bristol & Weston District Health Authority – 02/04/1982 – 30/09/1991



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[14] SI 1981/1837

[15] Section 97, 1977 Act

Bristol & District Health Authority – 01/10/1991 – 31/03/1996

NHS trusts

19 The legal framework for NHS trusts was established by the 1990 Act, which empowered the Secretary of State by order to establish bodies 'to assume responsibility … for the ownership or management of hospitals … or to provide and manage hospitals'.[16]

20 Each trust is a body corporate with a chairman appointed by the Secretary of State, and with executive and non-executive directors (the latter were not to be employed by the trust). However, NHS trusts are independent and the trust is not a servant or agent of the Crown or the Department of Health (DoH).[17]

21 There is nothing in the 1990 Act to spell out the duties of directors on the trust's board. The Secretary of State was, however, empowered to make Regulations to regulate the

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[16] Section 5, 1990 Act

[17] Section 5(8) and Schedule 2 paras 16(1) and 18, 1990 Act

appointment and tenure of chairmen and directors of NHS trusts.[18] These set the maximum number of directors at 11. Two were to be appointed by the RHA. All others were appointed by the Secretary of State. The tenure was not to exceed four years, but reappointment was allowed. The Regulations set out circumstances in which disqualification would occur (e.g. bankruptcy, sentence of imprisonment, loss of independence as a result of trade union office or membership of a health service body).

22 The executive directors of the trust had to include the chief officer, the finance officer, a medical practitioner and a registered nurse or midwife. A committee, composed of the chairman and non-executive directors of the trust, appointed the chief officer. Once appointed, the chief officer joined that committee in order to appoint the other executive directors of the trust.

23 The Regulations made provision for standing orders to govern proceedings of the trust (Regulation 19), and for the exclusion of directors from business in which they had a pecuniary interest (Regulation 20). The Regulations are 'procedural' in nature only. They give no guidance as to the duties or responsibilities of the directors, whether executive or non-executive.

24 The orders given by the Secretary of State in respect of each trust were meant to specify the functions of the trust.[19] The trust is required to carry out 'effectively, efficiently and economically'[20] those functions that have been conferred on it by this framework.[21] It has a duty to comply with guidance or directions from the Secretary of State (e.g. in circulars). An annual report has to be submitted to the Secretary of State, in a form determined by him; the Secretary of State also has the power to require trusts to submit further information.

25 The trust is also obliged to ensure that revenue covers outgoings and that it meets any financial objectives set from time to time by the Secretary of State.[22] NHS trust hospitals are funded from the revenue generated by contracting with NHS purchasers and others.

26 The trust has the power to do anything necessary in discharging its functions.[23] Under the 1990 Act Section 3, the RHA and DHA could enter into an NHS contract as a purchaser; under Schedule 2 para 10 a trust may enter contract as a provider.

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[18] Section 5(7). See also the NHS Trusts (Membership and Procedure) Regulations 1990, SI 1990/2160

[19] Schedule 2, part 1, para 1

[20] The Audit Commission has defined those terms, in relation to its own work, in its 1990 code of Audit Practice for Local Authorities and the NHS in England and Wales. 'Economy' relates to the terms on which resources are acquired; an economical organisation acquires them at the lowest cost. 'Efficiency' is concerned with the services provided in relation to the costs of provision; an efficient organisation produces either the maximum services for a fixed level of output or a fixed level of quality of service for the minimum output. 'Effectiveness' is a measure of how well a service achieves its goals. The statutory framework and any relevant guidance or directives set the goals

[21] Schedule 2, part 1, para 6(1)

[22] Section 10(2)

[23] Schedule 2 para 16(1), 1990 Act

27 The UBHT was formally established by the 'The United Bristol Healthcare National Health Service Trust (Establishment) Order'[24] which came into force on 21 December 1990. The Trust was established for the purpose specified in Section 5(1)(a) of the 1990 Act. The Trust's functions were to 'own and manage hospital accommodation and services' at various premises. It was to have a chairman, five executive directors and five non-executive directors. The operational date for the start of the Trust was 1 April 1991. Various transitional provisions were made to allow it to get up and running at that date.[25]

Management structures throughout the period in question

28 The management structures of the relevant health authorities changed significantly over the period covered by the Inquiry.

The South Western Regional Health Authority (SWRHA)

29 The 1973 Act established the SWRHA, which came into operation from 1 April 1974.

30 At that time, within the SWRHA were Avon Area Health Authority (Teaching) and a number of health districts. The Avon Area Health Authority (Teaching) included about 800,000 people in the Bristol and surrounding areas. The BRI and the BRHSC were both contained within the Bristol Health District (Teaching) which served a population of about 360,000 people, mostly within the Bristol area.[26]

31 Miss Catherine Hawkins, SWRHA Regional General Manager (RGM) from August 1984 to December 1992, explained the history of the SWRHA:

> ' … the South West region had been there since 1974. In fact, longer than that: in 1948 there had been a regional authority. What had changed was that in 1984 general management was introduced at regional and district levels. So, there had always been a regional authority dealing with programmes and strategic planning and financial allocation but it changed in 1984 when general management was introduced, and it changed again in 1991.'[27]

32 The SWRHA was one of 14 different RHAs in England, and within its boundaries were 11 separate DHAs. Among those 11 districts were Bristol and Weston, Southmead and Frenchay, which between them covered 880,000 population in the greater Bristol

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[24] SI 1990/2450

[25] Under para 6(2)(d) of Schedule 2 of the 1990 Act

[26] Southmead, Frenchay and Weston Hospitals were separate districts within Avon Health Authority (Teaching)

[27] T56 p. 18 Miss Hawkins

area.[28] The SWRHA itself spanned a far larger area, including Gloucestershire, Avon, Somerset, Devon, Cornwall and the Isles of Scilly.[29]

33 The RGM split the responsibilities within the SWRHA into five main areas (amongst others). These were, in general terms:

- Community Medicine (latterly called Public Health Medicine);
- Capital Planning;
- Service Planning;
- Finance; and
- Human Resources.[30]

34 Although the structure and organisation of the SWRHA changed over the period from 1984 to 1995, these main areas were always present in one form or another. For example, the Capital Planning and Service Planning departments merged and de-merged from time to time.[31]

35 The Regional Treasurer of the SWRHA was responsible for all of the Region's financial matters, including resource allocation to the districts, monitoring the financial position of the districts and providing financial advice to the Regional Health Authority Board.[32]

36 Dr Marianne Pitman was the Regional Specialist in Community Medicine. This title later changed to Consultant in Public Health Medicine, but the main functions of the position remained the same. The number of consultants in public health medicine varied between one and three at the most, and they had secretarial and administrative support. Dr Pitman's line manager and head of the department was the Regional Medical Officer (RMO)/Regional Director of Public Health (RDPH),[33] to whom she was managerially and professionally responsible. The RMO/RDPH created the work programme for the year that was agreed with the regional team officers, who were the executive directors of the SWRHA.[34]

37 The consultant(s) in public health medicine liaised with the RMO, as well as the public health departments located within the DHAs. Direct contact with the trusts,

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[28] T56 p. 18 Miss Hawkins

[29] T56 p. 19 Miss Hawkins. The Isles of Scilly were added in 1981

[30] WIT 0317 0002 Dr Pitman

[31] WIT 0317 0003 Dr Pitman

[32] WIT 0119 0001 Mr Wilson

[33] T58 p. 5 Dr Pitman. Office held by Dr Martin RF Reynolds, then Dr Marie J Freeman, then Dr A Mason; the title of RMO changed to RDPH at about the time community medicine became public health medicine, in about the middle of the period of the Inquiry's Terms of Reference

[34] WIT 0317 0003 Dr Pitman

once these were set up, was mostly through individual clinicians and associated managers.

38 The consultant(s) supported the Regional Hospital Medical Advisory Committee[35] (RHMAC) and later the Regional Primary Care Medical Advisory Committee (RPCMAC). The RMO attended each meeting. Dr Pitman attended when required. She also attended as an observer as many appropriate RHMAC sub-committee meetings as possible. This was not on a regular basis though, because the various different sub-committees were at times over 30 in number. Initially the RHMAC was made up of the chairmen of these sub-committees. Latterly, it was comprised of trust medical representatives with sub-committee chairmen attending as required or on request of the Chair.[36]

39 Dr Pitman's work with the RMO, as a result of attendance at these sub-committee meetings, was to provide support as required and to act as an additional conduit of information between the RMO and the sub-committee. However, not all matters would be channelled in this way. Any consultant could ask for an interview with the RMO if they had confidential issues which they wanted to discuss or impart instead of choosing to follow the route of raising the matter in committee or first with a consultant in public health medicine.[37]

40 However, it was Dr Alistair Mason's[38] experience as RMO that:

> 'It was very rare for consultants, whom I did not know, to come out of the blue with a particular problem concerning themselves or colleagues. Members of the medical advisory committees did on a number of occasions bring forward concerns about their colleagues.'[39]

41 The consultants in public health medicine were also involved in cross-RHA departmental strategic planning for service and capital developments.[40]

42 The role of consultant in public health medicine also involved Dr Pitman in the initiation procedures for setting up the supra regional service (SRS) of neonatal and infant cardiac surgery (NICS) in January 1984 and the discussions regarding its effect following its inauguration.[41]

Managerial relationships with the Department of Health

43 One of the main functions of the RHA was its role in strategic planning. According to Miss Hawkins, the RHA formed a view of which services should or should not be developed, taking into account national priorities passed down from the DoH/

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[35] The RHMAC is dealt with further below, see paras 61–74
[36] WIT 0317 0003 Dr Pitman
[37] WIT 0317 0004 Dr Pitman
[38] Dr Alistair Mason, RMO/RDPH from April 1988 to June 1994
[39] WIT 0399 0044 Dr Mason
[40] WIT 0317 0004 Dr Pitman
[41] WIT 0317 0004 – 0005 Dr Pitman

Department of Health and Social Security (DHSS) and the views expressed from the districts.[42]

44 The DoH/DHSS made their views and priorities known by issuing circulars and directives to the regions, and also through the medium of annual reviews which took place between the DoH and the Region. These reviews were between the Minister and the Chairman of the RHA. The Vice-Chairman would also normally attend, together with the RGM and the appropriate members of the RGM's team. As Miss Hawkins explained, the Minister would lead the departmental team, supported by civil servants as necessary.[43]

45 The purpose of the meetings was to review different aspects of healthcare according to the particular interests a particular Minister may have had:

> ' … but there was always a thread running through it [the meeting] about financial viability and how we had performed against national targets, whether we were achieving our overall strategic plan and whether there were any specific items of interest or concern on either side. It was a very open type of meeting where you could argue back, but then you would be given set targets or tasks to go away and achieve.'[44]

46 At the DHSS review in April 1984 SWRHA was told that it was not getting the best for patient care because it was not demanding more value for money from its districts.[45]

47 The need for the Region to change its management style filtered down to the districts promptly, with it being noted in a meeting between the Region and the B&WDHA[46] that it was the opinion of the DHSS that Regional strategy needed specific plans for achieving its objectives with the districts, rather than a mere statement of good intentions.

48 Miss Hawkins was the Chief Nursing Officer at the time of the review and had just joined the Region. She said:

> ' … we were told [by the DHSS] that the Region was so laid back that it could fall off the chair … and that is when we were told to stop being friends with the districts, in quotes, and to get to grips with them and to start making them perform well, because Region was not doing that.'[47]

49 General management was shortly to be introduced into the Region. Interviews were held in July and Miss Hawkins was appointed RGM in August 1984. The management style was changed in accordance with the Department's wishes, and services for

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[42] T56 p. 22–3 Miss Hawkins

[43] T56 p. 23 Miss Hawkins

[44] T56 p. 25 Miss Hawkins

[45] T56 p. 29–31 Miss Hawkins

[46] UBHT 0102 0433; notes of a meeting between SWRHA and B&WDHA on 11 June 1984

[47] T56 p. 29 Miss Hawkins

patients generally improved (especially in mental illness and mental handicap services).[48]

Managerial relationships with the district health authorities

50 There was regular and ongoing contact between the SWRHA and the district general managers (DGMs) of all the DHAs, including the B&WDHA. Either the DGM or one of the DHA's representatives would attend meetings with the Region's Finance Officer, Planning Officer and medical officers. In addition, there would be informal contact between the DGM and the RGM, if and when requested by either party on a less regular ad hoc basis.[49]

51 The Region held annual reviews with each of the 11 DHAs within its area. This again was a chairman-to-chairman review. Each of the chief executives attended with the relevant team officers, depending on what subject was being discussed at the time. Normally the Vice-Chairman of the RHA also attended the meeting, otherwise a non-executive from the RHA who had a particular oversight of a district was present.[50]

52 A team of assistant RGMs, who had responsibility to the RGM for the individual districts, assisted the RGM. A certain amount of feedback from the DHAs would also come to the RGM on an informal basis through these assistant RGMs following meetings with the DGMs and other officers of the individual DHAs. The size of the area covered by the RHA and the number of individual departments and specialties maintained within all the hospitals in this area determined the degree of their individual scrutiny by the RGM.

53 Miss Hawkins explained in oral evidence:

> ' … [the feedback from districts] would have been done on an informal network, because I did have AGMs [assistant RGMs] who were responsible for individual Districts, and that would have been done when they actually sat with them to see what should be coming up as agenda items at our reviews. I mean, cardiac surgery was a very small part, as I have tried to explain, of the total acute and other services in the Region, so it was not high on my agenda every single time I sat down with a DGM.'[51]

54 The function that the RHA could perform was limited by the authority and control it had over the districts. Miss Hawkins in her oral evidence was asked whether her role as RGM gave her the direct supervision of the 11 districts underneath the SWRHA. She replied:

> 'It was a very difficult system because the Regional Health Authority had monitoring and a degree of control, in italics, of its Districts without the actual

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[48] T56 p. 31 Miss Hawkins

[49] T56 p. 21 Miss Hawkins

[50] T56 p. 23–4 Miss Hawkins

[51] T56 p. 68 Miss Hawkins

> authority to affect them directly, because each District had its own Chairman and non-Executive Board who actually managed the Districts.
>
> 'So it was a situation where you had accountability and responsibility without true authority.'[52]

55 Continuing on the issue of the control the Region had over the DHAs, Miss Hawkins was asked whether these reviews were *of* the district or *with* the district:

> 'It was a situation where, when I came into office in 1984, we were tasked by the then Minister to take control of our Districts who were perceived not to be performing as well as could be expected and that Region needed to get a grip on things.
>
> '… I was a very strong executive and although we did not have direct control of Districts, they did feel accountable to us. That was partly style and partly the fact that I had a good team at Regional level who were in a position where they could challenge and naturally take things forward with their counterparts at District level.'[53]

56 Dr Pitman explained the position of the RGM within the RHA as follows:

> 'The RGM was the … head of the officers of the RHA, but there was also a Health Authority with a Chair. The regional team of officers were the executive officers and the lay members, who may have been drawn from clinical specialties as well as from other groups, where the non-executive directors intersect. Together they form the Health Authority.
>
> 'The Regional General Manager had a number of departments with the equivalent of directors at the head of them. One of them was community medicine or public health medicine, which also included pharmacy and dental advice, and the Regional Scientific Officer, who administered the scientific equipment budget for the Region, and that was things like linear accelerators, radiotherapy, and the larger pieces of investigational equipment, some of the catheterisation equipment.'[54]

57 In addition to the departments of Community Medicine (latterly called Public Health Medicine), Capital Planning, Service Planning, Finance and Human Resources, was the Works Department, which was linked to Capital Planning. The Service Planning Department and the Finance Department were also closely affiliated.[55]

58 With respect to the Public Health Department, the RMO delegated his function by allocating responsibilities to cover different areas, depending on how many people

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[52] T56 p. 22 Miss Hawkins

[53] T56 p. 24 Miss Hawkins

[54] T58 p. 6 Dr Pitman

[55] T58 p. 7 Dr Pitman

he had in the department, to the public health consultants and also to the other professional staff. Any one particular person would not be involved with a particular area all the time, but would do some of the routine work and due to their general involvement would be the first person to be called upon if something needed to be done. It was a question of delegation by the RMO.[56]

59 The number of areas any one individual had to keep a watch on varied from year to year, depending on what the priorities were and how many other consultants there were in the department. Dr Pitman was the only consultant in the department for 'substantial periods of time', at other times there were as many as three. Between them they looked after approximately 25 different specialties, not all of which would be active at the same time. Sometimes, four or five specialties would be involved in respect of the same medical discipline, such as was the case with cardiac surgery.[57]

60 The role of the RGM was mainly strategic, concerned with financial allocation and overseeing general performance, rather than the specifics of any one particular individual service, such as cardiac surgery.[58] In order to put this strategy-forming function into effect, the RHA used a committee structure.

The Regional Hospital Medical Advisory Committee (RHMAC)

61 The role of the RHMAC was to support the RHA in its strategic function. Its function was primarily reactive, responding to specific enquiries from the RHA for expert specialist knowledge. This specialist knowledge would come from the RHMAC's sub-committees, which would be commissioned to advise on a specific matter. This advice was then included in the RHMAC's reports and recommendations submitted back to the Region.

62 Prior to 1984, SWRHA had an RHMAC that dealt with a mixture of both primary and secondary services. This committee was then split, so that the secondary (hospital) services were separated from community services, allowing GPs to become more involved in the actual development of primary care. The remaining secondary hospital services side of the committee became the new RHMAC,[59] which became a key link between the RHA and the profession.[60]

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[56] T58 p. 7–8 Dr Pitman
[57] T58 p. 8 Dr Pitman
[58] T56 p. 47 Miss Hawkins
[59] T56 p. 52 Miss Hawkins
[60] T58 p. 8–9 Dr Pitman

63 Miss Hawkins explained:

> ‘We revamped the Regional Medical Advisory Committee so that it had representatives from every District serving on it, as well as the Regional Medical Officer, and I was a member, at that time, for the decision-making meetings.
>
> ‘Each time we [the Regional Health Authority] needed to look at acute or other services, then the subject was given to the Regional Hospital Medical Advisory Committee who would form a sub-committee for the specialty under review, and they would put together a strategic outline of the services that were under review. They would take it back to the main committee, who would take it to their Districts and when they signed up, it would form the strategic statement for the Region. So all Districts and all the specialty people had been involved in developing the service strategy.’[61]

64 From 1984 onwards, the RHMAC was made up of the chairmen of the various specialties’ sub-committees. The membership of the RHMAC was selected from across all the districts within the RHA. The consultants’ committee of each district (and later NHS trust) nominated two individuals. The chairman of the RHMAC and the RMO/RDPH then chose the committee from these nominations to ensure there was an equitable spread of specialties represented.[62] Typically there were 20 or so consultants chosen to make up the committee. Mr David McCoy noted that there was no specific consultant for cardiac surgery on the RHMAC while he was chairman.[63] From 1991 the DHAs were purchasing authorities which did not employ clinical consultants so were not represented on the RHMAC, but there was always a district public health physician in attendance who could give a DHA perspective.[64]

65 At the time of the purchaser-provider split, the constitution of the committee changed to trust-nominated medical representatives together with sub-committee chairmen attending as required or on request of the Chair. In addition, a primary care representative was also added.[65]

66 Therefore, the RHMAC membership was mainly provider-based after the split, with a minimal role being played by the DHAs. A representative from the consultants in public health medicine also sat on the RHMAC. Although accountable to the RMO in any event, this assisted the structure and communication by making the Department of Public Health in effect like another sub-committee.

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[61] T56 p. 51 Miss Hawkins

[62] WIT 0399 0044 Dr Mason

[63] WIT 0436 0001; Mr McCoy was chairman of the RHMAC from 1990 to March 1994

[64] WIT 0399 0044 Dr Mason

[65] T58 p. 9 Dr Pitman

67 The RHMAC produced a number of advisory statements, each of which would take a couple of months to develop. They would be worked on gradually over a number of weeks.[66] Dr Mason, in oral evidence, said:

> 'A major problem in drawing up the RHMAC strategic statements about services was the poor quality of the data about clinical activity. The data collected at regional level once fed back to clinicians had little credibility. Total numbers of discharges and deaths for a speciality in a hospital were reasonably accurate but: … analysis was only by speciality and not individual consultant …'[67]

68 The Cardiac Services Medical Advisory Sub-committee produced a document, *'Cardiac Services within the South West Regional Health Authority – A Strategy for 1988/98'*.[68] This was a document produced by taking advice from, amongst other sources, the RHMAC's sub-committee on cardiac surgery and cardiology. The purpose of the document was to advise the RHMAC and the RMO, and through them the RGM, as to the direction in which they felt, clinically, the Region should be moving.[69]

69 The sub-committee meetings were composed of clinicians from the relevant departments. The cardiac sub-committee meetings, for example, included cardiac surgeons, cardiologists and radiologists. It was concerned with heart disease of all types. In addition, there was the paediatric sub-committee which considered matters specific to children.

70 The cardiac service sub-committee was supported by Dr Pitman. The RHMAC strategic statement on cardiac services was published in November 1989.

71 The Chairman and the RMO/RDPH instigated all the work of the RHMAC, and the Committee responded to any requests for specific advice from the RHA or RGM.[70] The RHMAC meetings were held monthly. The discussions held were to review and advise on papers provided by the RMO/RDPH and reports provided by the sub-committees.[71] The RMO/RDPH subsequently presented the minutes of the meetings to the RHA meetings.

72 The RHMAC was purely advisory and had no executive or budgetary authority. The aim was to advise and review the present hospital situation in the Region and to advise on future new hospital developments, e.g. new buildings or departments, appointment of consultants or other hospital medical staff.[72] The advice given was generalised in nature, based on facts and figures provided by the RHA, e.g. length of

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[66] T58 p. 10 Dr Pitman

[67] WIT 0399 0003 Dr Mason

[68] UBHT 0156 0255; *'Cardiac Services within the South West Regional Health Authority – A Strategy for 1988/98'*, 29 September 1988

[69] T58 p. 60 Dr Pitman

[70] WIT 0399 0044 Dr Mason

[71] WIT 0436 0001 Mr McCoy

[72] WIT 0436 0001 – 0002 Mr McCoy

waiting lists, patient throughput, and shortages in staff and facilities. The Committee had no special knowledge of the quality of the service given.[73]

73 In order to advise the RHA in its strategic planning role, the RHMAC produced 29 strategic statements about clinical specialties or services, which were published in five documents between November 1989 and July 1991. Each sub-committee produced a report to the RHMAC, supported by one of the Regional public health specialists. The RHMAC then discussed the report and prepared a summary in a standard form. This was then sent back to the sub-committee for its approval prior to being submitted to the SWRHA.[74]

74 None of the individual RHMAC statements were formally endorsed by the SWRHA at the time they were presented until December 1992, when the Regional Strategic Framework, which incorporated edited versions of the statements, was formally adopted.[75]

Other channels of communication within the Regional Health Authority

75 Miss Hawkins explained that the Regional Team Officer meetings were attended by the senior management team: the RGM, the Finance Director, the Medical Officer, the Human Resources Director, the Capital Planner and the Service Planner.[76]

76 The channels of communication within the RHA were described by Dr Pitman as follows:

> ‘The RMO would have met regularly with the other heads of department and Catherine Hawkins, and would have relayed back information from those meetings which was relevant in his or her eyes to individuals within the department. There was not, as far as I remember, a regular meeting within the Public Health Department of everybody involved, but there would have been 1 to 1 meetings or 1 to 2 or 3 meetings at fairly regular intervals around specific topics.
>
> ‘Across the Regional Health Authority there were groups called the Capital Planning Group which would look at capital investment, and the Service Planning Group, and some of the letters which you have involve some of those managers who were involved in organising those and they would have asked relevant people within public health to come for specific items or to come for the whole meeting, depending on what was being discussed.
>
> ‘So there was quite a lot of horizontal communication, but most of the vertical communication, practically all of it, was through the head of department at my level.’[77]

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[73] WIT 0436 0002 Mr McCoy

[74] WIT 0399 0002 Dr Mason

[75] WIT 0399 0002 Dr Mason

[76] T56 p. 78 Miss Hawkins

[77] T58 p. 88–9 Dr Pitman

77 Miss Hawkins described the RMO as having had oversight of the Avon districts as part of the duties assigned to them.[78] She further explained:

> 'The situation was, as RGM in a very big Region and a very large budget in the billions, there was no way that I could have a dialogue with DGMs or important officers on every single occasion. There was also in my mind the fact that every now and again one would have to be quite rigorous with the DGMs in order to achieve the change of style and that could be more than confrontational in the early stages and was something to try and be avoided and to come in as the reinforcer and not the enforcer.
>
> 'So I set up a system where I had four major officers at Regional level: the Finance Officer, the Human Resources Officer, the DMO and the Capital Planner. So each one of those was assigned basic responsibilities overseeing certain Districts. The RMO was assigned the Avon Districts: Frenchay, Southmead, Bristol & Weston, because Southmead and the BRI were teaching hospitals and there was a lot of University liaison and medical teaching.
>
> 'So that the RMO could be the first point of contact by a DGM who would say, "We would like to do X", or "We do not want to do Y", "What will the RHA make of it?", "What will Catherine do?", or "We have a problem up there, come back and let me know and we can get together with Catherine and the team and try and sort something out".
>
> 'So, they were the first point of contact and had the first oversight of the District: anything of importance, they were supposed to come and keep me informed, not for me to dabble in it unless they needed that assistance, but to deal with things; to prepare a District for the review, give us feedback for the departmental reviews. So the RMO had oversight of Avon.'[79]

78 So the RMO would have more direct information and would have that information sooner, before it had been filtered through to the RGM. That was, unless the matter was so serious that a DGM brought it straight to the RGM.[80] Dr Mason said that the number of consultants and the distances to be travelled in the South West made keeping in close touch difficult.[81]

79 The post of RMO/RDPH was accountable to the RGM. The major role of the RMO at Regional level was in planning matters.[82] The core responsibilities of the post were:

- ensuring that the RHA obtained the best medical advice, particularly its strategic planning role;

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[78] WIT 0091 0001 Miss Hawkins
[79] T56 p. 118–19 Miss Hawkins
[80] T56 p. 119 Miss Hawkins
[81] WIT 0399 0044 Dr Mason
[82] WIT 0399 0044 Dr Mason

- ensuring the effective functioning of the district public health departments and reporting annually on the state of the public health in the Region; and

- implementing the procedures for clinical complaints against hospital doctors.[83]

80 In addition, the RMO/RDPH was also made responsible for the development of medical/clinical audit (1989–1993), the development of clinical computing and information (1988–1993), and for liaison with the Bristol districts (1988–1991).[84]

81 The RMO/RDPH had three formal mechanisms for obtaining medical views and opinions:

- He was the secretary of the RHMAC, which met monthly. It had over 20 specialist sub-committees that met periodically.

- He was also secretary of the RPCMAC, which also met monthly.

- He was also the Chairman of the Directors of Public Health Forum.[85]

82 The RMO/RDPH and these advisory committees were responsible for advising the RHMAC on what they considered should happen, and then it was the function of general management and later performance management to be responsible for ensuring that policy was carried out and the targets were achieved.[86]

83 In addition, informal medical advice came through general networking with doctors throughout the Region,[87] attending scientific meetings of particular specialty groups and visiting hospitals, particularly in respect of implementation of proposals concerning junior doctors' hours and quality of care initiatives.[88]

84 Until the trusts were set up in April 1991, the RMO was responsible to the RGM for liaison with the three Bristol health districts. This involved, where possible, a quarterly contact with the DGMs and assistance to the RGM in preparation of the annual review of the districts' performance.[89]

85 Dr Mason noted that this approach worked well with Frenchay and Southmead, but he was not able to meet Dr John Roylance,[90] District General Manager of the B&WDHA from 1985, as often as he would have liked.[91] He explained that Dr Roylance preferred to deal with general managers rather than medical advisors.

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[83] WIT 0399 0001 Dr Mason

[84] WIT 0399 0001 Dr Mason

[85] WIT 0399 0001 Dr Mason

[86] WIT 0399 0043 Dr Mason

[87] WIT 0399 0001 Dr Mason

[88] WIT 0399 0043 Dr Mason

[89] WIT 0399 0003 Dr Mason

[90] Dr Roylance was appointed DGM of B&WDHA from 1 February 1985 and held the office until 31 March 1991. On 1 April 1991 he became Chief Executive of UBHT, until his retirement on 21 October 1995

[91] WIT 0399 0003 Dr Mason

If he had any major issue he would discuss it with the RGM direct. Dr Mason said that he did not press for meetings, knowing that Dr Roylance was reluctant and that Dr Roylance communicated regularly with Miss Hawkins.[92]

86 Miss Hawkins had frequent informal meetings with Dr Roylance. This was facilitated by the proximity of the two organisations:

> ' … he and I met informally on several occasions …. The Region was in Kings Square House. The BRI was literally 100 yards away.'[93]

87 The powers that the RHA had previously exercised also changed in other ways once trust status was conferred on the UBHT:

> ' … the control of trusts went directly to the Department, so Region was not involved. Region continued to oversee the non-trust units and the Department had a section which managed or had direct contact with trust status units.'[94]

88 Dr Pitman noted:

> 'In the early 1990s the role of the Regional Health Authority in the trusts was diminishing with the setting up of Department of Health Regional Outposts for the performance management of trusts directly responsible to the Department of Health.'[95]

89 The SWRHA merged with part of the old Wessex Region in 1994, almost doubling the population it covered to six million. This was now the S&WRHA. The employees from both regional authorities were 'slotted in' with each other.[96]

90 From 1 April 1996 the S&WRHA was abolished, and the South and West Regional Office of the NHS Executive was created.[97]

91 The role of the regional office of the NHS Executive (NHSE) was different from that of the old RHA. It was staffed by civil servants who were ultimately responsible, via a number of tiers of management, to the Secretary of State.[98]

92 The setting up of regional outposts of the NHSME was announced in January 1992, and they became active from 1 April 1992.[99] Their function was to performance-manage the trusts, being separate from the health authorities and directly responsible to the Secretary of State. The regional outposts were established 'in order to carry out

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[92] WIT 0399 0046 Dr Mason
[93] T56 p. 94 Miss Hawkins
[94] T56 p. 12 Miss Hawkins
[95] WIT 0317 0004 Dr Pitman
[96] T58 p. 14 Dr Pitman
[97] T58 p. 14–15 Dr Pitman
[98] T58 p. 15–16 Dr Pitman
[99] Edwards B. *'The National Health Service 1946–1994: A Manager's Tale'* (1995), Nuffield Provincial Hospitals Trust

financial monitoring and to undertake appraisal of strategic capital investment on behalf of the NHS Management Executive to whom the NHS Trusts reported'. Also, according to Roger Hoyle[100], it was to 'co-ordinate with Regional Health Authorities and the Management Executive proposals for capital investment by Trusts through the use of commercial-type investment appraisal.' The liaison between the regional outposts and the RHA was seen as having a fairly low profile as far as Dr Pitman (and others) was concerned, because they contained no medical advisory staff. Their boundaries were not the same as the Region, but the regional outpost that the SWRHA dealt with was the one based in Bristol.[101] The regional outposts were abolished in 1996 and their performance-monitoring function was absorbed into the NHSME regional offices.

The Bristol & Weston District Health Authority (B&WDHA)

93 In 1982 the B&WDHA consisted of 22 hospitals, 12 health centres and eight clinics, divided up for management purposes into seven units. The BRI was included in the Central Unit and the BRHSC was included in the Children's and Obstetric Unit. The other units were the South Unit, Weston Unit, Winford Orthopaedic Hospital, Mental Illness Services and the Mental Handicap Service.[102]

94 The management structure of the B&WDHA that had existed prior to 1984 continued in place until the introduction of general management during 1985. There was a separate managerial hierarchy for each individual group of staff, so the professional, technical and administrative staff all had their own management trees.[103]

95 The consultants, on the other hand, were all viewed as equals and 'occupied what can best be described as a managerial plateau'.[104] Each consultant was a member of the Hospital Medical Committee (HMC). The HMC was supported by its Steering Committee, which was a smaller elected medical executive committee, and was also supported by the specialist divisions. The Steering Committee would act as a general steering group reporting to the HMC as a whole, and the specialist divisions comprised the medical advisory function reporting to the HMC.[105]

96 Each of the units within the B&WDHA contained its own management group made up of a unit administrator, a doctor and a nurse. These groups were accountable to the District Management Team, which included in its membership the District Administrator, the District Finance Officer, the Chief Nursing Officer, the District Medical Officer, the Chairman of the HMC, a general practitioner and a representative from the University of Bristol. Each unit management group managed by consensus, wherein decisions could only be made with the agreement of all members of the

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[100] WIT 0497 0001; Roger Hoyle was the Executive Director of the Regional Outpost of the NHS Management Executive responsible for monitoring NHS trusts in the former South Western and Wessex Regional Health Authority areas, from 1 April 1990 to June 1994

[101] T58 p. 16 Dr Pitman

[102] HAA 0130 0019 – 0021; draft consultative district operational and forward programmes 1983–1985 *'Your future health care – our concern'*, produced by the B&WDHA in July 1982

[103] This includes the nursing management and the professions allied to medicine, e.g. pharmacists and physiotherapists

[104] WIT 0108 0004 Dr Roylance

[105] WIT 0108 0004 Dr Roylance

group. This gave each member of the group the ability to exercise an individual veto over any decision. Of the District Management Team, the District Administrator[106] managed all the District's administrative staff and services, the Finance Officer managed all the finance staff, and the Chief Nurse managed all the nurses, but the consultant member (the Chairman of the HMC) and the general practitioner member acted in a representative capacity only, expressing the opinions of their colleagues.[107]

97 When required, professional advice was received by the District Management Team, in particular by the Chairman of the HMC, and the District Medical Officer (DMO).[108] For example, Dr Stephen Jordan and Dr Hyam Joffe, consultant paediatric cardiologists, gave professional advice on cardiological services, and Mr James Wisheart, consultant cardiac surgeon, advised on surgical services at the BRI and BRHSC.

98 The first major change at district level occurred following the publication of a DHSS Health Circular[109] in 1984, which required health authorities to appoint a general manager. This was in response to the Griffiths Report,[110] which had been published the previous year and recommended changes in the management structures of the NHS.

99 In January 1985 B&WDHA complied with this requirement with the appointment of a DGM,[111] and required him to produce a management structure for the DHA by 30 April 1985,[112] to be approved by the B&WDHA and subsequently submitted to the SWRHA. According to Dr Ian Baker, Consultant in Public Health Medicine, this proposal[113] put the DGM as 'directly and visibly responsible'[114] for the management of the district, being directly accountable to the DHA. He was the overall budget holder and was responsible for the development of policies within the DHA and for monitoring their implementation.

100 Dr Roylance was appointed as the first DGM of the B&WDHA (a post he was to retain until he became Chief Executive of the UBHT in 1991). He explained his main responsibilities on being appointed as follows:

> 'So in 1985, being appointed the first District General Manager, I had two primary responsibilities; there were others, but the two primary responsibilities were to introduce the general management function, by which I mean getting rid of functional management, nurses being managed by nurses, physiotherapists by physiotherapists, administrators by administrators. It could be said at that time

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[106] Mr V C Harral held this post until it disappeared under general management, when he became Acting General Manager of the South Unit until he retired in March 1986

[107] WIT 0108 0004 Dr Roylance

[108] WIT 0074 0010 Dr Baker

[109] HAA 0164 0004; DHSS Health Circular HC (84) 13

[110] Griffiths R. *'NHS Management Inquiry. Report to the Secretary of State for Social Services'* (1983), London: DHSS

[111] HAA 0126 0075 – 0084; minutes of the meeting of B&WDHA on 21 January 1985

[112] HAA 0126 0084; minutes of the meeting of B&WDHA on 21 January 1985

[113] WIT 0074 0424 – 0428 Dr Baker

[114] WIT 0074 0425 Dr Baker

when I took up the District General Management role there were about nine different health services in the District coming together only at District level.

'In introducing the general management function, it was expressly required to delegate operational management decisions as near to the bedside as possible.'[115]

101 He explained further what general management was intended to address:

> 'Until this form of management was introduced, the exercise of clinical freedom, I regret to say, was entirely independent of resources and that management, up until that point, had to use quite crude measures to try and prevent the major overspending of a service, things like closing operating theatres, closing wards, so it was not possible to overspend, because there was a complete separation of the exercise of clinical freedom from the responsibility of staying within budget.'[116]

102 After the introduction of general management and the replacement of the old consensus management system, the hospital and community services were restructured. The structure of the B&WDHA changed in that the seven different units that had existed before were now rationalised into two: the Central Unit and the South Unit. The Central Unit comprised six sub units and the South Unit five sub units. The BRI Sub Unit and the Children's and Maternity Sub Unit were both contained within the former.[117]

103 All the professional, technical and administrative staff were amalgamated into this unit system, with their pre-existing hierarchies remaining only as advisory structures for the general managers. The consultant staff retained their advisory structure and their clinical independence.[118]

104 Due to problems of size and the wide area that they covered, each of the two units had a unit general manager who was directly accountable to the DGM.[119] They assisted the DGM in co-ordinating, planning and monitoring the performance of the sub units. Each of the 11 sub units also had their own general managers.[120]

105 In addition to these there were also the following officers, all of whom were directly accountable to the DGM:[121] two assistant district general managers (ADGMs), who were managerially accountable to the DGM but had direct access to the B&WDHA on matters of their respective professional responsibilities; and an ADGM (Information), who carried on the service planning role of the previous post of DMO

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[115] T24 p. 9 Dr Roylance

[116] T24 p. 24 Dr Roylance

[117] WIT 0108 0004 – 0005 Dr Roylance

[118] WIT 0108 0005 Dr Roylance

[119] The Unit General Manager for the Central Unit was initially Mr John Watson, who was followed in the position by Mrs Margaret Maisey

[120] Mrs Marion Stoneham was Sub-Unit General Manager responsible for the BRHSC and the Bristol Maternity Hospital; Miss Janet Gerrish and then Ms Deborah Evans were General Managers with responsibility for the BRI

[121] WIT 0038 0058 – 0067 Ms Charlwood

under the pre-existing management structure.[122] This ADGM was accountable via the DGM to the Policy, Planning and Resource Committee for strategic and operational planning.

106 Strategic planning from 1984 addressed the DHSS's guidance contained in the document *'Care in Action'*,[123] which set out Government priorities in service planning.[124] The ADGM (Information) developed plans for the priorities adopted by the SWRHA from such Government proposals and submitted them via the DGM to the Policy Planning and Resource Committee.[125] This ADGM's role continued with strategic planning, although Dr Roylance's proposals under general management saw the initial planning process taking place at the sub unit level, with plans then being reviewed, discussed and integrated into a full District Plan.[126]

107 In addition, the role of the ADGM (Information) was that of a director of information, covering such matters as epidemiology, patient-care statistics, systems information and the District computing service, as well as assessing the desires and perceptions of the public.

108 The other of these ADGMs was the District Treasurer, who was responsible for the District Finance Department and the Divisional Supplies Service. He provided professional financial advice to the DGM and to the B&WDHA.

109 There was also a Personnel and Training Manager who reported to the DGM and was responsible for all matters relating to human resources. The Commercial Manager would deal with all the competitive tendering requirements.

110 In addition to the management structure there were four advisory committees which gave professional advice on their particular areas of expertise to the general managers at both unit and district level. These committees were the HMC, the District GP Committee, the Nursing Committee, and the Professional and Technical Staff Committee.

111 The majority of professional advice at district level was channelled through the Chair of the HMC. He was advised by Chairs of the clinical divisions. There was a division for paediatric services and one for surgical services.[127] It was through this structure of clinical divisions that the medical staff had direct involvement in the management of services.

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[122] Dr Baker was the DMO at the B&WDHA, and continued as the ADGM (Information) when the post was created in July 1985 until October 1991

[123] DHSS. *'Care in Action – A Handbook of Policies and Priorities for the Health and Personal Social Service in England'* (1981), London: HMSO; WIT 0074 0081 – 0140

[124] WIT 0074 0004 Dr Baker

[125] WIT 0074 0004 Dr Baker

[126] WIT 0074 0010 Dr Baker

[127] WIT 0074 0010, 0424 Dr Baker

112 There were also two free-standing committees that reported directly to the DHA. They had no executive functions, but discussed and developed policies independently to be presented to the DHA meetings. These were the Finance Committee and the Policy, Planning and Resource Committee.

113 Two further committees were added in 1985: the Performance Assessment Committee[128] and the Research and Education Committee. In 1986 the Finance Committee was expanded to become the Finance, Property and Computing Committee.

114 The basic structure of the DHA otherwise remained unchanged until the start of the transitional period to the separation of the purchaser and provider functions in mid-1989, and the creation of the B&DHA in October 1991.

Transition of the Bristol & Weston District Health Authority (B&WDHA) into the Bristol & District Health Authority (B&DHA)

115 In 1989 the Government White Paper *'Working for Patients'* was published.[129] This proposed the creation of an internal market in the NHS through the separation of purchaser and provider responsibilities. It recommended the establishment of self-governing NHS trusts and GP fundholders, with funding being allocated to the purchasers (DHAs and fundholders) rather than to the providers. The philosophy behind these changes was that the internal market would arise due to funding following the patient, rather than being granted as a fixed budget from the health authority. In addition, management arrangements were altered at local level, re-organising health authorities along business lines.

116 Dr Baker explained:

> 'In 1990 the SWRHA issued Planning and Review Principles for 1991 onwards[130] and guidelines[131] to accompany the separation of the purchaser and provider functions within the NHS. This change meant that B&WHA was required to plan for the needs of its own population and commission services to meet these needs within its own resource allocation.'[132]

117 From mid-1989 the DGM and the Board of the B&WDHA produced and reviewed the proposals for the changes in the management structure. Two new committees were set up and remained in existence between 1989 and 1991, the Purchaser Committee and the Bristol Provider Committee, which dealt with the planning of both halves of the split. The proposals for the split were submitted to the RGM of the SWRHA at the end of August 1990.[133] The relevant legislation took effect on 1 April 1991, at which point

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[128] For details of the functions of the Performance Assessment Committee, see Chapter 18

[129] Department of Health. '*Working for Patients*' (1989) (Cm 555)

[130] HAA 0066 0003; minutes of the SWRHA RGM/General Managers meeting on 7 March 1990

[131] WIT 0074 0385 Dr Baker

[132] WIT 0074 0005 Dr Baker

[133] HAA 0047 0020 – 0022; letter from Dr Roylance to Miss Hawkins dated 31 August 1990

the UBHT officially came into existence. The new Chief Executive of the UBHT[134] had been appointed in December 1990 in anticipation of the changes that were to take place. The B&WDHA continued in existence until 1 October 1991, when it officially became the B&DHA. However, by this time all its pre-existing provider functions had been delegated to the UBHT and it was left with its residual purchaser-based roles and responsibilities.

118 In 1990 the executive managers were also divided into those in the District purchaser unit and those in the provider unit. The post of District Medical Officer/Assistant District General Manager (Information) became the Director of Public Health Medicine,[135] and was linked to the purchaser unit. The main responsibilities became those of strategic planning and advice for the commissioning of services for, amongst others, cardiac services.[136]

119 The purchaser unit also had a Director of Health Development and Appraisals, as well as a Director of Finance and a Director of Quality and Monitoring.[137] The Director of Finance, Mr Anthony Parr, initially led the purchaser unit. Mr Parr left the District in early 1991, when the Director of Public Health Medicine became Acting District General Manager until October 1991, and the District was merged with the other DHA to form the B&DHA.[138]

120 The management structure in the DHA from April 1991 no longer had a need for the units and sub units that had existed previously. The DGM[139] now had six main officers reporting to him. Two of these centred on finance, one being the District Treasurer and the other being the Director of Contracting. In addition, there was the Consultant in Public Health Medicine,[140] the Consultant in Communicable Disease Control, the Policy and Planning Analyst and the Senior Planning Officer.

121 The B&DHA also retained a committee advisory structure and had a number of committees that advised on matters within their own particular areas of expertise. These were the Health Policy Committee, the Health Information Committee, the Finance and Contracting Committee, and the External Relations and Personnel Committee.

122 The B&DHA came to an end when it formally merged with the Avon FHSA on 1 April 1996, to become the Avon Health Authority (Avon HA). This was a result of legislation[141] to effect the merger of all the DHAs and FHSAs. The same legislation also abolished the SWRHA. In its place was created the South and West Regional Office of the NHSE.

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[134] Dr Roylance

[135] Dr Baker continued in this post throughout the period of the Inquiry's Terms of Reference

[136] WIT 0074 0005 Dr Baker

[137] The titles of offices changed as the purchaser unit evolved – HAA 0047 0020; cf. HAA 0144 0027

[138] WIT 0074 0011 Dr Baker

[139] Dr Baker was Acting DGM until 1 October 1991

[140] Dr Baker's permanent role

[141] The Health Authorities Act 1995

123 In effect, the Avon HA inherited the planning, purchasing and commissioning role of the B&DHA (which in turn had formerly been enjoyed by the B&WDHA) and the Avon FHSA. The South and West Regional Office of the NHSE inherited some of the functions and responsibilities of the SWRHA. The provider functions that had devolved to the trusts in April 1991 remained vested in the UBHT.

124 From its creation in October 1991 the B&DHA continued with a strategic planning function and set up a planning group, 'the Strategic Cell', to develop a framework which was responsive to national and regional requirements, and assessments of local needs and local service responses. Dr Baker led this group and it was within this framework that the purchasing function of commissioning and contracting for individual services took place.[142] Dr Baker told the Inquiry:

> 'I used a planning and advisory network of clinicians, GPs, Clinical and Associate Directors, General Managers and others in NHS Trusts, Local Authorities, and the University with which I worked ... A similar network covered my support function to the commissioning managers of the Health Authority in developing specifications and, negotiating annually, service contracts.'[143]

Provider functions taken on by the UBHT

125 The transition to the purchaser-provider split involved two years of preparation before the establishment of trust status, and in this time there were a number of further management changes. Twelve clinical directorates were created, each managed by a clinical director, who was a consultant, and a general manager. Dr Roylance explained that the larger directorates were further split into associate directorates, with associate clinical directors and associate general managers.[144] He told the Inquiry:

> 'The aim was for the Clinical Director to be "in charge of" the doctors and for the General Manager to be responsible for everyone else, and to ensure that the necessary administration and support services were in place for the directorate to run efficiently. In the discussions which took place before this change it was agreed that the most appropriate way forward would be to view the Clinical Director and General Manager as being in a managerial "bubble", jointly sharing the managerial responsibilities; thus, neither was directly responsible to or for the other. These two were assisted in their management roles by the chief nurse of the unit, a directorate personnel officer and a senior member of the Finance Department.
>
> 'The only other level in the management was that at operational level with ward sisters or their equivalents taking full responsibility for wards or their Units.'[145]

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[142] WIT 0074 0005 Dr Baker

[143] WIT 0074 0005 Dr Baker

[144] WIT 0108 0006 Dr Roylance

[145] WIT 0108 0006 – 0007 Dr Roylance

126 Dr Roylance explained the transition period further in his oral evidence:

> ' … before we had completed the introduction of General Management, it was decided to add to it the purchaser/provider split, and by 1989 we were beginning to introduce shadow contracts or work agreements, service agreements, and we were endeavouring to flex the management in a way that responded to that new requirement. It was also a way of endeavouring for the first time to bring the consultant body within the general management function, so it was partly the continued evolution of General Management, I think it is fair to say precipitated by the new thinking of purchaser/provider split.'[146]

127 It was the responsibility of the DGM in 1991 to divide the District into a continuing DHA purchasing authority, and into trust provider units for the Bristol and Weston parts of the District.[147]

128 Originally, it was the intention that the general manager would support and be directly accountable to the clinical director,[148] but this view changed and they were both enclosed in what Dr Roylance described as a 'managerial bubble',[149] running the directorate in a joint capacity.

129 Eventually it was clear that their roles were that the clinical director took the final responsibility for policy within the directorate and the general manager took responsibility for effectively implementing management policy. So the 'managerial bubble' evolved with the clinical director reporting to the DGM pre-trust status, and the chief executive afterwards, and the general manager of the directorate reporting to the clinical director. This happened over a broad period of time, according to Dr Roylance, some time between 1990 and the time he retired in 1995, with each directorate evolving at a different rate.[150]

130 The new management arrangements were such that clinical directors led the services and held the budgets. The clinical directors negotiated, signed and implemented contracts for services from the purchaser authorities, and were responsible for turning these contracts into the policies and programmes for their directorate. The general managers supported the clinical directors in the implementation of these programmes, and were accountable to, and supported by, the Central Unit's Director of Operations.[151] The general managers provided the whole of the management function in implementing these contracts and managing the budgets. After the introduction of trust status, the general managers and clinical directors were accountable individually to the chief executive and, ultimately, to the Trust Board.[152]

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[146] T24 p. 45 Dr Roylance

[147] WIT 0108 0005 Dr Roylance

[148] HAA 0047 0021; letter from Dr Roylance to Miss Hawkins dated 31 August 1990

[149] The 'managerial bubble' is discussed in detail in Chapter 8

[150] T24 p. 57 Dr Roylance

[151] Mrs Margaret Maisey

[152] WIT 0170 0004 Ms Orchard

131 Dr Roylance explained that initially the Director of Operations met on a monthly basis with the general managers to give them managerial support in the evolution of their roles.[153] The clinical directors reported to monthly meetings of what became the UBHT's Management Board, which after a few months became chaired by the Chief Executive[154] of the Trust.[155]

132 Dr Baker explained that, in the Central Unit, the Clinical Director for Children's Services was Dr Joffe and the Clinical Director for Surgery was Mr Roger Baird, whose directorate contained the Associate Directorate of Cardiothoracic Surgery headed by Mr Wisheart.[156]

133 This arrangement continued after the changes of 1991 and the purchaser-provider split, and the above people continued in their posts.

134 The changes led to an alteration in the management role of the medical staff. From 1985 onwards, medical staff had been involved in the management of services through the clinical divisions structure. From 1990 medical staff who became clinical directors or associate clinical directors were in a position to negotiate changes in services through planning or contracting. General managers working alongside clinical directors and associate clinical directors had a supportive role and had influence in particular on non-medical staff within services.[157] Dr Baker told the Inquiry:

> 'This system of management was conceived to give doctors lead responsibilities with back-up from those with general management experience and skills. This system was reflected at all levels in the District (and later UBHT). The system was headed by a District General Manager and later UBHT Chief Executive John Roylance, who was himself a doctor.'[158]

135 The clinical directorate structure adopted before the formal purchaser-provider split continued in place within the UBHT, with each directorate being led by its own clinical director. Some of the larger directorates contained a number of smaller associate directorates, each with their own associate director. The Directorate of Surgery[159] contained the Associate Directorate of Cardiothoracic Surgery,[160] covering both adult and paediatric cardiac surgery at the BRI and the BRHSC.

136 The system of clinical divisions was retained after the purchaser-provider split, although not all of the specialty groups retained them in full or in some cases at all,

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[153] T24 p. 59–60 Dr Roylance

[154] Dr Roylance became the first Chief Executive of the UBHT, officially from 1 April 1991

[155] T24 p. 61 Dr Roylance

[156] WIT 0074 0010 Dr Baker

[157] WIT 0074 0011 Dr Baker

[158] WIT 0074 0011 Dr Baker

[159] Mr Baird was Clinical Director for Surgery until November 1993, when Mr Patrick Smith succeeded him. See UBHT 0081 0131

[160] Mr Wisheart was Associate Clinical Director for Cardiac Surgery until 1992, and was succeeded in this post by Mr Dhasmana, who held it until 1995

and their functions were altered. The clinical directorates were made responsible for organising the services which the specialty provided and for the contract-making process, but, as Dr Trevor Thomas, consultant anaesthetist, explained:

> '… it was perceived that that was only part of the activity and responsibility of specialty groups, and that there was a continuing need for, if I may call it a professional network which addressed problems of education, interfacing with Royal Colleges, and the like.
>
> 'So, for some time, and indeed, in some instances there is still a divisional system within some specialties. Some specialties, I know, felt that that was inappropriate and did away with their divisional structure very early on…'[161]

137 Thus, Dr Thomas told the Inquiry that the divisional structure continued in existence in certain specialties after the purchaser-provider split and was still in place in 1995.[162]

Targets

138 Targets, typically financial or clinical, were set for the services by the RHAs and imposed on the hospitals through the DHAs. The B&WDHA was subject to targets set by the SWRHA and was constrained by the policies of the RHA in what it could or could not do.

139 Dr Pitman explained that the Region held the budget for any significant development of a major Region-wide service, and the District would not embark on such a development without specific support from the Region. There would have to be discussions with the Regional Finance Officer on cost and expected levels of service.[163] She said:

> 'It would have been a regional team of officers, the Regional Finance Officer and probably the RMO and others who were involved, like the Service Planning Officer, who decided at what level they should be encouraging the District, and Districts at that time were encouraging their units to hit those targets or guidelines.'[164]

140 If the targets set for operations were not met, the Region was involved further. It addressed the matter in reviews to discuss ways in which the targets were to be met in future.

141 Policy flowed down from the DHSS to Region to District to the hospitals that provided the service. For example, in 1984 there was a view at Ministerial level that it would benefit patients to be treated locally and not travel across regional boundaries, and

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[161] T62 p. 75–6 Dr Thomas
[162] T62 p. 76 Dr Thomas
[163] T58 p. 29 Dr Pitman
[164] T58 p. 30 Dr Pitman

also that a greater case throughput led to more experience which in turn led to greater expertise and therefore better outcomes. It was at the April 1984 meeting between the SWRHA and the DoH, that a desire to increase the cardiac surgery caseload, for both adult and paediatric cases, to 600 per annum at the BRI was expressed on behalf of the Minister.[165]

The relationship between district health authorities and the UBH and UBHT

142 Prior to the separation of the purchaser and provider functions in the period up to 1991, the B&WDHA imposed obligations by way of resource allocation mechanisms, planning processes and contracts of employment. In the two years prior to the creation of trusts, the necessary changes to systems and structures that were being implemented in shadow form included the development of contracts as part of an ongoing process. These were not legally binding contracts, but took the form of service agreements which were created and refined 'so that by the time the Trust was created there was considerable experience and expertise in the development of continuation budgets'.[166] The changes in management had also been introduced in advance, 'so that when the Trust was created there was a very smooth transition with no immediate impact on the provision of healthcare'.[167]

143 In areas other than those funded as a supra regional service, the obligations between any of the DHA purchaser units (such as the B&DHA) and the NHS trust provider units (such as the UBHT) after the purchaser-provider split were imposed by the contract system of service provision. According to Pamela Charlwood, Chief Executive of Avon HA from October 1994[168] and Regional General Manager of SWRHA from 1993 to 1994, in initially drafting these contracts, the B&WDHA took advice from three main sources:[169]

- The DoH issued a paper in 1990 which gave initial advice on formulating service specifications, which included reference to quality requirements.
- The NHS Management Executive (NHSME) issued a paper, *'Contracts for Health Services: Operating Contracts',* in February 1990.[170]
- The SWRHA set up a Service Contracts Working Party, which presented to the DHAs a report on service contracts, and which mentioned the need to assess outcomes of treatment.[171]

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[165] UBHT 0102 0434; minutes of meeting April 1984 and T56 p. 32 Miss Hawkins

[166] WIT 0108 0016 Dr Roylance

[167] WIT 0108 0016 Dr Roylance

[168] Then Avon Health Commission – the shadow form of Avon HA

[169] WIT 0038 0027 Ms Charlwood

[170] Executive Letter EL(90)MB24 *'Contracts for Health Services: Operating Contracts'*

[171] HAA 0037 0021; report of the service contracts working party of the South Western Regional Public Health Medicine Sub-Committee dated 4 January 1989

The SWRHA also produced draft contracts for use by the districts.

144 In preparing these contracts, which included those to be used for the provision of cardiac surgical services, B&WDHA received input from its Purchaser Committee, which later divided to create the specialised Contracts, Quality and Monitoring Sub-Committee.

145 The B&WDHA produced the form of contract for cardiac surgery,[172] for use as the service agreement between the purchaser authority and the provider department.[173] This contract included quality criteria and targets in terms of referral rates for different classes of patient and for different procedures, and aimed to provide feedback to the District. It provided for systems of quality assurance to be put in place to 'include elements of quality control, identification of service deficiencies, and mechanisms for correcting and reviewing problems'.[174] Specific sections dealt with the process of medical audit, to include audit of outcome, the medical process and the management process. Separate sections detailed nursing audit and audit of support services, together with monitoring provisions and obligations to report back to the DHA.[175]

146 The contract provided that:

> '15.1 The audit will include audit of outcome, the medical process and the management process. In addition to the statements in this document, the Cardiac Surgery Unit will set up an audit group to meet regularly and to provide the Bristol & Weston Health Authority with sufficient information for it to ensure that adequate audit is taking place.
>
> '15.2 The audit of outcome will include measures of 30 day mortality, one year mortality and one year symptomatic state. Symptom relief assessments to be agreed with the referring cardiologists.
>
> '15.3 The audit of process will include days spent in intensive care, days on a ventilator, units of blood and oxygen used.
>
> '15.4 Audit information will be made available to the Director of Public Health Medicine as the Purchaser's representative. ...'[176]

147 The responsibility for the purchaser-provider contracts passed to the B&DHA in 1991, specifically to the Director of Contracting[177] and the Finance and Contracting Committee. Further service specifications were produced as was a quality/monitoring manual.

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[172] For application to cardiac services other than those designated as supra regional, i.e. for adults and children over 1 year of age

[173] HAA 0011 0245 – 0252; service agreement dated 14 March 1991

[174] HAA 0011 0248; service agreement dated 14 March 1991

[175] For details of the audit provisions of these contracts, see Chapter 18

[176] HAA 0011 0249; service agreement dated 14 March 1991

[177] Ms Deborah Evans was Associate Director, latterly Director, of Contracting for B&WDHA from April 1991, and Director of Contracting for B&DHA from October 1991

148 The reviewing and updating of contracting requirements was an ongoing process during the life of the B&DHA. This included feedback to the Finance and Contracting Committee from the provider units and purchaser-driven reviews of services, which in turn fed back into B&DHA's future purchasing intentions.[178]

149 In January 1992 UBHT and B&DHA had a contract-negotiating meeting to assess contract requirements against performance.[179] A paper was tabled, listing topics for outcomes to be monitored and reported in 1993/94.

150 From May 1992 a report on contract monitoring was given to each board meeting of the B&DHA, where actual activity levels provided would be measured against the contracted activity levels purchased. Any shortfalls would then be reviewed with the SWRHA and addressed with the provider units.[180]

151 The situation by 1995 is summarised by Ms Charlwood:

> '... By 1995 the NHS Management Executive had moved from a policy which required contracts to be monitored for activity, to an approach which required contracts to be monitored for outcomes. In May 1995 the NHSME commended *"Clinical Involvement in Contracting, A Handbook of Good Practice"*.[181] This included checklists, one item of which asked purchasers whether contracting had been informed by clinical audit, and whether that could be demonstrated. It also included a reminder[182] ... that EL(94)20 on clinical audit in 1994/95 and beyond outlined a number of approaches to developing contracts for audit, "but whatever approach is taken it is clear that clinicians have the leading role in developing audit proposals and ensuring that the outcomes of clinical audit are used to inform future contracts". Providers[183] ... should "ensure that there is a shift from the activity and financial focus of existing contracting so that the contracting process is increasingly informed by the clinical audit process; covering issues around good practice, clinical effectiveness and quality of service delivery". Authorities needed to demonstrate that clinical audit had informed the contracting process.'[184]

Staffing and contracts of employment

152 The Personnel/Human Resources Department of B&WDHA[185] was responsible for producing and reviewing job descriptions and the criteria for appointments, as well as for training regimes and patterns of deployment.[186]

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[178] WIT 0038 0029 Ms Charlwood

[179] WIT 0038 0029 Ms Charlwood; HAA 0003 0021

[180] WIT 0038 0029 Ms Charlwood

[181] See HAA 0163 0155; *'Clinical Involvement in Contracting, A Handbook of Good Practice'*

[182] See HAA 0163 0166; *'Clinical Involvement in Contracting, A Handbook of Good Practice'*

[183] See HAA 0163 0171; *'Clinical Involvement in Contracting, A Handbook of Good Practice'*

[184] WIT 0038 0030 Ms Charlwood

[185] Mr Ian Stone was District Personnel Manager 1982–1985, then District Manpower Manager 1986–1991; from 1 April 1991 he became Director of Personnel at UBHT

[186] WIT 0074 0012 Dr Baker

153 Increases in staffing took place in response to the planning requirements of the SWRHA/B&WDHA Project Team and on the basis of advice from the existing medical staff of the District. For the DHA, advice on medical staffing for planning purposes came from the DMO, Dr Baker.

154 Clinicians would raise the need to replace an outgoing consultant or for the appointment of additional staff via the clinical groups and advisory committees. A job description would then be prepared with advice from the relevant Royal College, incorporating contractual requirements as laid down by the DoH. They would then be submitted to the DHA, which would approve the appointments through its Annual Programme processes.[187] The standard of a candidate would be ascertained by examining their qualifications, then a shortlist would be produced of those who were to be interviewed. Formal appointments advisory committees, which included clinical representatives and representation by the relevant Royal College, conducted the interviews.

155 Control of the number of medical staff posts overall was exercised by the DHSS/DoH via the RHAs. Approval for new and replacement posts had to be sought from the regional manpower committees.[188]

156 The Regional Manpower Committee was an advisory committee of the SWRHA. The RMO advised the Regional Manpower Committee on national and regional medical manpower planning requirements. The Committee had to pre-approve any appointments, bearing in mind DHSS/DoH manpower planning requirements, before forwarding the prospective appointment to the Central Committee of the DHSS for its approval.[189]

157 Criteria and procedures for appointments of consultants were laid down by HC(82)10[190] and HC(90)19.[191] These Health Circulars advised on the composition and procedures of the Advisory Appointments Committee, which made recommendations to the DHAs for the appointment of consultant staff. Dr Baker explained that the DHA could accept or reject these recommendations, but they were usually accepted.[192]

158 As B&WDHA was a teaching district, it recruited consultant medical staff and held their contracts of employment. In non-teaching districts, the SWRHA held the contracts of employment. The role of the DHA therefore embraced ensuring competent staff were recruited and that there was sufficient provision within the contract of employment to maintain the standard of service, for example by training and study leave requirements.

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[187] WIT 0038 0025 Ms Charlwood

[188] WIT 0074 0012 Dr Baker; T36 p. 42; T30 p. 47–9

[189] WIT 0074 0013 Dr Baker

[190] HAA 0164 0375 – 0384; Health Circular HC(82)10

[191] HAA 0164 0385 – 0387; Health Circular HC(90)19

[192] WIT 0074 0012 Dr Baker

159 With regard to who held the contracts of the consultants at the hospitals, Miss Hawkins explained that the RHA would not be able to suspend a consultant directly:

> 'We held the contracts for all consultants except those in the Teaching Authority. They [the Teaching Authority] held theirs, so that was why we would have to have had the dialogue with the Chairman, the Vice-Chairman, even the DHA itself with the RHA to tell them of the problems, to involve them and to get them to suspend operations.'[193]

160 Senior registrars were employed by the SWRHA. Responsibility for their appointment lay with the Regional Committee in Specialist Training (RCST), which applied the criteria and procedures set out in HC(82)10.[194] The RCST was also an advisory committee of the SWRHA, reporting through, and accountable to, the RMO and his staff. The Medical Post-Graduate Dean was appointed to the RCST jointly by the SWRHA and the University, in order to take account of the national and regional policy for medical education and training. Dr Baker explained that the RCST was supported by a number of specialty sub-committees; for example, the Sub-Committee for Medical Specialties covered training in cardiology and the Sub-Committee for Surgery covered training in cardiac surgery.[195]

161 Dr Baker explained that responsibility for the appointment of registrars lay with the DHA between 1984 and April 1989. Thereafter it was transferred to the SWRHA and the RCST, following advice from the DoH.[196] Senior house officer (SHO) posts were subject to a nationally-imposed ceiling and their numbers were regulated by the RCST. This ceiling was lifted by 1995, and SHO posts became the responsibility of the Regional Task Force on Junior Doctors' Hours, chaired by the RMO and advised by the Post-Graduate Dean.[197]

162 The Advisory Appointments Committee assessed the experience of consultants at the time of appointment. Once they were appointed, their training was self-regulating. They were entitled to 30 days' study leave over a three-year period, with expenses paid from a budget held by the DHA. In addition, sabbatical leave could be taken. This was unpaid, although grants were available from various awarding bodies and other sources.[198]

163 Although as a teaching authority the DHA drew up and held the contracts for the consultants, it did not scrutinise the continuing training or study of the consultants employed. Ms Charlwood told the Inquiry:

> 'A standard form of consultant's contract allowed study leave. Job programmes identified time for research and audit, when the latter became an expectation.

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[193] T56 p. 120 Miss Hawkins

[194] HAA 0164 0375 – 0384; Health Circular HC(82)10

[195] WIT 0074 0013 Dr Baker

[196] HAA 0164 0393; Executive Letter EL(89)P88

[197] WIT 0074 0014 Dr Baker

[198] WIT 0074 0014 Dr Baker

The [District] Health Authority supported professional self-regulation and development through funding and overall regulation of study and professional leave allocations. Since training and retraining was an individual professional responsibility guided by professional bodies, no Health Authority system supervised training/study or the resulting competencies of individuals.

'After recruitment, the maintaining and monitoring of standards and competence at B&WDHA level was by exception only, in terms of reports of inappropriate professional conduct. The work performance of consultants was largely self-regulated, with oversight by Directors of Clinical Divisions and operational managers. Infrequently, problems, usually about untoward behaviour or attendance, were referred to the District Medical Officer and/or the clinical representatives on the Health Authority.'[199]

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[199] WIT 0038 0025 Ms Charlwood

Chapter 6 – Funding and Resources

Introduction

1 The Inquiry received evidence on the way in which paediatric cardiac services were funded in Bristol.

2 The first section of this chapter describes the policies and systems relating to the distribution of funds for healthcare which were in place nationally and regionally, during the period 1984–1995.

3 The second section sets out the way in which monies were distributed and managed within the Bristol hospitals.

4 The third section deals with the funding of paediatric cardiac surgical services in Bristol. It deals first with the contracting process for the over-1s (from 1991 onwards), and then the allocation of funds as a supra regional service for the under-1s, from 1984–1994.

5 The final section of this chapter draws together material received by the Inquiry that showed the impact of resources on clinicians, patients, or parents during the years 1984–1995.

Funding at a national level

6 The account in this section draws, in particular, on a paper commissioned by the Inquiry from Mr Gwyn Bevan[1] entitled, *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*,[2] the Budget Books of the Bristol and Weston District Health Authority (B&WDHA) 1984–1991, the Budget Books of the United Bristol Hospitals NHS Trust (UBHT) 1991–1995, and statements and documents provided to the Inquiry by Mr Graham Nix, Director of Finance and Deputy Chief Executive of UBHT.

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[1] Reader in Policy Analysis, Department of Operational Research, London School of Economics

[2] INQ 0047 0001; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*. See Annex B

The allocation of resources to the Regional Health Authority

The Resource Allocation Working Party (RAWP)

7 From 1977, the allocation of resources to health authorities for hospital and community health services has been based upon methods recommended by the 1976 '*Report of the Resource Allocation Working Party'* (RAWP). The report introduced:

- setting health authority *targets* for revenue based upon the relative estimated needs of their populations;
- setting health authority *targets* for capital, based on the estimated relative needs of their populations, and estimates of the value of capital stock;
- setting the *pace of change* in reconciling health authority allocations to targets, subject to ceilings and floors on gains and losses;
- estimating the *service increment for teaching* (SIFT[3]) rates per student for undergraduates studying medicine and dentistry;
- making extra allowances for higher costs of employment in areas such as London (London Weighting).[4]

The overriding principle of RAWP was to provide an equitable pattern of resource allocation that would lead to equality of access to healthcare throughout the country.[5]

The distribution of healthcare funds to the regional health authorities

8 Revenue allocations to health authorities began with funds that were 'top-sliced' from the general budget, and earmarked for particular projects or costs. The most important of these, for the purposes of the Inquiry, were the funds for supra regional services (from the 1984/85 financial year) and the SIFT funds, for costs associated with the training of undergraduates in medicine and dentistry. The remaining sums formed the main allocation available for health authorities. The RAWP methodology was then used to calculate the allocations of sums by way of revenue and capital to each of the regional authorities.

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[3] Later, service increment for teaching and research

[4] Various changes were made to the RAWP methodology over the period of the Inquiry's Terms of Reference. These are summarised by Mr Bevan at INQ 0047 0012 – 0013; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*. See Annex B

[5] UBHT 0339 0058; B&WHA Budget 1984/85 – Distribution by Formula to Regions

'Top-sliced' funding

9 Further details of the allocation of 'top-sliced' funds in respect of the costs of training clinical undergraduate students, and the difficulties in estimating the true size of such costs, can be found in the paper from Mr Bevan.[6] The purpose of top-slicing funding for certain specialised, supra regional services was to protect and develop such services by funding agreed volumes at agreed costs.[7] Such protected funding was introduced for neonatal and infant cardiac surgery (NICS) for the first time in the financial year 1985/86,[8] and removed with effect from the financial year 1994/95, after this service was 'de-designated'. From the 1994/95 financial year, the funding of NICS changed, with costs being apportioned between regions on the basis of past usage measured by inpatient days.[9]

10 Mr Bevan wrote:

> 'This policy of funding supra-regional services at actual costs developed outside national policies on resource allocation and was justified by objectives other than seeking an equitable distribution of resources. For Neonatal and Infant Cardiac Surgery, these are indicated by a paper prepared by the Department, which explained the advantages of concentration in a few centres to achieve high standards of diagnosis and treatment: as established centres had lower than average mortality.'[10]

Revenue allocation

11 Mr Bevan wrote:

> 'For each RHA the Department derived *target* allocations for revenue: its estimated fair share of the total for England. This was based upon its *catchment* population: the numbers and estimated relative needs of its resident population, with adjustments for cross-boundary flows. … [11]
>
> 'The Department's policy was, over time, to move each RHA's main revenue allocation towards its target, at a manageable pace of change (to avoid extra resources being squandered, and disruption to services from having to make reductions too quickly). "Ceilings" and "floors" were set on rates of change in allocations to each RHA dependent on the growth monies available each year. RHAs were ranked according to how their actual allocations compared with their

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[6] INQ 0047 0029 – 0030; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*. See Annex B

[7] See the recommendations of the SRSAG October 1983; WIT 0482 0345 – 0362 Dr Moore

[8] NICS having been designated as a supra regional service during 1984/85

[9] INQ 0047 0024; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*. See Annex B

[10] INQ 0047 0031. Criticisms of the system, from the perspective of the policy aim of achieving equitable rates of access and use, are to be found at INQ 0047 0035; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*. See Annex B

[11] Further details of the process whereby targets were derived, and the changes or adjustments made over the period of the Inquiry's Terms of Reference can be found at INQ 0047 0024 – 0027; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'* (emphasis in original). See Annex B

targets. There was an important distinction between "above-target" RHAs and "below-target" RHAs (with revenue spend higher and lower than their targets). The Department's policy was broadly one of "levelling up": to direct growth money at "below-target" RHAs, which meant that "above-target" RHAs received little or no growth money. For a "below-target" RHA, the greater the distance of its allocation from its target, the greater would be the share of "growth" money allocated to that RHA.

'The introduction of the "internal market" from 1991 changed the structure of the capitation formulae for revenue allocations so that these applied to *resident* (not *catchment*) populations …'[12]

12 Between 1978 and 1985 the South Western RHA (SWRHA) was consistently below 'target' and therefore received slightly more growth money than the national average.[13] The allocations to the SWRHA are discussed further at para 16.

13 Throughout the period of the Inquiry's Terms of Reference, resource allocation was subject to financial constraints. One such constraint was the need to fund 'real' growth from 'efficiency savings'. Such 'efficiency savings', announced by the Secretary of State in December 1982, were set at 0.5% of actual allocations. In 1984/85, this approach was replaced by a requirement to submit to the Department of Health a programme of 'cost improvements' of 2% of the allocation. Health authorities were allowed to retain any savings which were generated, unlike the previous reductions for 'efficiency savings' that had been redistributed nationally and regionally using the RAWP equalisation principles.[14]

Capital allocations and capital charges

14 SWRHA's capital allocations varied from between 6% and 8% of the total capital allocations for all RHAs, and from between 6% to 8% of its main revenue allocation.[15]

15 The methodology of capital allocation by the DoH to the regions is discussed by Mr Bevan at paragraphs 56–61 of his paper.[16] Between 1983/84 and 1990/91, capital was allocated on the basis of three criteria: the population target share; a capital stock equalisation element; and 'ceilings' and 'floors' on rates of change. The aim was to achieve an equitable distribution of capital throughout the regions.[17] The methods available to the NHS to assess the need for capital were, however, inadequate or

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[12] INQ 0047 0015; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'* (emphasis in original). See Annex B

[13] UBHT 0339 0058; after taking into account the further growth monies of 1.6% (£8.8million) which were provided for 1984/85, the South Western Region remained 4.4% below target

[14] UBHT 0339 0043

[15] INQ 0047 0050; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*

[16] INQ 0047 0027 – 0029; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*

[17] INQ 0047 0033; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*

crude.[18] After 1990/91 and with the introduction of the 'internal market', a system of capital charging was introduced: this is discussed further at para 54 below.

The pattern of funding in England

16 Mr Bevan advised the Inquiry:

> 'To estimate changes over time, it is essential to remove the effect of inflation and estimate expenditure in "real" terms (i.e. constant prices). There are two price indices that are used to do this: one is based on changes in pay and prices in the general economy (the GDP deflator), the other on pay and prices of staff and consumables in the NHS (the HCHS[19] deflator). There is a general tendency for pay to increase faster than general inflation, and most of HCHS expenditure is on pay.
>
> 'Figure 1 shows changes in the allocations of HCHS resources for England in "real" terms over the period 1982 to 1995. The sources of these data are official publications by the Department.[20] Thus Figure 1 shows that, using the GDP deflator, there were increases in NHS expenditure each year over this period, and in contrast, using the HCHS deflator, shows that expenditure to have been at a standstill between 1984 and 1988. After the publication of '*Working for Patients*'[21] in 1989, Figure 1 shows substantial increases in 'real' terms in the total HCHS allocated to the NHS. Hence the resource position was transformed in terms of spend on the NHS.[22],[23]

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[18] INQ 0047 0044 – 0045 (paragraphs 103–5)

[19] Hospital and Community Health Services

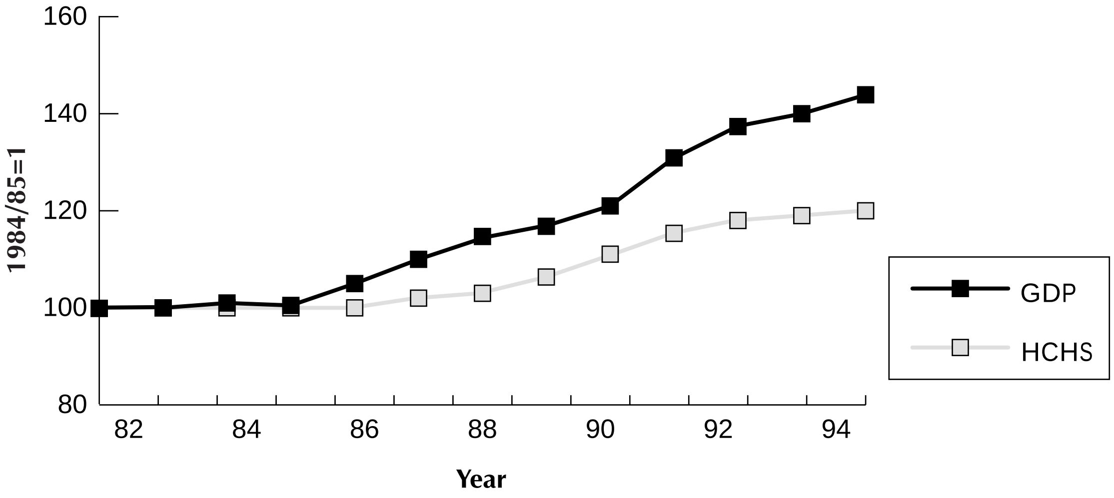
[20] The footnote by Mr Bevan continues: 'Source: Technical Appendix, Table 1, columns 1 and 2. These data give a good indication of the changing resources available for HCHS in England as they are largely unaffected by the change in the funding of RHAs (from catchment to resident populations) and largely exclude capital charges introduced following the NHS reforms.' INQ 0047 0046; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*. See Annex B

[21] *'Working for Patients',* January 1989, Department of Health

[22] The footnote by Mr Bevan continues: 'But these extra resources were also required to help launch the NHS internal market with its various transaction costs: for example, of contracting, invoicing, price determination.' INQ 0047 0046; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*. See Annex B

[23] INQ 0047 0046; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*. See Annex B

Figure 1: Real spend HCHS England



NB Figures 1 and 3 on pages 234 and 235 are reproduced from *'National & Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*. See Annex B. Figure 2 is not referred to in this chapter

Allocations to the South Western Regional Health Authority

17 The South Western RHA was an RHA that was 'below-target'. Between 1979/80 and 1988/89, the Region moved from having an allocation that was about 96% of its target to one of about 98.5% of its target. Whilst there are complications in measuring its position in 1990/91,[24] thereafter the Region remained just a little below 100% of its target allocation. Mr Bevan wrote:

> 'Although South Western RHA benefited in terms of higher-than-average revenue allocations, before 1988–89, this was within a stringent regime of little or no "real" growth in the total. Figure 3 shows a bleak picture for 1984–85 to 1988–89 of limited growth in its main allocation followed by reductions so that, in "real" terms, the allocation for 1988-89 was marginally lower than for 1984–85. After that there was "real" growth each year.'[25]

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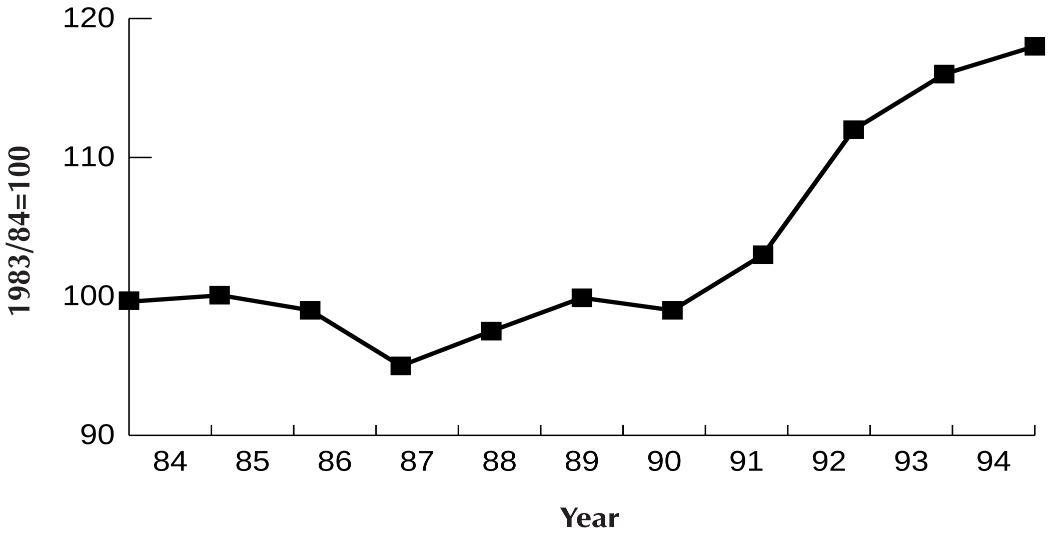
[24] INQ 0047 0047 – 0049 and table at INQ 0047 0050; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*. See Annex B

[25] INQ 0047 0049; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*. See Annex B

Figure 3: Changes in SWRHA's revenue allocation



NB Figures 1 and 3 on pages 234 and 235 are reproduced from *'National & Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*. See Annex B. Figure 2 is not referred to in this chapter

The distribution of funds by the Region to district health authorities

18 Bill Healing[26] explained in his written evidence to the Inquiry the process of allocation from the RHA to the district health authorities (DHAs) in general terms. He explained that:

> 'The basis of funding to District Health Authorities is calculated as follows:-
>
> 'a) recurring Allocation from the previous year;
>
> 'b) +/- any technical adjustments to reflect changes in responsibility;
>
> 'c) + inflation (as determined by the Government);
>
> 'd) + growth (depending on whether an Authority is over/under-funded compared to a national formula);
>
> 'e) + any special or non-recurring allocations.'[27]

The supra regional and regional services: 1984–1990

19 The 'top-slicing' of funding for neonatal and infant cardiac services, from 1985/86 onwards, imposed an obligation on the RHA to pass the centrally earmarked sums to the DHA. The sums allotted by the Supra Regional Services Advisory Group (SRSAG) to neonatal and infant cardiac services in Bristol are set out in the Table 7, at para 83.

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[26] Finance Director, Avon Health Authority, formerly Finance Director of the B&WDHA

[27] WIT 0092 0004 Mr Healing

20 In addition, the Region identified a number of regional specialties. These included cardiac surgery. Regional policy, in 1984/85, was to fund initial developments in such specialties for three years on a non-recurrent basis. After that they were to be financed by the districts, in proportion to the use made of the services by the population of each district. However, in practice there was continuing pressure to expand cardiac services at the BRI, since the level of provision of cardiac services was significantly below both national targets and provision in many other regions. As a result, Mr Bevan suggested that in practice '… regional protection of cardiac services at the BRI was not limited to the three years as stated as the regional policy.'[28] Further details of regional funding for expansion for cardiac services are to be found at Table 1, para 28 below.

21 The income derived from carrying out neonatal and infant cardiac surgery might be said to have formed a small part of the District's income. Mr Bevan wrote:

> 'The funding of supra-regional services accounted for 0.2% of total revenue funding of Bristol and Weston DHA in 1984–85. The introduction of funding for Neonatal and Infant Cardiac surgery in 1985–86 increased this to 1.2%, and thus presumably, offset the fall in funding in "real" terms for that year by about 1%. After 1985–86 supra-regional services accounted for 0.5%–0.8% of total revenue funding of the DHA (until 1990–91).'[29]

However, Mr Bevan nevertheless makes the point that adjustments to the RAWP allocations in respect of supra regional services were important for the District, since

> 'The funding of supra-regional services accounted for between 1.1% and 1.8% of revenue spending on acute services in Bristol.'[30]

22 Full details of the amount of NICS funding received by the Bristol hospitals from 1984–1995, and the processes by which those sums were allocated, are set out in a later section of this chapter.

23 As regards the allocation of SIFT funding to the DHA, as a teaching hospital, the BRI received a large share. Mr Bevan wrote:

> 'Bristol's teaching hospitals received nearly 70% of SIFT allocated to the RHA, and the BRI nearly 50%. SIFT accounted for about 8% of the total revenue budget of the DHA.'[31]

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[28] INQ 0047 0053; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*. See Annex B

[29] INQ 0047 0060; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*. See Annex B. After 1990/91, the sums in respect of NICS were paid directly to the UBHT by the DoH, as the purchaser, until 1994/95, when 'de-designation' meant that districts, and subsequently areas, assumed responsibility for the purchasing of these services

[30] INQ 0047 0069; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*. See Annex B

[31] INQ 0047 0069; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*. See Annex B

Revenue allocations

24 The revenue allocations by the SWRHA to the B&WDHA were determined each year according to the SWRHA's own version of the Department's RAWP formula. The SWRHA's approach was designed to make the national model sensitive to local pressures.[32] The formula was subject to change from year to year.[33] In essence, the RHA used the national formula to distribute funds to the districts within its boundaries.[34] Mr Bevan commented:

> 'What comes across as the driving force of the RHA is a commitment to achieving equity between DHAs.'[35]

25 The allocations took into account the previous year's baseline figure, the predicted rates of inflation in pay and prices, a share of any growth funds received from the DoH and an adjustment for efficiency improvement.[36]

26 The formula also took into account the complexities arising from the flow of patients across district boundaries. Notional financial allowances were made for patients from one district who were treated in another. Equally, notional charges were made for a district's patients who were treated elsewhere.[37] These adjustments affected the distance financially between the B&WDHA and the RAWP target, as defined by the SWRHA.

27 In 1988 the SWRHA developed new policies to remove these cross-boundary adjustments; the policies anticipated the changes made in 1991/92 with the introduction of the 'internal market'. Under the new system, adjustments to cross-boundary flows within targets would be replaced by planning agreements, with payments being made directly by the purchasing districts to the supplying districts. The policy was introduced on a pilot basis in 1989/90. From 1990/91 (the year before the 'internal market' was introduced), payments were made by purchasing districts to supplying districts for the estimated actual costs of treating cross-boundary flow.[38]

28 The B&WDHA's funding was 8.8% above the target set by the Region as part of the sub-Regional resource allocation formula in the financial year beginning 1984/85. This meant that in that year it was better funded than other health authorities within the South Western Region, to the extent of £5.3 million.[39] As a result, the B&WDHA received a proportionally smaller share of growth monies in subsequent years, as can

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[32] UBHT 0266 0075; NHS Resource Allocation – South Western Region Issues

[33] UBHT 0266 0290; SWRHA, Regional Resource Allocation Working Party

[34] INQ 0047 0054; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'.* See Annex B

[35] INQ 0047 0057; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'.* See Annex B. This commitment was reflected, for instance, in the proximity of the DHAs within the SWRHA to their target allocations, by 1983/84; all were relatively close to their targets, compared to those in many other regions

[36] UBHT 0339 0058; B&WDHA Budget

[37] UBHT 0266 0073; SWRHA RAWP

[38] INQ 0047 0054; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'.* See Annex B

[39] UBHT 0339 0059; B&WDHA Budget 1984/85. See also INQ 0047 0059

be seen from Table 1 below.[40] In his paper, Mr Bevan set out the changes in total revenue funding received by the District between 1983/84 and 1989/90.[41] He commented that:

> 'This shows a grim position for the DHA, wholly consistent with its being an over-target district in a RHA receiving no "real" growth.'[42]

Further, during the 1980s, the NHS's planning system required DHAs to consider 'priority' services: services which required particular development. These included the care for the elderly, mental illness and psychogeriatrics. Mr Bevan observed:

> 'These developments took place within the constrained budget of the DHA and hence imply that acute services would have been subject to even greater financial pressure than the DHA.'[43]

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[40] The table has been produced by the Inquiry from information contained in B&WDHA's Budget Books

[41] INQ 0047 0061; Figure 4. *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*. See Annex B

[42] INQ 0047 0059; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*. See Annex B

[43] INQ 0047 0062; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*. See Annex B

Table 1: Financial growth allocations 1984/85 to 1990/91 (all sums represent cash value at the relevant time)

Year	Increase in funding, year on year (growth money) South Western RHA		Increase in funding, year on year (growth money) Bristol & Weston DHA		Growth in funding for cardiac care (adults and children) Excluding supra regional funding[1]	
	Percentage	Cash (£)	Percentage	Cash (£)	Revenue (£)	Capital (£)
1984/85	Not available	Not available	Not available	Not available	383,000	Not available
1985/86	1.8	10,300,000	0.5	423,000	Not available	Not available
1986/87	1.2	7,100,000[2]	0.25	184,000	308,500[3]	Not available
1987/88	1.1	7,200,000	0.4	372,000	345,000	1,417,000[4]
1988/89	1.27	9,151,000	1.0	1,032,000	75,000[5] 960,000[6] 59,000[4]	Not available
1989/90	2.5	Not available	2.7	2,587,500	1,664,500[5] 57,000[7]	Not available
1990/91	3.3	Not available	1.0	1,109,000	1,785,000[5] 95,000[8]	Not available

1. Figures shown are in respect of B&WDHA
2. The RHA retained £1.4 million for regional developments: Budget Book 1986/87
3. RHA three-year revenue funding to expand cardiac surgery
4. Development of cardiac catheterisation at BRHSC
5. Contributions from other health authorities towards the cost of running cardiac surgery
6. Increase in cardiac surgery – regional specialty development funded by the RHA
7. Expansion of cardiac surgery and catheterisation
8. Development of cardiac services

29 Attempts were made to expand cardiac services. As can be seen from the Budget Book, in 1984 the RHA allocated £383,000 to the B&WDHA for the expansion of adult cardiac surgery by 100 cases to 375, with effect from April 1984. This money was held in reserve by the SWRHA and allocated to the appropriate budgets as the costs were incurred.[44] Further details of the sum allocated to fund growth in this field are to be found in the last column of Table 1, above. Mr Bevan noted that:

> ‘Regional Allocations 1986–87… shows significant funding of cardiac surgery from regional reserves from 1986–87 to 1988-90 (to 490 cases) and for an increase from 480 cases to 600/700 from 1986–87 to 1990–91. Financial Allocations and Policies (1988 edition) shows significant funding for an increase to 675 cases from 1988–89 to 1990–91:

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[44] UBHT 0339 0045; B&WDHA Budget 1984/85

Year	**86/87**	**87/88**	**88/89**	**89/90**	**90/91**
	£'00s	**£'00s**	**£'00s**	**£'00s**	**£'00s**
Regional Allocations 1986–87					
To 480 cases	715	272	178	415	
480 to 600	750	750	750	750	
480 to 700	900	900	900	900	
Financial Allocations and Policies (1988 edition)					
To 675 cases			1,135	1,168	1,149

He continued:

> 'Funding over three calendar years may naturally span four financial years. There may also be slippage so that funding indicated in, for example, 1986–87 might not take place that year. Nevertheless, these figures suggest that regional protection of cardiac services at the BRI was not limited to the three years as stated as the regional policy.'[45]

30 The attempts to expand cardiac services continued after the NHS reforms of 1991, through contracts placed by purchasers.[46]

Private funding

31 Mr Nix was asked by Counsel to the Inquiry about a letter to Mr John Watson[47] dated 2 December 1987, in which Mr Keen[48] protested about the fact that the income received from private patients undergoing cardiac surgery (who paid £330 per day for accommodation) was not credited to the cardiac surgery budget.[49] Mr Nix explained that this was because:

> '… the unit itself had funding to provide this level of service, and it was financed in part overall for the Trust from private patient income. So, if you like, they have a spending budget and we also had an income budget. The income budget for the Health Authority came … from the Regional Health Authority plus the money coming on the private patient route. I should say, we did not do an awful lot of private patient work, so this is not part of any private major funding stream.'[50]

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[45] INQ 0047 0053; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*. See Annex B

[46] Further details of this continued policy are set out at para 70

[47] Unit General Manager, BRI

[48] Consultant cardiac surgeon, BRI

[49] UBHT 0295 0063; letter from Mr Keen to Mr Watson dated 2 December 1987

[50] T22 p. 117 Mr Nix

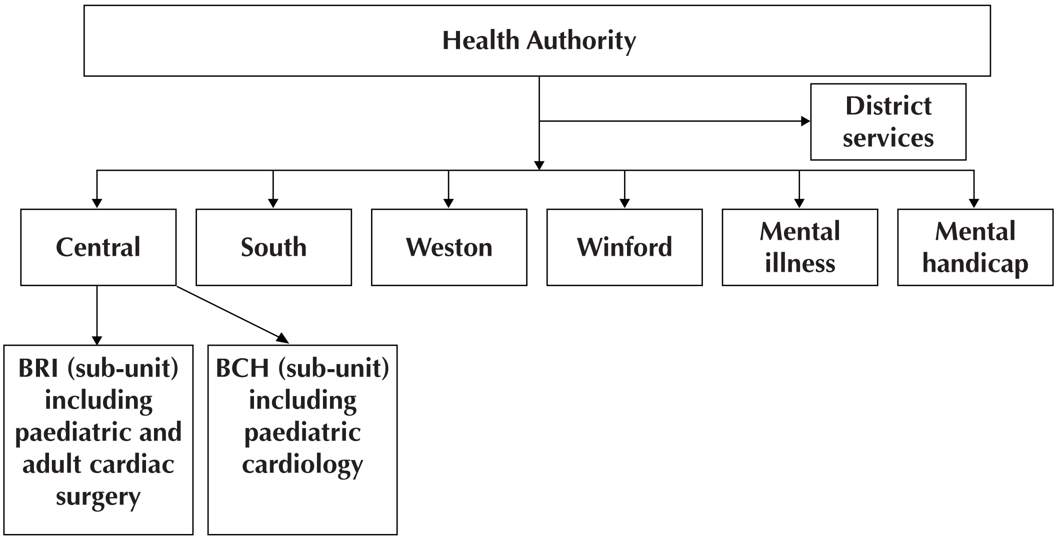
Management of funding by the District prior to 1991

32 From the beginning of the period of the Inquiry's Terms of Reference, the general manager of a district health authority was accountable for the financial performance of the district.[51] Dr John Roylance became District General Manager of B&WDHA in 1985 and retained this position until April 1991, when he became Chief Executive of the UBHT. General managers were encouraged to delegate budgetary control. All health authorities, including B&WDHA, were able to determine for themselves to what level budgets should be delegated and what flexibility individual budget-holders were to be given.[52]

33 Until the formation of the UBHT, the acute services of the B&WDHA were managed through two units: the Central Unit and the South Unit. Mr John Watson was the Unit General Manager of the Central Unit, which included the BRI and the BRHSC. Mrs Margaret Maisey was the General Manager of the South Unit.[53]

34 The structure of the management units within the District is summarised in Figure 1:

Figure 1: The structure of the Bristol & Weston Health District Authority and its units, 1984–1991



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[51] UBHT 0099 0087; DHSS Health Circular *'Financial Directions for Health Authorities in England'* HC(84)20: effective from the date of the General Manager's appointment

[52] See, again, the Circular HC(84)20, UBHT 0099 0089: 'Each General Manager should be able to delegate responsibility for a budget or part of a budget to an individual officer who should be responsible for the activities provided for within that budget and/or the supply of information to the Treasurer to assist budget making and monitoring'

[53] WIT 0106 0012 Mr Nix

35 Both the Central Unit and the South Unit had designated financial managers, supported by a qualified accountant and a financial team.[54]

36 The B&WDHA's budget statement for 1984/85 stated that it was a prime aim of the recent restructuring of the NHS[55] that decision-making be devolved to the operational level. An essential feature of this delegation was the devolving of budgets from district level to units, for which the responsible unit managers (administrator, nurse and doctor) would be accountable. Acting together, they should be able to manage services in the unit within service and budgetary objectives agreed with the district management team.[56]

37 The 1984/85 budget statement continued:

> 'Responsibility for managing budgets on a day to day basis rests with the budget holder. This will be an individual responsibility for District managed services but within units will be both an individual responsibility of each budget manager with a collective responsibility placed on the Unit Management Group …'
>
> 'The further delegation of budgets for 1984/85 is entirely consistent with the devolution of decision making and accountability to unit level. However, the Chief Nursing Officer, District Works Officer and other officers with District-wide responsibilities have a legitimate wider interest over the respective total budgets for their service and are to be consulted when annual budgets are determined.'[57]

38 The senior finance officers from the District Health Authority's finance department, as Unit finance officers, had a general responsibility for providing financial advice to the Unit Management Group. This included assisting in the compilation of annual budgets and reporting regularly to the Unit Management Group on budgetary performance, together with consideration of the financial implications of changes in the pattern of service being provided, the pursuit of efficiencies and the implementation of cost improvement programmes.[58]

39 Mr Nix stated that, although the principal financial accountability to the District Health Authority was through Mr Watson and Mrs Maisey, the actual day-to-day responsibility for financial management was at ward or department level.[59]

40 The Regional policy in respect of capital allocations is discussed by Mr Bevan in his paper, *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'* (see Annex B). The methods used followed national methods of capital allocation.[60] In 1984/85, 85% of capital

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[54] WIT 0106 0185 Mr Nix

[55] The Budget referred to changes which took place in 1982

[56] UBHT 0339 0061; B&WDHA Budget

[57] UBHT 0339 0062; B&WDHA Budget

[58] UBHT 0339 0062; B&WDHA Budget

[59] WIT 0106 0181 Mr Nix

[60] INQ 0047 0055

resources were allocated by the Regional Health Authority to the districts within the Region on the basis of projected populations, weighted by the use of services according to age and gender, and by morbidity. The remaining 15% was distributed in relation to the replacement value of the existing capital stock, weighted according to the age of the asset. This situation was recognised as being inequitable and it was planned to phase it out over the ensuing seven years.[61]

41 According to the B&WDHA Budget Books, the following capital allocations were made by the authority (see Table 2):

Table 2: Capital allocations, B&WDHA 1983/84–1990/91
(actual cash figures as shown in the Health Authority's Budget Books)

Year	Allocation £'000	Transfer from revenue included in capital allocation £'000
1983/84	2,173	627
1984/85	4,032	1,216
1985/86	4,160	2,433
1986/87	5,012	1,866
1987/88	4,205	412
1988/89	2,949	140
1989/90	4,068	468
1990/91	3,903	1,025

42 In 1989/90, 25% of the RHA's capital allocation was earmarked for the districts' capital programmes. This 25% allocation was allocated to DHAs in proportion to their revenue allocations.[62]

43 Mr Nix stated that in the case of B&WDHA, decisions as to which proposed plans for capital expenditure should be supported were taken by committees. The Policy Planning and Resources Committee (PPRC) considered business plans, strategic plans and service developments. The Finance, Property and Computing Committee (FPCC) considered the capital programme and investment (and monitored the financial position of the health authority).[63]

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[61] UBHT 0339 0180; B&WDHA Budget
[62] UBHT 0339 0848; B&WHDA Budget
[63] WIT 0106 0011 Mr Nix

UBHT's funding after 1991

44 After the introduction of the purchaser-provider split in 1991, the UBHT negotiated contracts[64] with its purchasers on an annual basis.

45 Mr Nix stated that he, as Director of Finance, and representatives from the individual clinical directorates were involved. He stated that the aim was to make certain that the various directorates had 'ownership' of what was required by the contract and also to ensure that the directorates could achieve what the purchasers were seeking.[65] Ms Deborah Evans[66] confirmed this process. She stated in her written evidence to the Inquiry:

> 'In the period October to December each year most of the contracting discussions would happen at the level of a clinical directorate or sub-directorate and a contract manager from the Health Authority, often with a manager from the central UBHT contracting support team sitting in. Between January and March each year discussions would also take place at Executive Director level between the Health Authority and each Trust to discuss the overall balance of additional funding between specialities and Trusts and to address any so far unresolved delivery issues at specialty level.'[67]

46 Mr Nix explained that the UBHT was required to negotiate with around 500 different purchasers, ranging in size from the Avon Health Authority (AHA)[68] involving a contract in the region of £100m, to a local GP fundholder, where the amount involved could be £50.[69] The major purchasers however, during the period from 1991 to the end of the period of the Inquiry's Term of Reference, were the district health authorities rather than GP fundholders.

47 Table 3 below sets out the UBHT's income revenue as a trust from 1991–1995, and the income of the Directorate of Surgery. It also shows the income, where it has been possible to identify it separately, of paediatric cardiac surgery and paediatric cardiology.

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[64] Although the term 'contract' was used, these were in fact service agreements with no legal force

[65] WIT 0106 0024 Mr Nix

[66] Executive Director of Avon Health Authority, formerly Director of Contracting of Bristol and District HA

[67] WIT 0159 0013 Ms Evans

[68] Established with effect from 1 April 1996, following the merger of the former District Heath Authority and Family Health Services Authority

[69] WIT 0106 0024 Mr Nix

Table 3: UBHT income revenue 1991–1995
(All sums shown are as shown in the UBHT budget statements at the cash value of the relevant year)

Year	Gross income (£)	Directorate of Surgery (including audit & paediatric cardiac surgery) (£)	Adult and paediatric cardiac surgery (£)	Directorate of Children's Services (including paediatric cardiology) (£)
1991/92	128,010,000 [UBHT 0339 0007]	11,298,000 [UBHT 0338 0012]	Not specified	8,283,000 [UBHT 0338 0012]
1992/93	133,854,000 [UBHT 0338 0024]	18,113,610 [UBHT 0338 0122]	3,832,190 [UBHT 0338 0117]	11,424,040 [UBHT 0338 0051]
1993/94	138,371,000 [UBHT 0338 0155]	20,513,400 [UBHT 0338 0262]	4,758,600 [UBHT 0338 0257]	11,914,280 [UBHT 0338 0190] (paediatric cardiology specified as £366,140)
1994/95	141,775,000 [UBHT 0338 0350]	22,520,000 [UBHT 0338 0376]	Not specified	13,669 [UBHT 0338 0365]

48 In the early 1990s, block contracts[70] for a fixed sum were the principal form of contract. Such contracts provided security of income to trusts. However, Mr Nix stated that they carried the risk that the numbers of patients would outstrip those that had been assumed when the agreement had been negotiated.[71]

49 Ms Evans stated:

> 'Bristol and Weston Health Authority (and subsequently Bristol and District Health Authority) used "sophisticated block contracts"as its main type of contract. These were arrangements within which the purchasing Health Authority paid a fixed contract sum for access to a defined range of services or facilities. Indicative patient activity targets were included with some identification of case mix. This type of contract was the most common form in use across the NHS, particularly in the acute sector.'[72]

50 Ms Evans explained that, initially, the emphasis was on a 'steady state' that protected the newly established providers:

> 'The national contract pricing requirements … had the effect that if a Health Authority wished to switch a number of cases away from one hospital and buy them at another one, it would be difficult to realise enough cash to buy the equivalent service elsewhere. It was theoretically possible to require Trusts to release the relevant semi-fixed and fixed costs although this would take two or three years to achieve. There were also national regulations about "periods of notice" required if Health Authorities wished to reduce the value of their

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[70] Block contracts operated on the basis that the provider agreed to provide a specified service (e.g. accident and emergency services) to a purchaser. They may be compared to 'cost and volume' contracts (a specific number of patient episodes at a specified price) and 'cost per case' (the cost of one specific patient or patient episode of care)

[71] WIT 0106 0175 Mr Nix

[72] WIT 0159 0012 Ms Evans

> "contracts" with a Trust by a significant sum. These values were not always precisely stated at national level, but it was local practice to give 12–18 months' notice for sums over £100,000.
>
> 'The difficulty in switching tranches of work from one hospital to another, or from hospital to primary care settings, had the effect of focusing attention either on remodelling services within an NHS Trust or on ways of developing services using the marginal annual increase in funding to the NHS.'[73]

51 Mr Baird stated in his written evidence to the Inquiry:

> 'There was a lot of over-simplification initially. For example, every operation had an average sum of money attached to it, and the system of accounting did not take the complexity of the procedure into account. We dealt with Finished Consultant Episodes (FCE's) rather than patient admissions, discharges and deaths which we had had before 1991. Dealing in FCE's had the effect on hospital activity of counting a patient twice if, for example, the patient was admitted to hospital under a physician and later transferred to a surgeon. The contract money for operations was *not* given to surgery to share out to cover the support services, eg anaesthesia. The clinical support services such as anaesthesia, pathology, radiology, etc were funded by central top-slicing, as were the Finance Department, the IT Department, general works and buildings maintenance, hotel services and so on.
>
> 'Consultants continued to compete for funding for their areas of work, although the routes to gain funding were different — there were still winners and losers. Winners included complex, low volume work such as cardiac surgery and bone marrow transplants which received investment to aid their development. Losers tended to be the high volume, low cost work which was locked tightly in contracts. Long waiting lists have already been a powerful lever for growth money.'[74]

52 Mr Nix stated that within the UBHT there was no system of cross-charging between services, as this was considered to be costly to administer. Clinical support services were allocated a share of income based on an agreed formula that was reviewed annually.[75]

Capital funding after 1991

53 From 1 April 1991 the NHS introduced a system of charging for the use of capital assets owned by self-financing trusts. Such assets were transferred into the ownership of trusts on their establishment. Interest on the value of the assets was payable to the DoH.[76] In turn, a capital charge was included in the charges made by providers to purchasers. This charge was intended to cover interest payments, depreciation and

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[73] WIT 0159 0011 Ms Evans

[74] WIT 0075 0009 Mr Baird (emphasis in original)

[75] WIT 0106 0188 Mr Nix

[76] UBHT 0338 0013; UBHT Budget. See also HOME 0003 0084; *'Working for Patients: Capital Charges: Working Paper No 5'* (DoH, 1989) and HOME 0003 0028; *'Working for Patients: Self-Governing Hospital Trust: Working Paper 1'* (DoH, 1989)

the repayment of loans. In 1991/92, the aim of launching the NHS 'internal market' in a 'steady state' meant that capital charges were:

> '... introduced so as to have no impact: charges were estimated by providers and allocated by purchasers according to existing use.'[77]

Previously, capital to fund the replacement or development of equipment or buildings had been sought from either the major capital programme (managed by the RHA) or from the DHA's own capital programme. The UBHT's Budget statement commented:

> 'Capital was always seen as "free" and the more that could be obtained and used the better'.[78]

54 Trusts were required to determine the need for capital against a five-year rolling programme of capital investment.[79] The capital programme for trusts was controlled by the DoH through the setting of an External Financing Limit (EFL).[80] The UBHT's capital programme and EFL is shown at Table 4 below.

Table 4: United Bristol Healthcare NHS Trust capital programme (cash value at the year indicated)

Year	**Capital £'000**	**External Financing Limit £'000**
1991/92	8,993	–1,161
1992/93	8,048	2,622
1993/94	7,304	–670
1994/95	10,761	2,486

The budget-setting process after 1991

55 Mr Nix stated that all the executive directors of the Trust Board were fully involved in discussions with the various directorates and the purchasers.[81] At the end of the process, the Trust Board approved all budgets. Mr Nix stated in his written evidence to the Inquiry that there was extensive opportunity for individual directorates and clinicians to influence the outcome of this budget-setting process.[82] The UBHT, he went on, encouraged clinical directors and other clinicians to be fully involved in the

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[77] INQ 0047 0028; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'.* See Annex B, and see further INQ 0047 0027 – 0029; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*. See Annex B

[78] UBHT 0338 0013; UBHT Budget

[79] UBHT 0338 0013; UBHT Budget

[80] An EFL was, in effect, a cash limit on the net external financing of an NHS trust. NHS trusts had a financial duty to meet (or come within agreed limits of) the EFL. The EFL was calculated as the difference between agreed capital spending and internally generated resources. A positive EFL meant that the NHS trust could have access to public dividend capital to help finance capital expenditure. A negative EFL meant that the NHS trust had sufficient internal resources. The EFL was set after taking into account: 'The projected capital charges for the year; the interest chargeable on the opening balances; ... the estimated depreciation charges [for the financial year in question]; an estimated ... capital dividend set to 'claw back' the difference between the interest funded through prices and the actual interest payable for the [previous financial year]; minor expected variations in working capital; [and] the centrally approved capital programme.' UBHT 0338 0139; UBHT Budget

[81] WIT 0106 0181 Mr Nix

[82] WIT 0106 0181 Mr Nix

discussions with purchasers and in the preparation of papers. There were regular reports to the senior managers, the hospital medical committee, and meetings of the clinical directors, as well as to the Trust Board.[83]

The delegation of budgetary control after 1991

56 The UBHT drew up its own Standing Financial Instructions (SFI).[84] Mr Nix stated in his written evidence to the Inquiry that overall responsibility for finance lay with the Chief Executive and the Trust Board. Clinical directors were accountable to the Chief Executive for the directorates' performance, including financial performance. In this regard, they had the assistance of general managers.[85]

57 Paediatric cardiac surgical services were delivered through two different directorates. Paediatric cardiac surgery formed part of the Surgical Directorate, with Mr Roger Baird as the Clinical Director. Mr Wisheart was Associate Clinical Director of Cardiac Surgery; Mr Dhasmana later succeeded him.[86] Paediatric cardiology was separately managed, as it formed part of the Children's Services Directorate.[87]

58 From 1 April 1995 cardiac surgery was removed from the Directorate of Surgery by the creation of a Directorate of Cardiac Services. This included the disciplines of both surgery and adult cardiology.[88] In October 1995 paediatric cardiac surgery and paediatric cardiology were brought together within the Children's Services Directorate, when paediatric cardiac surgery was relocated to the Children's Hospital.

59 Mr Nix explained that the aim of appointing associate directors was not only to ensure that clinicians were involved in the management of the services they provided, but also to place the responsibility for achieving the patient service contracts and the financial targets on those who were delivering the service.[89]

60 He explained further that:

> 'Budgetary control was delegated to the Associate Directorates and then within them to the wards, theatres, perfusionists, cardiology, etc. All budgets were reviewed annually and mainly rolled forward at the same level as for previous years, with an increase for inflation and for any developments agreed with purchaser Health Authorities or GP fundholders'.[90]

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[83] WIT 0106 0181 Mr Nix

[84] UBHT 0023 0297; UBHT Standing Financial Instructions

[85] WIT 0106 0182 Mr Nix. Further details of the directorate structure and of hospital management structures, are to be found in Chapter 8

[86] UBHT 0338 0114; UBHT Budget

[87] UBHT 0338 0044; UBHT Budget

[88] WIT 0106 0023 Mr Nix

[89] WIT 0106 0023 Mr Nix

[90] WIT 0106 0034 – 0035 Mr Nix

61 The report of the Director of Finance dated March 1992 set out rules for virement[91] and budget guidelines for clinical directors.[92] The arrangements gave complete discretion to the clinical directors to transfer between revenue budget headings during the year, to use funds for minor capital schemes, and to carry forward underspending.[93]

62 When implementing any budget changes during the financial year, clinical directors and their managers were required to take account of the advice of their financial manager and those other officers who possessed a relevant professional interest.[94]

63 Any proposal to reduce the level of service to patients had first to be approved by the Chief Executive.

64 As with the District Health Authority, senior finance staff acted as financial managers in respect of each directorate. They were responsible for providing advice on financial management to directorates. This included establishing principles for the compilation of annual budgets, regularly advising on budgetary performance and service agreements, ensuring the proper appraisal of all proposals for changes in service, and encouraging the search for efficiencies, cost improvements and initiatives for income generation.[95]

65 Within the UBHT, financial management was on three levels:

- senior financial managers, providing strategic financial advice to clinical directors;
- a qualified accountant, working with the clinical director and general manager on a day to day basis;
- a team at operational level, supporting the budget managers.

66 Mr Nix explained that budget managers received monthly expenditure reports, with detailed transaction reports and summaries provided at directorate level for the Trust. The expenditure reports included an analysis of income against planned expenditure and data on actual workload against the plan as analysed by the purchaser. The purpose in supplying the data to the directorates was to assist them in meeting the targets set by the purchasers and the financial targets set by the Trust.[96]

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[91] This is the ability to move money between designated budgets or budget sub-heads, e.g. to be able to spend money designated for capital expenditure on revenue costs

[92] UBHT 0338 0027; Report of the Director of Finance 1992/93

[93] UBHT 0338 0027; Report of the Director of Finance 1992/93

[94] UBHT 0338 0034; Budget 1992/93: ‘Budget Flexibility and Guidelines for all Budget Managers’

[95] UBHT 0338 0033; Budget Management

[96] WIT 0106 0036 Mr Nix

Funding for Paediatric Cardiac Services (PCS)

67 Funding for paediatric cardiac services (PCS), from April 1991 onwards, came from two separate sources. The first was for children over 1. It came from the general contracts or service agreements placed by local purchasers. The second source of funding was for children under 1 and it came from the DoH under supra regional arrangements.[97]

Contracts for cardiac services

68 The Inquiry received evidence from former staff of the B&DHA concerning the commissioning arrangements that they, as local purchasers, had made for cardiac services to children over 1 year old. Ms Deborah Evans stated:

> 'Bristol and Weston Health Authority had no involvement in the process of negotiating service agreements or of setting or monitoring quality standards for supra-regional services. One effect of designation as a supra-regional service on the Health Authority was that it did not have these responsibilities for services so designated.'[98]

69 The number of children requiring cardiac services for whom each district had responsibility was small. Pamela Charlwood[99] stated in her written statement to the Inquiry:

> '…B&DHA had been acting as a lead purchaser since 1991/92[100] for the adult cardiac services offered to all District Health Authorities in the South West Region. This required sharing service specifications, aspects of negotiations and monitoring data. Because of the small number of cases (twenty per annum) each of which was complex, paediatric cardiac services for children over one year old were commissioned through a block volume contract with no detailed specification.'[101]

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[97] See Chapter 7

[98] WIT 0159 0009 Ms Evans

[99] Chief Executive, Avon Health Authority from 1994, previously RGM SWRHA 1993/94

[100] But see the evidence of Ms Evans, to the effect the B&DHA co-ordinated a contracting process for one year only; thereafter it had no 'lead role'. WIT 0159 0018

[101] WIT 0038 0036 Ms Charlwood

70 The contract for the provision of health services for 1992/93 between the UBHT and the Bristol & District HA, for example, was a 'block contract'. It dealt with prices in Schedule (1)(a).[102] This listed the various departments providing services. They included 'cardiac surgery – BRI' and 'cardiac surgery – BCH'. Columns then represented the 'price' (cost per case) and 'volume' (the number of cases) and the total of these multiplied together, in respect of inpatients and outpatients. Cardiac surgery was a relatively high-cost discipline: the inpatient cost per case at the BRI was £6,977.94 (266 cases).[103] Children who were to receive treatment at the BRI were not separately identified.

71 This agreement operated in tandem with a parallel 'cost and volume contract.'[104] By this latter agreement, the DHA indicated a willingness to pay for additional cases above the indicative level agreed in the block contract, up to a specified ceiling. The relevant areas in which such an agreement was made included adult cardiac surgery: additional Coronary Artery Bypass Grafts (CABG) were provided for in a scheme aimed in part at clearing the waiting list for this procedure.[105]

72 These agreements reflected attempts to expand the capacity of the adult cardiac and cardiological services, and to cut waiting lists through the medium of contracts placed by purchasers. The Inquiry received from the Avon HA, for instance, details of the investment made by the B&DHA in cardiac services from 1992 onwards, set out in Tables 5 and 6 below:

Table 5: Additional recurring investment made by B&DHA in cardiology and cardiac surgical services, 1992/93 to 1995/96

Year	Investment
1992/93	£150,000
1993/94	£500,000
1994/95	£500,000
1995/96	£300,000
Total	£1,450,000

Note: All the above investment was in adult cardiology and cardiac surgery at UBHT.[106]

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[102] HAA 0156 0008; Schedule (1)(a)

[103] The corresponding figure for the BRHSC, where no open-heart surgery was performed, was £4,604.99 per cases; some 20 cases were planned for, all of which, necessarily, involved children

[104] HAA 0156 0012; Schedule (1)(b) 'cost and volume contract'

[105] See Chapter 3 for an explanation of this term

[106] WIT 0159 0054 Ms Evans

Table 6: Waiting list initiatives – care of adults purchased by B&DHA from UBHT in cardiology and cardiac surgery, 1993/94 to 1995/96

Year	Number and type of treatment	Price
1993/94	30 Coronary Artery Bypass Grafts (CABGs)	Included in block contract
1993/94	46 CABGs 8 angioplasties	£48,676
1993/94 & 1994/95	55 cases, approximately: 30% valve replacements 70% CABGs	£350,000
1994/95 (Project 44)	30 catheterisations 6 angioplasties 15 CABGs 2 valve replacements	£127,000
1994/95 (Project 47)	3 pacemaker insertions 6 angioplasties 57 catheterisations (mix of inpatients and day cases) 2 valuloplasties	£51,386
1995/96	340 cases (mix of inpatients and day cases cardiology and cardiac surgery)	£220,000

Note 1: A waiting list initiative was defined as an agreement for additional work, above that specified in the annual service agreement aimed at reducing inpatient, day case or outpatient waiting times.

Note 2: Within a specified case mix and price, monitoring would be against individual named patient returns.[107]

73 Ms Evans added:

> ‘The national drive to reduce waiting times and the decision to invest in additional treatment were two highly significant influences on Bristol and District Health Authority’s assessment of its need for adult cardiological and cardiac services. However there was an important clinical factor which made the picture more complex. This was the growth in emergency treatments for cardiology and cardiac surgery over the period.
>
> ‘… between 1989/90 and 1995/96, the emergency workload in adult cardiac surgery almost tripled (from 48 cases to 140 cases) and for adult cardiac surgery the workload almost doubled (from 224 cases to 523 cases) …
>
> ‘The effect of this combination of factors was that at certain times, particularly from 1993/94 onwards, it appeared that the UBHT (and by report other NHS Trusts) were having difficulty in meeting the combined demand from Health Authorities.’[108]

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[107] WIT 0159 0055 Ms Evans

[108] WIT 0159 0017 Ms Evans

74 She said further:

> 'The amount of additional investment which the Health Authority made in adult cardiac services was invariably a matter of contention during contract negotiations as clinicians put forward a strong professional view that more investment was needed and the Health Authority gave assurances that adult cardiac services was its top priority for the limited additional funds available.'[109]

75 The extent to which cardiac services benefited was contested. Mr Baird stated:

> 'However, funding for cardiac surgery was "ring-fenced", and the size of its ITU [a.k.a. ICU, or Intensive Care Unit] was protected. My perception is that cardiac surgery revenues benefited from the purchaser/provider split. But, when plans were being formulated involving major capital investment to move paediatric cardiac surgery to BRHSC [Bristol Royal Hospital for Sick Children], the purchasing Health Authority's policy was to minimise growth of high-tech expensive acute care, because it was plain that the service could be provided with the facilities already available. Instead, more care in the community by district nurses was favoured. This had an impact on the funding of cardiac surgery through pressure on contracts which reflected purchasers' reluctance to fund the demand in full.'[110]

76 He continued:

> '… as I have already explained, my feeling was that the cardiac surgical service fared well from the purchaser/provider split, because of additional contracts throughout the South West and South Wales rather than central funding. At the end of each year, any underspend on cardiac surgery was welcomed by the other Associate Directorates to offset their overspends, i.e. work carried out without funding recovered under existing contracts. In terms of developing cardiac surgery, it will have fared better as an independent Directorate, then having an opportunity to utilise its own financial gain.'[111]

77 Avon Health Authority commented on Mr Baird's view:

> 'Major capital investment was a matter that lay between UBHT and the Regional Health Authority, SWRHA; this did not concern the District Health Authority.
> As appears from Appendices 8 and 9 to the statement of Deborah Evans, the DHA was spending substantial amounts on cardiac services, consistently with the high priority it gave to favouring the funding of that service along with renal services, another very acute speciality. The DHA had a range of strategies which embraced both acute services and community-based care. It is an over-simplification to say that the DHA's "policy was to minimise the growth of high-tech expensive acute

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[109] WIT 0159 0026 Ms Evans

[110] WIT 0075 0010 Mr Baird

[111] WIT 0075 0013 Mr Baird. See further WIT 0075 0022 (Mr Dhasmana, commenting on Mr Baird's views)

care"; one consideration for a Purchaser is the extent to which "high-tech expensive acute care" best meets the community's needs.'[112]

78 Mr Wisheart commented on the statement of Mr Baird:

'Para 42

'1. Ring fencing of Cardiac Surgical Funds.

- 'The term "ring-fenced" was appropriately used only in relation to the Supra-Regional scheme funding for the under ones.
- 'I believe that the other income generated by cardiac surgery was not "ring-fenced".
- 'Both before and after 1990 funds came to the hospital for cardiac surgery. My understanding was that as long as the volume of work was delivered any residual, marginal sums of money could be used at the discretion of the hospital.
- 'Mr Baird acknowledges this in Para 52.'[113]

79 Mr Wisheart agreed that 'surplus' funds from cardiac surgery were used to offset the financial overspends of other associate directorships within the Directorate:

- 'What Mr Baird describes here is essentially correct.
- 'The irony is that when cardiac surgery was transferred from the Directorate of Surgery to the Directorate of Cardiac Service it then bailed out an overspent Sub-Directorate of Cardiology.'[114]

Supra regional funding for the under-1s

80 Throughout the period 1 April 1984 to 31 March 1994, funding for the service for children aged under 1 year came from a fund managed centrally by the DoH: the Supra Regional Services Fund. With effect from 1 April 1994, supra regional funding ceased.[115]

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[112] WIT 0075 0021 Avon Health Authority

[113] WIT 0075 0025 Mr Wisheart. Paragraph 52 of Mr Baird's statement is set out at para 76 above

[114] WIT 0075 0026 Mr Wisheart

[115] See Chapter 7

81 The financial effect of a service being designated as supra regional was that the money already being spent on that service by each of the designated supra regional centres was identified and 'protected' within the RHA's allocation for the following year. 'This meant that the region is obliged to make that amount of money available to the appropriate district for expenditure on the designated service.'[116]

82 When allocations were made for second and subsequent years, the total allocation for the previous year was increased in line with inflation and was again 'protected' within the RHA's allocation.

83 The allocations made were as follows in Table 7:

Table 7: Supra regional services paediatric cardiac surgery allocations – Bristol (cash value at the year indicated)

Financial year	Allocation (£) (cash value as at the year allocated)
1984/85	705,000[1]
1985/86	784,000
1986/87	341,000
1987/88	492,000
1988/89	573,000
1989/90	602,000
1990/91	689,000
1991/92	1,818,000[2]
1992/93	2,019,000
1993/94	2,048,000

1. An estimated figure provided by the BRI
2. UBHT 0277 0276; capital charging was included. A description of capital charging is at para 15

84 In determining the initial allocations to be 'protected' when the service was first designated, the Supra Regional Services Advisory Group (SRSAG) was dependent on financial data provided by the relevant regional treasurers. However, from 1985 onward, it moved towards an allocation system in which requests for additional funds were compared with workload costings. RHAs were allocated the amount they requested, or the costed workload, whichever amount was the lesser.[117]

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[116] UBHT 0278 0611. The sum was also discounted when assessing the region's distance from its RAWP target. In addition to 'protecting' the amount of money already being spent, the SRSAG was also authorised to recommend that an additional sum ('new money') be pre-empted from the NHS allocation to enable the service to be expanded. This sum would be added to the RHA's allocation to be made available to the district for expenditure on the service. Such 'additional' sums were normally made on a recurring basis and were also discounted when assessing the RHA's distance from its RAWP target

[117] This system included NICS from the financial year 1986/87: UBHT 0278 0611 – 0612

85 The SRSAG initiated a study of the services provided in each unit and the cost involved, so that recommendations might be made at a later date as to the level of expenditure to be protected during 1984/85 and funding levels for 1985/86.[118]

86 In his written evidence to the Inquiry, Mr Angilley[119] stated that the actual and forecast financial workload data sent in by the SRS centres was the basis for the following years' SRS (supra regional services) funding.[120]

87 Using activity data supplied by Mr Wisheart, Dr Joffe and Dr Jordan ('with slight amendments for details supplied by the nursing staff in both the Children's Hospitals and the Bristol Royal Infirmary')[121] the costs in Bristol for the years 1983/84 and 1984/85 were calculated.[122]

88 The protected funding level for 1985/86 was notified to the SWRHA in January 1985.[123] The allocation for Bristol was £784,000: the fifth highest allocation of the nine centres in the UK.

89 In December 1984 the first meeting of representatives from each of the nine centres designated to provide NICS discussed the definition of the protected service and the system for collecting information about expenditure and workload.[124] The representatives were invited to report on the current situation within each unit and the problems that they were encountering. The representatives from Bristol were Dr Joffe and Mr Wisheart. They reported that:

> 'The children's hospital dealt with Supra-Regional specialities of various kinds. The surgical work was carried out at the Bristol Royal Infirmary which treated only adults. Additional staff were needed since there was only one fully dedicated paediatric cardiac surgeon and there was a shortage of nursing staff. A large amount of "soft" money had been used for the purchase of equipment; on the surgical side: the RHA was embarking on an extensive programme of expansion, and plans for the development of paediatric surgery lay within the development of cardiac surgery generally, which has obvious nursing and manpower implications.'[125]

90 Further information to assist regional general managers in the funding of SRS was supplied by the Department in its paper RGM(85)9.[126]

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[118] In April 1984 the DoH wrote to the Regional Administrator at the SWRHA requesting up-to-date information on activity and costs for the purposes of this study. The SWRHA Regional Administrator in turn wrote to the relevant local administrators to obtain the relevant information: UBHT 0278 0593

[119] Administrative Secretary to the SRSAG 1987–1992

[120] WIT 0034 0002 – 0003 Mr Angilley

[121] UBHT 0278 0573; letter from Mr Hucklesbury to Mr McCelland dated 25 May 1984

[122] UBHT 0278 0573; letter from Mr Hucklesbury to Mr McCelland dated 25 May 1984

[123] UBHT 0278 0564 – 0566; letter from Mr Hurst dated 28 January 1985

[124] ES 0002 0006; meeting on 5 December 1984

[125] ES 0002 0009; minutes of meeting of representatives of the designated supra regional centres, 5 December 1984

[126] UBHT 0278 0609; RGM (85)9

91 In March 1985 the SWRHA wrote to Dr Roylance (then the District General Manager of B&WDHA) seeking information on workload and expenditure to be used in calculating the allocation for 1986/87.[127] In August, Dr Ian Baker (then District Medical Officer, B&WDHA) supplied completed schedules showing the statistical and expenditure data for NICS.[128] Dr Baker indicated that an expansion of the workload for NICS was planned in 1986/87 and an increase in expenditure of £87,000 which was partly due to the development of the new catheterisation laboratory.[129]

92 In September 1985 Mr Antony Hurst (then Administrative Secretary to the SRSAG) wrote to Miss Catherine Hawkins[130] indicating that the SRSAG had given some preliminary thought to the recommendations it might make to ministers on allocations for 1986/87.

93 On 17 October 1985 Dr Martin Reynolds (Chief Medical Advisor/Assistant General Manager, SWRHA) responded to Mr Hurst objecting to the proposed methodology for the allocation of funds for 1986/87.[131]

94 On 1 November Mr Hurst replied indicating that he had put Dr Reynold's objections to the SRSAG at their meeting on 23 October, along with similar objections, which were received from the West Midlands:

> 'The Advisory Group considered these objections carefully, and looked in some detail at its proposal methodology and at the implications for the individual centres. It fully appreciated that the methodology was somewhat rough and ready, but decided that it was the best that could be devised in the circumstances …'[132]

95 Dr Reynolds had asked Mr Hurst to supply details of the calculations used by the SRSAG. On 11 December 1985 Mr Hurst replied drawing attention to a document sent, in confidence, to regional general managers in late November.[133]

96 When the financial allocations for 1986/87 were announced in January 1986,[134] it was also announced that ministers had decided that capital funding should be brought within the arrangements for supra regional funding from 1 April 1987. Regional health authorities seeking capital allocations for 1987/88 were to submit any application by 15 June 1986.[135]

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[127] UBHT 0278 0519; letter dated 11 March 1985

[128] UBHT 0278 0509; letter from Dr Baker to Mr Churchill at SWRHA dated 5 August 1985

[129] Figure shown at UBHT 0278 0507 – 0508; Schedules

[130] UBHT 0278 0504; letter dated 26 September 1985

[131] UBHT 0278 0497; letter from Dr Reynolds to Mr Hurst dated 17 October 1985

[132] UBHT 0278 0500; letter from Mr Hurst to Dr Reynolds dated 1 November 198

[133] UBHT 0278 0493; letter from Mr Hurst to Dr Reynolds dated 11 December 1985

[134] UBHT 0278 0474; letter from Mr Hurst to General Managers dated 16 January 1986; and UBHT 0278 0492; 'Supra Regional Services, 1986–87'

[135] UBHT 0278 0474 – 0483; letter from Mr Hurst to General Managers dated 16 January 1986; and UBHT 0278 0492; 'Supra Regional Services, 1986–87'

97 As with revenue funding, the sums to be allocated to supra regional services for capital funding had to be found from within the total resources available nationally for allocation to health authorities. Proposals for capital funding for supra regional services were to be referred to the SRSAG. Regions were advised by the DHSS about schemes that might be approved for funding:

> '1. New development, or expansion, of a unit to enable a greater quantity of service to be provided, will be funded through a central pre-emption on health authority capital. Such schemes will be subject to Advisory Group scrutiny of the level of increased service planned.
>
> '2. Replacement and/or upgrading of existing capital stock without any increase in the number of patients treated and developments which mainly consist of replacement or upgrading, will be funded in part by the host region, pro-rata to the use made of the unit by its own residents (averaged over the preceding three years) and the remainder by central pre-emption on health authority capital.'[136]

98 The protected revenue funds for Bristol for 1986/87 were £326,000. In addition, £15,000 'additional central pre-emption' was added, making a total of £341,000. 'Pre-emption' meant that this sum of money was anticipated as being available from the following year's financial allocations. Bristol's allocation of funds was the lowest of the nine centres, the next lowest being Newcastle with a total allocation of £693,000. The reason for the reduction in the amount allocated was directly related to the return made by Bristol to the SRSAG.[137] Fewer patients (137) had received inpatient treatment in 1984/85 than had been anticipated (247).[138]

99 In February 1987,[139] the Secretary of State announced his decision for the 1987/88 funding. He stated that the 'protected funding level' for Bristol was to be £357,000, and that the 'additional central pre-emption' was £135,000. This made a total of £492,000. The 'additional central pre-emption' was significantly larger than any granted to the other centres. The overall allocation to Bristol was such that, of all centres, it ranked second lowest, the lowest being Harefield.[140]

100 The announcement also indicated that: 'The Advisory Group envisaged that there would be little need for expansion in the total service'.[141]

101 1987/88 was the first year in which the SRSAG considered applications for capital allocations. Two centres carrying out NICS applied for capital funding. They were Liverpool (which applied for £89,000) and Bristol (which bid for £265,000).[142]

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[136] UBHT 0278 0483 'Supra Regional Services, 1986–87'

[137] UBHT 0278 0477 'Supra Regional Services, 1986–87'

[138] UBHT 0278 0543 – 0556

[139] UBHT 0278 0410 DHSS press release

[140] UBHT 0278 0416; Harefield Hospital was thereafter to plan and perform its work in conjunction with the Brompton Hospital

[141] UBHT 0278 0417 DHSS press release

[142] For further details see Chapter 7

102 The SRSAG gave priority in capital allocation: '… to those Supra Regional Services and those Supra Regional Centres where an expansion of workload is envisaged during 1987/88 and beyond.'[143]

103 On 13 November 1987, the DHSS wrote to Catherine Hawkins indicating that the application for capital funding for extending the areas for wards and for operating theatres in the BRI had not been recommended for funding.[144]

104 Mr Nix wrote in a memorandum of 3 December 1987 to Mr Boardman:

> 'The bid to the DHSS was a combined effort between myself and the Regional Treasurer in an attempt to obtain funding to offset the capital injected by the Regional Health Authority into the developments at the BRI and the Childrens Hospital for cardiac services. The fact that we have not received any funding does not effect [*sic*] this District, it just means that the RHA has had to foot the full capital bill.'[145]

105 The total supra regional allocation of funds to Bristol for NICS for 1988/89 was £573,000, including an additional central pre-emption of £59,000.[146]

106 The SRSAG asked the SWRHA to provide a short report on the funding allocated to NICS in Bristol. On 19 August 1988, Catherine Hawkins wrote to Dr Roylance asking him to provide a brief account of the benefits obtained from the expenditure of supra regional funding and confirmation that increases in workload proposed for 1988/89 would be achieved as a result of the allocation of the funds.[147]

107 The funding allocation for 1989/90 was announced in December 1988. Bristol was allocated a total of £602,000.[148]

108 The allocation for 1990/91, announced on 3 January 1990, gave Bristol a total of £689,000.

109 The NHS reforms planned to take effect in April 1991 meant that the SRSAG would act as the 'purchaser' of the services for NICS from that date.[149] The process of contracting is set out later in this chapter.

110 In 1992, Bristol made a second bid for SRS capital funding, this time in the amount of £300,000. The money was to enable them to locate all paediatric cardiac surgical services on one site.[150] The projected total cost was £550,000. The proposal was that

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[143] UBHT 0278 0421 DHSS press release

[144] UBHT 0278 0279; letter from S Hiller, DHSS, to Miss Hawkins dated 13 November 1987

[145] UBHT 0278 0258; letter from Mr Nix to Mr Boardman dated 3 December 1987

[146] UBHT 0062 0430; letter from Mrs Clark to Dr Freeman dated 24 March 1988

[147] UBHT 0278 0177; letter from Miss Hawkins to Dr Roylance dated 19 August 1988

[148] UBHT 0278 0154 – 0156 DoH press release dated 29 December 1988

[149] UBHT 0064 0090 – 0091 *'Supra Regional Services 1991–92'*

[150] DOH 0002 0141; SRS(92)12

the remainder of the cost would be met by the UBHT. A paper, dated April 1992, prepared by the Secretariat of the SRSAG stated:

> 'The proposal submitted was only a draft outline requiring further discussion and planning. Until a firm proposal and a justified business case is received members are invited to defer this request.'[151]

111 Mr Nix told the Inquiry that he had not been aware that this bid had been submitted to the SRSAG until it was drawn to his attention by the Inquiry.[152] The bid appears to have been submitted by Dr Joffe.[153] Mr Nix went on to say that he had written a paper, setting out what work would be necessary to make a submission, dated 9 June 1992.[154] Thereafter, an 'outline submission' or 'interim statement' had been submitted about two weeks later in a document sent under cover of a 'with compliments' slip from Dr Joffe. The bid, Mr Nix went on, was clearly 'not extensive in its content'.[155]

The process of contracting

112 With the introduction of the internal market in the NHS in April 1991, the SRSAG became a 'purchaser'. It indicated that its role would be: '… to advise Ministers on the units with which contracts should be placed…'.[156] At its meeting in July 1990 it was noted that the National Health Service Management Executive (NHSME) was to provide arrangements for monitoring contracts.[157]

113 On 13 December 1990, a discussion took place about the draft contract with Bristol for the year 1991/92.[158] The discussion was between Mr Cameron,[159] Mr Nix, Mr Wisheart, Dr Joffe, Mr Barrington and three Department of Health representatives. The contract, which was in draft,[160] provided that the Unit: '… will ensure that the quality of the service is clinically and socially satisfactory, and will seek constantly to improve it.' It was to monitor regularly: '… all relevant aspects of the service, and make the results available to the purchaser.'[161] The Unit was to provide an Annual Report, dealing with matters such as 'quality of service' and 'statistics' as well as information on waiting lists and copies of the standards on quality agreed with the major purchaser(s). There was also an obligation to supply to the Department of Health a copy of the relevant part of the return to the UK Cardiac Surgical Register (UKCSR).[162]

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[151] DOH 0002 0148; SRS(92)12

[152] T23 p. 34 Mr Nix

[153] JDW 0003 0142

[154] This date is after the decision had been made to defer a request for funding pending a 'firm proposal and a justified [business] case'. T23 p. 35 Mr Nix

[155] T23 p. 35 Mr Nix

[156] UBHT 0064 0091; January 1991

[157] DOH 0002 0194; minutes of meeting on 26 July 1990

[158] UBHT 0277 0254; draft contract

[159] Mr Ewan Cameron, Assistant Treasurer, Senior Assistant Director of Finance

[160] The final version of the contract is at DOH 0004 0001, signed at DOH 0004 0009; the version signed incorporated the points discussed above

[161] DOH 0004 0004; contract

[162] DOH 0004 0007; contract. For the Register, see Chapter 19

114 In October 1991, the DoH commissioned a study by a management consultancy of the cost of the SRS.[163] By this time, removal of the NICS service from the supra regional system, or 'de-designation', was under discussion by the SRSAG.[164] De-designation took place with effect from 31 March 1994 and raised complex financial issues.[165] The funding previously made available directly from the DoH for neonatal and infant paediatric cardiac surgical services was instead apportioned by it amongst the regions, on the basis of past usage. Regional general managers promised to ensure a period of 'steady-state' for such services in the year following their removal from the supra regional arrangements.[166] Mr Nix gave evidence that at the time he was concerned about the proposed method to be used for the distribution of funds to the local purchasers. But he stated that, in the event, the possibility of losing funding through the reorganisation of funding arrangements did not materialise.[167]

115 As regards the effect which the de-designation of Bristol *alone* (without the de-designation of the other centres) would have had on the Bristol Unit, Dr Roylance stated in his written evidence to the Inquiry:

> 'Although I did not know it at the time, I now understand that the possibility of the unilateral de-designation of Bristol was being considered by the Supra-Regional Services Advisory Committee. It is right to point out that the unilateral withdrawal of centrally allocated funds for neonatal and infant paediatric cardiac surgery would have had no significant impact on the institution as a whole. The reduction in funding would have been addressed in negotiations for contracts for the successive year, presumably allowing an immediate increase of adult cardiac surgery within the resources at the BRI.'[168]

The effect of the cessation of supra regional funding

116 Following de-designation and the cessation of SRS funding on 31 March 1994, the SRSAG funds were reallocated to the various purchasing health authorities. Mr Nix stated that decisions about purchasing then rested with individual health authorities.[169] The UBHT entered into contracts directly with each of the health authorities, just as it did for other services provided by the Trust.

117 Mr Nix stated that 'in simple terms', when a child was referred from outside the area of the Avon HA, the health authority in whose area the child lived would be sent an invoice for the cost of the treatment.[170] The cost of treatment for those patients who

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[163] UBHT 0064 0182 – 0183; UBHT 0277 0141

[164] This topic is addressed, in detail, in Chapter 7

[165] UBHT 0064 0292 – 0316: UBHT 0277 0006 – 0007

[166] DOH 0002 0249; detailed figures are at DOH 0002 0253

[167] WIT 0106 0033 Mr Nix. See Chapter 7

[168] WIT 0108 0017 Dr Roylance

[169] WIT 0106 0032 Mr Nix

[170] WIT 0106 0009 Mr Nix

lived within the Avon HA's boundaries was included in the block contract between the Avon HA and the UBHT.[171]

118 Deborah Evans stated:

> 'For the years 1994/95 and 1995/96, neo-natal and infant cardiology and cardiac surgery was no longer a designated supra-regional service. The terms under which services became de-designated were that health authorities received a sum of money relating to their usage of the service and were required to purchase an equivalent level of service in Year 1 (1994/95). In other words, they had to spend the same amount of money with the same NHS Trust for the same volume and type of service.'[172]

119 Miss Lesley Salmon stated:

> 'Following de-designation the Unit had to be more concerned about the number of referrals and where referrals were coming from in order to maintain income levels to sustain the service. In effect, the health authorities were responsible for purchasing the services they wanted and had to make sure they had enough money to continue the service. Financing of the service after de-designation was less certain, and the business side of paediatric cardiac surgery had to be more actively managed. The ongoing daily management issues that had to be actively managed all of the time were trying to get the right number of cases through, for the right health authority, for the right cost. … Every case counts because contracts are agreed at a cost per case. This was a high risk area financially for the Trust.
>
> 'After de-designation it became clear that the amount of money that the Trust had been getting for the under 1 contract was quite generous. I was aware that there was an issue about recovering enough money from purchasers to continue to fund the service after de-designation. This was a financial issue I was not involved in negotiating.
>
> '… There was some concern amongst clinicians that contracts might take precedence over clinical need, but this was not a problem in practice as urgent cases still took priority.'[173]

120 Dr Ian Baker stated in his written evidence to the Inquiry:

> 'De-designation placed the planning and commissioning of cardiac services for the neonates and infants with individual Health Authorities with little by way of specific guidance. The volume of service required by any one Health Authority was small although the range of defects presenting and the range of treatment required

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[171] WIT 0106 0009. The agreement between the Bristol and Weston Health District Authority for 1994/95 is at HAA 0156 0383. The agreement between the UBHT and Avon Health Authority for 1995/96 is at HAA 0161 0001

[172] WIT 0159 0015 Ms Evans

[173] WIT 0109 0003 Miss Salmon

> could be large in any one year. Determining the range of care required and a level of investment for acceptable outcomes became difficult …
>
> 'There appeared to be no handover advice from the DoH or their clinical advisors.'[174]

The financial management of the budget for Paediatric Cardiac Surgical Services, 1984–1990

121 As set out earlier paediatric cardiac surgical services during the period 1984/91 were part of two separate management sub-units within the B&WDHA. The seven budget books, which cover this period, provided to the Inquiry by Mr Nix, do not separately identify the financial allocations made to the various services provided in the sub units. It is not possible to identify how the funding associated with NICS (from the SRS) was distributed to the different components of the paediatric cardiac surgical service. The funding is not separately identified as income coming into the Central Unit, nor is it separately identified in the narrative that precedes the financial allocations. Rather, the SRS funding was added to the general sum of the District's funding.

122 Within the Central Unit's budget, the only specific reference to cardiac surgical services is to cardiac perfusion. This is in the 1985/1986 Budget Book, which shows three entries:

Cardiac perfusion	Approved budget [£]	Revised budget [£]
Prof & Technical	57,030	67,990
Travel	1,360	1,360
Other	50	50[1]

1. UBHT 0339 0243

Resources

123 The word 'resources' is used in this section to mean not only financial and material resources, but also to the availability of human resources. It refers to staffing, qualifications and the workload imposed on staff.

The relation between funding and clinical services

124 Dr Roylance commented:

> '… I am not aware of any positive incentives in relation to the services offered that were created by the methods of funding paediatric cardiac surgery. Indeed,

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[174] WIT 0074 0030 Dr Baker

> throughout my time first as District General Manager and then as Chief Executive, I was constantly seeking to persuade all clinicians that issues of funding of services mattered. The tendency during that period was for all those in the National Health Service to regard any purported or proposed financial restrictions on clinical activity as unacceptable, if not frankly immoral. This was the "culture change" referred to in the notes of the meeting of the Executive Directors Group held on 8 May 1991,[175] on which I have been asked to comment.
>
> 'As far as I am aware, throughout the relevant period, children referred to Bristol for care were accepted and treated solely on the basis of their clinical need, and were referred elsewhere if that was considered to be in their best interests.'[176]

125 Dr Roylance continued:

> 'Throughout the period under review I, as District General Manager and then as Chief Executive, was repeatedly urged to effect an improvement in each and every service that we provided. I cannot now recall any specialty or department which did not press for improvements, usually requiring substantial sums of additional capital and revenue expenditure.
>
> 'The demands for improved facilities, etc. were very often expressed in exaggerated and emotive terms. I do not say this intending to be pejorative: people working in the health service have always been characterised by the strongest desire to do the very best possible for their patients and it is a source of very real frustration and distress to carers that what may technically be possible is often practically not available. Lack of funding for the maintenance, development or improvement of a service has always been one of the most frustrating problems within the National Health Service.
>
> 'I was committed to obtaining the maximum possible level of funding for the services we provided, and I believe that there was a strong culture within the Trust of creativity in the identification and securing of additional sources of income, led by Graham Nix as Finance Director. However, I have never seen overspending as an acceptable solution to the problem of under-funding: it was my responsibility to ensure that the District Health Authority and then the Trust provided the best possible care within the resources available. Indeed, during the selection process that led to my appointment, I was required to give a presentation on how, within a 5 year timescale, I would bring the Health Authority within budget. When I was appointed, the Appointments Committee made clear that this was my primary responsibility.
>
> 'Once the budget had been set, therefore, I could not allow it to be exceeded. However, I know that elsewhere in the NHS overspending sometimes occurred and I am sure that the fact that from the year after I took up the post of DGM we

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[175] UBHT 0240 0742; notes of the meeting of the Executive Directors Group, 8 May 1991

[176] WIT 0108 0003 Dr Roylance

> remained consistently within budget was sometimes a source of additional frustration to those clinicians that saw other Authorities and Trusts "getting away with it", although I believe that we had done much to change the culture within the Trust, as I set out in my statement on Issue B.
>
> 'It is against this background that requests were repeatedly made over a number of years for improvements in the provision of paediatric cardiac surgery. Unfortunately, this fact alone did not distinguish this service from any other. One of the tasks of a District General Manager was to balance the competing needs of all the services within the District, and with the introduction of contracting it became harder to find "spare" money for ad hoc projects. Cross-funding was not permitted, so that savings made in other areas of the Trust could not be used for paediatric cardiac surgery: the funding for the improvements had to come from cardiac surgery itself.'[177]

126 Dr Roylance went on:

> 'I had been aware for some time that paediatric cardiac surgery was not achieving its full potential. The experts in the field were all agreed that UBHT needed to appoint a dedicated surgeon for the paediatric work and move the surgery to the Children's Hospital. The necessary management action had therefore been identified and work was being done to achieve both of those aims. In the financial climate of the time, where budgetary constraints were many and cross-funding of services was expressly prohibited, it had proved extremely difficult to identify the necessary funding.'[178]

127 Mr Baird commented, in his written evidence to the Inquiry, on the change to trust status:

> 'Dr Roylance had to push us into functioning as a Trust in the first wave. Initially there were the advantages of flexibility and leading the way. Trust status was achieved against opposition from many doctors in Bristol. However, the subsequent development of the NHS has proved that his decision to make us a first-wave Trust was a wise one.
>
> 'The theme was that money followed the patient thereby bringing business values to the NHS. There was resistance to this: staff simply wanted money to develop their services, as had been the traditional way of working.'[179]

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[177] WIT 0108 0118 – 0119 Dr Roylance

[178] WIT 0108 0127 Dr Roylance

[179] WIT 0075 0008 Mr Baird

Cardiac surgery and cardiological services at the BRI

128 Dr Johnson (Chairman of the Division of Anaesthesia), wrote to Mr Wisheart, Mr Keen and Mr Dhasmana, in June 1988:

> 'I am afraid that the Summer months are going to be a little problematic regarding experienced staffing of the Cardiac Unit. The most difficult months will be July and August when we will not have Steve Bolsin and there will be considerable consultant leave being taken. Donald [Dr Donald Short, consultant anaesthetist UBH/T] will provide you with full details, but I would ask you to be patient with us and go carefully on workload until September, when I hope that our anaesthetic service will match your every requirement (or almost so).'[180]

129 Dr Russell Rees, consultant cardiologist (adults), set out his views about the resources available for cardiological services in a letter to Mrs Margaret Maisey dated 3 June 1991:

> 'Thank you for asking me to list the main problems with cardiology following our meeting with the Chairman.
>
> 'We are faced with difficulties which have gradually built up over the years as district and regional demands for cardiological services have rapidly increased outstripping local resources and regional funding. The problems are inter-related and are listed below.'

As regards beds, he stated: 'There is a severe shortage [of beds]… '. As regards staffing, he wrote: 'At present we are just about coping, but serious problems will appear if we successfully contract for more work and our bed state improves … This lack of junior support for our senior registrars was severely criticised by the review body of the Royal College of Physicians at their last review, when withdrawal of recognition was threatened if things were not improved.'As regards emergency services, he wrote: 'As a result of delays, this aspect of our work is rapidly increasing. Many patients wait much longer than desirable in peripheral hospitals before transfer. Their management when they arrive disrupts planned work both by ourselves and surgeons. There are always appreciable delays before these patients can be transferred from our [cardiology] beds to the cardiac surgical unit, and seriously ill patients can wait three to four weeks. If we were to increase our throughput substantially, it would have serious implications for the surgical unit.'[181]

130 Surveys of cardiological staffing levels conducted on behalf of the British Cardiac Society (BCS) and others, indicated the national situation at various times. In 1988:

> '… there were less than six cardiologists per million population. The United Kingdom, with Ireland, has fewer cardiologists than all other European countries

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[180] UBHT 0162 0084; letter from Dr Johnson dated 13 June 1988

[181] UBHT 0038 0280 – 0281; letter from Dr Rees to Mrs Maisey dated 3 June 1991

> with reliable figures. The ratio for Europe as a whole is approximately 45 per million population; the recommended figure for the United States of America is 60 per million. The distribution of cardiologists in England and Wales is still very uneven. Seven million people – nearly 15% of the population – have no immediate access to special expertise in cardiology…
>
> 'The total number of cardiologists within the regions shows wide disparities that do not appropriately reflect the differences in population. For example the South Western region has one cardiologist for every 246,500, whereas North West Thames has one cardiologist for every 140,500.'[182]

131 In 1992, the position as regards paediatric cardiologists was stated to be as follows:

> 'The present staffing levels for paediatric cardiology in the United Kingdom are perilously low, and not comparable to those in most developed countries. Their training depends on eight senior registrar posts with two others agreed but not yet implemented.'[183]

132 In Bristol, there were problems in recruiting a paediatric cardiologist during the 1980s. Dr Martin was eventually appointed on a proleptic basis.[184]

133 The paediatric cardiology service in Bristol was provided by consultants only; there were no junior staff training to be paediatric cardiologists, who would have been capable of relieving their consultant colleagues of some of their workload.

The status of paediatric cardiac surgical services in Bristol

134 Dr Joffe told the Inquiry that he considered that paediatric cardiac surgery and paediatric cardiology were given a lower priority than adult cardiac services. Developments in the children's services were, he said, achieved: '… on the back of adult developments…'.[185] He commented, in evidence in the following exchange:

> 'Q. In comparison with the adult service it was the orphan service, was it?
>
> 'A. Yes, it was the stepchild, it always has been …'[186]

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[182] BCS 0001 0018 – 0020; Chamberlain D, Bailey L, Sowton E, Ballantyne D, MacBoyle D, Oliver M. *'Staffing in Cardiology in the United Kingdom 1988 Fifth Biennial Survey'*. From the Sussex Centre for Medical Research, University of Sussex, Brighton, in collaboration with the Cardiology Committee, Royal College of Physicians of London and the British Cardiac Society

[183] BCS 0001 0096; Chamberlain D, Parker J, Balcon R, Webb-Peploe M, Cobbe S, Boyle D, Tynan M, Hunter S, Reval K. *'Eighth Survey of Staffing in Cardiology in the United Kingdom 1992'*

[184] Appointment of a consultant on a proleptic basis is where the appointment is made in anticipation of further training taking place in the consultant grade

[185] T90 p. 32 Dr Joffe

[186] T90 p. 33 Dr Joffe

Resources for neonatal work

135 Paediatric cardiac surgical services in Bristol were part of a larger range of neonatal[187] services. In 1986, a document from the B&WDHA, entitled *'Strategy for Neonatal Care 1986–1994'*, stated:

> 'Professional representation has indicated a desire to increase the quality of services generally and to maintain or improve access to services in Bristol Maternity and Children's Hospitals for obstetric and neonatal referrals from within and outside the South Western Region. A key request was an increase in nursing levels to manage the desired workload without undue stress on those concerned … The strategy has been accepted as one which takes into account a Regional commitment, "to provide adequate facilities for the intensive care of infants (in consultation with neighbouring authorities if necessary)", and a pragmatic assessment of the opportunities for implementation throughout the decade. The adequacy of facilities for intensive care contributed by this District will be determined on a year to year basis in the light of developments in other Districts and agreement on the best balance of all aspects of obstetric, neonatal and children's care within the District's Children's and Maternity Unit.
>
> 'Members of the Authority's Policy, Planning and Resource Committee and District Managers acknowledge that in interpreting the policy of the Authority and accepting the resource assumption for planning that there will be a shortfall of attainment for future care of neonates. Members are not unaware of the extra strain which will be placed upon staff in the exercise of their professional judgment and in their relationship with the parents. If the District's resource allocation increases in the future and the policies of the Authority change, the opportunity to respond to future demand … will be taken.'[188]

136 Mr Nix commented on this document in the following exchange:

> 'Q. I appreciate that is not essentially concerned with neonatal cardiac surgery, but what it is, so it would seem … suggesting is that there was a shortfall of attainment, and going to be a shortfall in attainment in the care of neonates [in] the following years, and "shortfall in attainment" means essentially a lack of provision, which comes back in the end to staffing and money; is that right?
>
> 'A. Yes, what was technically going to be achieved for neonates was going to be expanded and is still expanding even now and there are strains on the service.'[189]

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[187] That is, children of under 1 month old

[188] UBHT 0238 0236, dated 1 May 1986. This strategy was adapted as policy: UBHT 0076 0058

[189] T22 p. 88 Mr Nix

Strains on resources more generally

137 The Inquiry received evidence of many other examples of strains on resources. After an inspection visit to the BRI and BRHSC in 1992: '… because of major alterations in the organisation of medical services at these hospitals' the Regional Advisors of the Royal College of Physicians (RCP) reported that there was:

> '… a happy, hardworking, cohesive hospital team.'[190]

The RCP Regional Advisors also identified:

> '… major problems due to the great increase in workload in emergency medicine without commensurate increase in resources. When a full complement of staff is present, the system is just able to cope, but if anyone is on leave those remaining can be stretched to the limit and the level of cover is inadequate to ensure proper training. It seems probable that, at times, the quality of patient care may fall below safe levels. In my [Professor Alberti's] discussions with Managers, it was clear that they are aware of these difficulties …'[191]

138 Dr Roylance told the Inquiry:

> 'When we were at District … we had a finite sum of money, which everybody, including me, agreed was woefully inadequate, and we had what people have described as an "infinite demand". … And this I tried to say is a fundamental challenge to the health service. You do not resolve it by pretending it was not there or wishing it was not there, you have to address it. I believe one of the major steps which helped in addressing that issue was to separate the very difficult task of deciding what was necessary from the challenge of delivering what was decided …'[192]

139 Dr Roylance went on:

> 'If you strategically plan a new unit like the Children's Hospital and then do not get contracts for it, I think somebody ought to have the situation discussed with them. I mean what I am saying here is that the cardiac disease was a major cause of death and demand in the regional services is high and so on, and this is an issue that we are not meeting the demand for cardiac services and we were not committed to developing the service. Of course the Trust is and was committed to developing the service, but only as far as the purchasers were committed to buying that service.'[193]

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[190] WIT 0032 0259 Professor Sir George Alberti

[191] WIT 0032 0259 Professor Sir George Alberti

[192] T25 p. 153–4 Dr Roylance

[193] T24 p. 156 Dr Roylance

Beds

140 As regards shortages of beds, a visit to the Bristol hospitals in October 1986 by the General Professional Training Team of the Royal College of Physicians reported that:

> 'The number of beds in the Bristol Royal Infirmary in Medicine is just about adequate to enable training of the present Junior Staff level, and further reductions in bed numbers might impair the training programme. Junior Staff were genuinely concerned that they spend too much time attempting to find beds.'[194]

141 As regards delays in admitting paediatric patients, the minutes of meetings of the Division of Children's Services[195] commented on shortages of beds in the Children's Hospital throughout 1987:

> '*April*. Restriction of admissions … Dr Hinde reported that the bed situation in the Children's Hospital had eased somewhat over the past month, although this was a normal trend for the time of year. Notwithstanding this, the ITU had been closed to admissions between 17th–20th March, and the whole Hospital had been closed on 24th March. In addition, a total of 7 transfers to Southmead had had to take place during April (to date) because of lack of available cubicles for children needing isolation. It was noted with concern that the BCH was still not functioning fully as a District General Hospital for Children.
>
> 'It was further noted that the only long-term solution to the problem was to open one of the closed wards, but that this would require funding for additional nursing staff. Miss Stoneham advised Division that the deficiencies in the service being provided by the Hospital were regularly pointed out to the District Health Authority.'[196]
>
> '*May.* Restriction on admissions … Dr Hinde reported that, during the past month, it had not been necessary to refuse any admissions. This was considered, however, to be the normal seasonal pattern, and Division still endorsed the need for action to be taken to avoid a repetition of the severe bed problems that had been experienced during the Winter months.'[197]
>
> '*July.* Closure of hospital to admissions. Dr Hinde wished to draw the Division's attention to the situation which had once again arisen recently, when there had been no paediatric beds available in Bristol for emergency admissions. On that occasion it had been necessary to discharge sick children from BCH against informed medial opinion.

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[194] WIT 0032 0255 Professor Sir George Alberti

[195] Of the Bristol and Weston District Health Authority

[196] UBHT 0211 0085; minutes of meeting held on 21 April 1987 (month emphasised in original)

[197] UBHT 0211 0078; minutes of meeting held on 19 May 1987 (month emphasised in original)

> 'The Chairman acknowledged receipt of Dr Hinde's letter on this issue, and undertook to respond when he had had an opportunity to consider it more fully, and to bring the concern of Division about patient safety once again to the attention of the Health Authority.'

The minute noted that savings of £26,000 had to be identified out of the medical staffing budget over the next ten years.[198]

142 In January 1991, the minutes of the meeting of the Division of Surgery recorded:

> 'Because of the lack of funds, the ITU would remain at its present size of 7 beds when the ceiling replacement and refurbishment were undertaken.'[199]

143 In relation to paediatric cardiac surgery at the BRI, Mrs Fiona Thomas[200] stated in her written evidence to the Inquiry:

> 'Some surgeons complained at times if there was a shortage of beds for adult cases as children were staying in ITU and blocking beds.'[201]

She stated that, at this time, the adult service was being expanded, but that beds in the ITU were often occupied by children. This only enabled a certain number of adult patients to be operated upon on any given day.[202]

144 Fiona Thomas explained, in the following exchange:

> 'Q. So it could be the case, could it not, that there would be adults ready, willing and able to have their operations, but no available space in intensive care to house them after the operation?
>
> 'A Yes. It is the same situation as there is today, yes: lack of beds, basically, in the intensive care unit. Patients are not well enough to move through as we would have necessarily planned, yes.
>
> 'Q. So there is always a demand for particularly adults to have surgery, and one of the bottlenecks is to be found in intensive care?
>
> 'A. Yes.

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[198] UBHT 0211 0049; minutes of meeting held on 21 July 1987 (month emphasised in original)

[199] UBHT 0200 0046; minutes of meeting held on 9 January 1991

[200] Clinical Nurse Manager, BRI

[201] WIT 0114 0029 Fiona Thomas

[202] WIT 0114 0029 Fiona Thomas

> ‘Q. But that bottleneck would be more marked, more profound in the days when there were children in the intensive care because they would be there for longer?
>
> ‘A. Yes, and you could have three or four beds blocked for a longer period of time because they were not moving through, yes.
>
> ‘Q. So that led to some tension, did it?
>
> ‘A. Yes, it did, yes.’[203]

145 Kay Armstrong[204] told the Inquiry that it was a regular occurrence to be told at the start of a day that an operation would have to be cancelled because of the lack of an intensive care bed, or a shortage of trained nurses in the ICU or the operating theatres.[205]

146 Dr Piers Rowlandson, a referring consultant paediatrician from Swindon, stated in his written evidence to the Inquiry that delays due to shortages of beds were not peculiar to Bristol. He explained that children with heart problems were referred from Swindon to either Bristol or Oxford. He stated that, initially, Oxford had not appointed a dedicated paediatric cardiac surgeon, but that even:

> ‘… when Oxford had appointed a paediatric cardiac surgeon the choice was still Bristol for many patients because of lack of beds in Oxford. Bristol too often had a problem finding a bed. The whole service seemed chronically under resourced.’[206]

Nursing staff and sessions for cardiac surgery

147 In December 1985, the Acting General Manager of the Children and Obstetrics Sub-Unit, Geraldine Martin, wrote to clinicians and the managers at local health authorities. She noted the ‘particularly acute’ staffing difficulties at the Special Care Baby Unit at the Bristol Maternity Hospital. Patients who normally resided outside Avon would no longer be admitted. She continued:

> ‘With regard to the Bristol Children’s Hospital, acute staffing difficulties also persist here and by taking the above action additional pressures will be placed on ITU. Referrals to the ITU will however continue as at present but acceptance of referrals will have to be subject to the availability of nursing staff. Before any referrals are formally accepted by any member of the medical staff the current and expected workload on the Unit and within the Hospital as a whole should be checked by the Registrars on duty or On Take Consultant with the Senior Nurse in charge so as to ensure that appropriate care can be given to that referral. If neonatal surgical patients have to be refused then the referring Clinician should be advised to seek equivalent paediatric surgical expertise in either Southampton, Oxford,

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[203] T32 p. 48 Fiona Thomas

[204] Cardiac Sister, BRI, 1984–1995

[205] T59 p. 12–13 Mrs Armstrong

[206] REF 0001 0036; letter from Dr Rowlandson dated 31 August 1999

> Birmingham, or London, and Miss Noblett, Consultant Paediatric Surgeon, has already alerted these centres to this situation.
>
> 'This restriction on bookings to S.C.B.U.[207] will be operative with effect from 1st January 1986 and will continue until such time as the staffing situation improves on the Unit, and further notification will be made at that time.'[208]

148 On 27 January 1987, Mr Dhasmana wrote to the Chairman of Children's Services, Dr Martin Mott, and the Chairman of the Division of Anaesthesia, Dr Robert Johnson, suggesting that an additional operating session for cardiac surgery at the BRHSC be held on a Monday morning, as the theatre time and space were available. Mr Dhasmana stated that Mr Wisheart supported him in this.[209]

149 On 24 March 1987, Dr Mott wrote to Mr Dhasmana, saying that this could not be accommodated: '… the nursing staff required to support the extra session are not available, and you will be well aware of the fact that our nursing allocation is already used to the full.'[210]

150 The matter was raised again by Mr Dhasmana in January 1989 in a letter to Dr Roylance:

> 'I am now requesting, through your office, reconsideration of my earlier proposal. There is a space available and if this session could be funded it would provide me one morning session every week. This would help to cut down the Waiting List on my routine cases, and reduce some of the emergency work which I do outside the normal routine hours. I am enclosing a copy of my previous letter for your perusal.'[211]

151 No progress having been made, Mr Dhasmana continued to work outside routine hours. He again raised the matter at a meeting of the Division of Children's Services[212] on 20 February 1990.[213] The minutes recorded:

> 'Mr Dhasmana raised the need for an additional cardiac surgery operating session at BCH. At present a proportion of cardiac surgery was undertaken out of hours because of the lack of scheduled sessions, both inconvenient and costly. … Miss Stoneham agreed to look into this.'

152 During his oral evidence, Mr Dhasmana confirmed that, in his letter of 17 November 1988 to Dr Alastair Mason, Regional Medical Officer, he had stated that there

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[207] Special Care Baby Unit at Bristol Maternity Hospital

[208] UBHT 0238 0411; letter from Ms Martin dated 30 December 1985

[209] JPD 0001 0001 – 0002; letter from Mr Dhasmana to Dr Mott dated 27 January 1987

[210] UBHT 0212 0083; letter from Dr Mott to Mr Dhasmana dated 24 March 1987

[211] JPD 0001 0007; letter from Mr Dhasmana to Dr Roylance dated 20 January 1989

[212] Of the Bristol and Weston District Health Authority

[213] UBHT 0208 0091; minutes of meeting held on 20 February 1990

was a: '… lack of resources and it was a constant struggle for time, for theatre space, and also for medical and nursing manpower to look after my cases.'[214]

153 In January 1988 the minutes of a meeting of the Division of Children's Services recorded:

> 'Nurse staffing …
>
> 'As discussed at the previous meeting of Division, a working group has been convened to discuss possible solutions to the problems caused by the acute shortage of nursing staff. As a result, it had been agreed to close Ward 31 for a period of one month, in order that the situation could ease somewhat, and to allow an intensive programme of training in paediatric nursing for RGNs to take place. Miss Perrett said that it was planned to reopen Ward 31 over the weekend of 23rd/24th January, and, although the temporary closure *had* partially eased the nursing situation, the previous difficulties would return once the ward re-opened. Although cover had been maintained on the ITU, this had only been done with difficulty, and on some occasions, the Unit had relied on bank staff for cover. However it had been possible to send a number of nurses on an intensive two week training course designed to give them a greater understanding of paediatric nursing, and this had been extremely well received by the participants.'[215]

154 Michelle Cummings, mother of Charlotte, told the Inquiry of her experience in the ICU at the BRI in 1988:

> 'I do know, when Charlotte was in intensive care, that she had a student nurse looking after her. I think there was a question, being that it was the BRI, it was not the Children's Hospital, it was a mixed intensive care, whether there were actually enough paediatric trained nurses, and I spoke to many of the nurses about this, and it was something they themselves were extremely concerned about. I know they were extremely concerned over the resources that were available to them at that time. So, yes, there were definitely students there, and at times, instead of having a 1-to-1, it was a 1-to-2, so one nurse would be looking after two …'[216]

155 In the following exchange, Belinda House, mother of Ryan, told the Inquiry of her experience in 1989, when a transfer from Southmead Hospital to the BRHSC had to be arranged:

> 'Q. So were arrangements made to make that transfer?
>
> 'A. Well, that was very traumatic. Mr [*sic*] Joffe told us we had to be at the Children's [Hospital]. The doctor again got on the phone, because he had to arrange for theatre space, at a convenient theatre at the Children's. He spent an

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[214] UBHT 0174 0013 Mr Dhasmana

[215] UBHT 0211 0108; minutes of meeting held on 19 January 1988 (emphasis in original)

[216] T3 p. 142 Michelle Cummings

> awful lot of time doing that, which was very distressing for him. He then found the theatre space and could not find the nurses to staff the theatre. That went on for a very long time, until Julian and I actually suggested, could we pay agency nurses, because we were so desperate, because we knew this procedure had to happen within so many hours.
>
> ‘Q. Can I stop you there. You say he was having difficulty finding theatre space. That is theatre space at the Children’s Hospital?
>
> ‘A. At the Children’s Hospital.
>
> ‘Q. You then went on to say there was difficulty finding nursing staff?
>
> ‘A. Yes.
>
> ‘Q. Was that in relation to nursing staff at the Children’s Hospital, or in relation to nursing staff to manage the transfer?
>
> ‘A. That was both. That was nurses to look after Ryan in the theatre, and also, Ryan needed quite a senior nurse to go with him in the ambulance with the incubator and they also needed a senior nurse left on the SCBU at Southmead Special Care Baby Unit.
>
> ‘Q. Were they able to find nurses?
>
> ‘A. Yes, finally they found the nurses …’[217]

156 In her written statement to the Inquiry, Belinda House stated:

> ‘It also then appeared that there was no ambulance available in the whole area with the equipment needed for such a Transfer. It was a horrific situation for everyone concerned, until eventually a suitable ambulance was located. This was the beginning of our education to the fact that the NHS, at the time, was desperately underfunded, so much so that Ryan’s life was put at risk.’[218]

157 In a letter dated 7 February 1990, Drs Monk, Masey and Bolsin (consultant anaesthetists) wrote to Margaret Peacock.[219] They stated that on 26 January 1990, the cardiac anaesthetists on duty had agreed to do one extra cardiac case in order to enable surgeons to reduce waiting lists. Pressure had then been caused by the admission of a patient with a major cardiovascular problem, on an emergency basis; extra staff were not available. They protested that in future they would not allow more than two cardiac cases to be anaesthetised unless they were given categorical

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[217] T6 p. 62 Belinda House

[218] WIT 0025 0003 Belinda House

[219] General Manager (Inpatient Services), BRI

assurances that emergency staff would be available to help with life-threatening emergency cases.[220]

158 Ms Alison Whiting[221] replied on 22 February 1990. She set out the nursing levels and workload, and said that no guarantee could be given that similar emergencies would not take place in future.[222]

159 By a letter dated 12 July 1990, Dr Bolsin recorded his view that, in view of his ‘experience in this department’, it was unreasonable to start major cardiac cases after 3pm, other than in exceptional circumstances. He would not do so in future, and stated that he would instruct his juniors similarly.[223]

Equipment

160 Mr Wisheart, in his written evidence to the Inquiry, described the availability of equipment:

> ‘A post-cardiac surgery ICU requires a substantial amount of expensive equipment. This equipment also tends to become increasingly developed and sophisticated with the passage of time. The cost of such equipment was a challenge and often a problem. The sources of money to purchase equipment were as follows:
>
> ‘REGIONAL CAPITAL:
>
> - ‘At a time of significant or major development such as 1987–88 when the Ward was totally refurbished, we obtained replacement of a substantial amount of our capital equipment.
>
> ‘DISTRICT/TRUST MAJOR MEDICAL EQUIPMENT BUDGET:
>
> - ‘For the renewal of equipment from year to year we had to compete with other demands for equipment within the Trust. It was common for the total cost of requested equipment to exceed the total of money available by a considerable factor.
>
> ‘DEPARTMENTAL DISCRETIONARY FUNDS:
>
> - ‘Patients and families who were treated in the Unit often gave donations, sometimes significant ones and it was possible to purchase equipment using this money.

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[220] UBHT 0118 0001; letter to Ms Peacock dated 7 February 1990

[221] ITU/Theatre Service Manager, BRI

[222] UBHT 0118 0005; letter from Ms Whiting to Ms Peacock dated 22 February 1990

[223] UBHT 0118 0007; letter from Dr Bolsin dated 12 July 1990

‘EMERGENCY RESPONSE:

- ‘If there was a totally unexpected breakdown in the function of vitally important equipment then the Trust kept a reserve fund which could be used to enable the work to continue.

‘CHARITABLE ORGANISATIONS:

- ‘Sometimes equipment was donated by charitable groups.

‘While there were times when we felt that we were well equipped and had the resources to replace equipment as we wished, there were certainly other times when we felt we were unable to replace old equipment when this should have been done. This was another reflection of what appeared to be reality, namely that the resource available to us fell far short of the demands that were placed upon us.

‘When we became a sub-directorate in 1991, Ms Lesley Salmon and I began to compile a list of our equipment, its age, expected life and cost, as a first step in the development of a programme of regular replacement.

‘To the best of my knowledge, we never undertook surgery when there was not functioning and safe equipment available to meet the needs of the patient who was being cared for. As an example, if there was no suitable ventilator available for the patient, then the operation would have to be postponed.’[224]

161 Dr Joffe stated:

‘We struggled to acquire suitable echocardiography equipment during the early 1980s, and it was only though the financial support of charitable organisations that we were able to purchase a 2D echocardiography machine in about 1984, and a second in about 1989. The situation improved after Trust status, when we acquired our third machine, in lieu of the outmoded first apparatus. We were always short of cardiac technological staff and, throughout 1984 to 1995 we shared technicians with the adult cardiac catheterisation service at the BRI. It was only in this way that we could ensure that, for emergency catheterisation after hours, there would be someone on call who was familiar with the BCH equipment. The paediatric cardiologists performed all echocardiography procedures themselves until the late 1980s, when we were able to appoint our first echocardiographic technician with financial help from the Paediatric Oncology Department for whom we provided a regular service. In the early 1980s, the paediatric cardiologists reported on all angiograms as part of the cardiac catheterisation reports. This was taken over by Dr Wilde in the mid 1980s, and his overall advice and assistance was most welcome. By the early 1990s, he became overwhelmed by the demands of adult

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[224] WIT 0120 0216 – 0217 Mr Wisheart

cardiology and was no longer able to participate in the angiographic procedures himself, but still reported on the angiograms.'[225]

162 Dr Geoffrey Burton, consultant anaesthetist,[226] stated:

> '… some centres (e.g. Great Ormond Street) had much more equipment sourced from generous charity monies, whereas we had to work on a much more restricted budget and had relatively little money sourced from charities …
>
> 'In Bristol, we were only paid for three sessions to cover a day of cardiac surgery — frequently this did not even cover the time spent in the operating theatre, let alone continuing care for several days in the Intensive Care Unit. We were working on a very "tight" budget and it was not unusual for me to work for over 80 hours in the week and be paid for only 37½ of them.'[227]

163 As regards equipment, Mr Wisheart stated:

> 'The equipment in operating theatres is fairly well standardised and is very similar from one hospital to another. This includes the basic operating theatre equipment such as tables, lights, diathermy, anaesthetic equipment such as ventilators, the surgeon's equipment such as instruments and the perfusionists equipment, the bypass machinery. The patient's life is dependent upon many items of equipment working reliably and effectively; therefore they must be well maintained.
>
> 'The main variability is that equipment and instruments are constantly evolving. Any given surgeon or institution will buy the newer equipment either sooner or later; there are often financial issues involved. However, these changes tend to be incremental rather than truly decisive in nature.'[228]

164 Mrs Rachel Ferris stated:

> 'Lack of capital investment was clearly reflected in the state of the equipment that was available in the Directorate. Much of this seemed to be reaching the end of its life span, with frequent need for maintenance and repairs. There was no rolling replacement programme for capital equipment. This seemed to be a particularly acute problem because cardiac services is such a high tech area of work, with some very complex and expensive equipment in use. (For example, to equip a new catheter laboratory might cost in the region of £1 million, which would be a substantial proportion of the Trust's capital budget for the year.) Work had been undertaken to devise a rolling programme for replacing equipment in a planned way, to try to ensure that the equipment did not let us down in providing a high

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[225] WIT 0097 0306 Dr Joffe

[226] Dr Burton was appointed as lecturer, Department of Anaesthesia in the University of Bristol, in 1959. His clinical practice covered both the BRI and the BCH until the summer of 1991

[227] WIT 0555 0004 – 0005 Dr Burton

[228] WIT 0120 0172 Mr Wisheart

> level of service to patients, and I wanted to build upon and give greater emphasis to this. I was not very familiar with much of the equipment and was assisted by Dr Pryn and Fiona Thomas.'[229]

165 Dr Pryn stated that when he arrived at the UBHT, he took an active interest in the nature and state of the equipment that was available to him:

> 'Despite relatively old equipment, this was sufficient for full compliance with the standards proposed by the Royal College of Anaesthetists (Guidance for Purchasers 1994) and Association of Anaesthetists Recommendations for Standards of Monitoring during Anaesthesia and Recovery 1994. The one area of monitoring that was not available was capnography.[230] There were no capnographs present in the cardiac theatre suite when I joined BRI in 1993. It was felt that this was acceptable, although not ideal, as (i) fixed volume ventilators with expired volume monitoring were used in theatre and (ii) the blood gas analyser was readily available in the theatre itself. New theatre monitors, with the capability of capnography, were purchased in 1995, and around the same time capnography became available in the anaesthetic room as well. …
>
> 'When I arrived at the BRI I found that much of the equipment, both in theatre and in the intensive care unit was old, and there were no mechanisms for replacement. I assumed responsibility for the co-ordination of equipment purchase. Document UBHT 0084 0101 is the list of "minor" equipment which I identified as being required. There was, in addition to this list, a list of major equipment. By way of example the syringe pumps in use in theatres had a number of problems. The replacement product which I recommended was purchased.'[231]

166 Mrs Ferris stated:

> '… I would say that it is not quite right that "there were no mechanisms for replacement".
>
> 'There was a clearly defined mechanism for the replacement of major medical equipment. This involved undertaking a bidding process and completing an application form by 30 September each year for items of capital equipment over the value of £15,000. These bids were meant to be prioritised within the Directorate and then considered by the Trust's major medical equipment committee. A decision would be made about these bids by December of the same year or January of the following year.

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[229] WIT 0089 0013 Rachel Ferris

[230] Capnography is the measurement of exhaled carbon dioxide values

[231] WIT 0341 0021 – 0022 Dr Pryn

> 'The main problem as I saw it, was that despite this clear mechanism, the Trust had insufficient capital to meet the demands made upon the major medical equipment committee. In particular the decision to build the new Children's Hospital had led to a situation whereby £1.5 million of capital per annum had to be put aside for the Children's Hospital. As a consequence, the major medical equipment committee only had around £1.5 million per annum to spend on large capital items. As I said in my statement, the cost of capital for Cardiothoracic Services was very high, and it was clear to me that it was not possible to meet a rolling programme of the replacement of capital equipment through the major medical equipment committee.'

167 She added:

> 'As far as minor medical equipment was concerned there were mechanisms for bidding for equipment, but these were inconsistent.'[232]

168 As regards the absence of capnography monitoring equipment, Dr Pryn told the Inquiry:

> 'There must have been other institutions that did not have capnography throughout, but in an area like cardiac surgery, where it is extremely technical, you would have expected the state-of-the-art monitoring, and clearly this was not state-of-the-art.'[233]

169 He responded in the following exchange:

> 'Q. Is that a fair summary of your impression of the equipment in Bristol, that it was adequate but it would not be state-of-the-art?
>
> 'A. Yes. Fair.'[234]

170 Dr Pryn referred to:

> '… an ongoing battle and "battle" is the right word, because you are competing with other departments in the hospital for very limited funds, and some of the wording on this document[235] is specifically coloured to paint the picture — a more dramatic picture than perhaps was necessary, just so we could have our voice heard. It is a battle to get money.'[236]

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[232] WIT 0341 0100 Rachel Ferris

[233] T72 p. 77 Dr Pryn

[234] T72 p. 78 Dr Pryn

[235] The list of minor equipment which Dr Pryn prepared

[236] T72 p. 83 Dr Pryn

171 Dr Pryn told the Inquiry that the cardiac surgical unit at the BRI when he was appointed as an intensivist in August 1993:

> '… was a unit that was often run minute by minute by relatively inexperienced doctors, with their senior cover not being that available, and it was a unit run by trainees who were not used to general intensive care issues, were quite familiar with managing the cardiovascular system, but were relatively poor at integrating that with the other systems, for instance, the respiratory system. … Their background was not in general intensive care.'

He told the Inquiry that he felt that more input was required from staff with a general intensive care background, and that senior cover needed to be more available. It was an awareness of this, he said, that had fuelled his own appointment and that of Dr Ian Davies.[237]

172 The Inquiry's Expert, Dr Michael Scallan, consultant anaesthetist, Royal Brompton Hospital, commented on the points made by Dr Pryn in the following exchange:

> 'The shopping list we see here is the sort of shopping list that you see in many hospitals. There is a constant need to upgrade equipment, to replace equipment. A lot of the equipment that we use these days does not have a life really of more than ten years, and you have to think of moving forward to the next generation of equipment.
>
> 'So what we see here is a very fair shopping list.
>
> 'Q. If we had gone into other NHS units across the UK performing paediatric cardiac surgery at about this time, are we likely to have seen similar issues about the replacement of machines of this nature?
>
> 'A. Yes. I think that is a fair comment, yes.
>
> 'Q. So there is nothing here that strikes you as being out of the ordinary in terms of the needs of this particular unit?
>
> 'A. I think the section on the equipment in the theatres and in intensive care does suggest that that equipment should have been replaced a little earlier. I think that was the middle 90s. What was in existence does appear to have been rather old equipment and quite correctly the need to upgrade it — the case for the need to upgrade it was made in this list.'[238]

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[237] T72 p. 20 Dr Pryn

[238] T72 p. 82–3 Dr Scallan

173 When Dr Scallan referred to equipment being unavailable at his hospital, the Chairman of the Inquiry explored the point in the following exchange:

> ‘Q. (The Chairman) You say that you encountered some of the same difficulties. Would that persuade you to say that therefore one can say that whatever was provided at your institution or at Bristol was adequate and appropriate, or does it persuade one to say that against a different standard, a slightly more absolute standard, neither were up to snuff?
>
> ‘A. (Dr Scallan) To answer that question in a slightly indirect way, I think the standards are evolving all the time and as new equipment becomes available and becomes used, so it creeps into what is considered basic monitoring, or basic standards. So in an ideal world, you could say that both institutions were short of the ideal standard.’[239]

174 In January 1992, the first of the ‘recommenced’ audit meetings of paediatric cardiology and cardiac surgery reviewed the audit topic ‘closure of the patent ductus by a transvenous insertion of the Rashkind device’ in 24 cases. Conclusions were reached upon the most appropriate procedure. The note of the meeting read, under the heading ‘Action Taken/Clinical Changes Instituted’, ‘Unable to implement due to lack of finance… Cost £1783 + VAT more than for cardiac catheter.’[240]

175 Dr Roylance was asked by Counsel to the Inquiry to comment on this note in the following exchange:

> ‘Q. On the face of it, this is a document which — I may have to ask those more closely connected with the delivery of the cardiac service about it, but this is a document which might suggest that a lack of finance was preventing the delivery of optimal care.
>
> ‘A. Yes.
>
> ‘Q. Have I misunderstood or not?
>
> ‘A. No, I mean, I believe you have not misunderstood.’[241]

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[239] T72 p. 98 Dr Scallan

[240] UBHT 0061 0156; minutes of meeting on 22 January 1992. See Chapter 18

[241] T24 p. 142 Dr Roylance

Disruptions in service

176 The Inquiry was shown a letter from Mr Paul Walker, consultant physician and cardiologist (adults), to Ms Linda Williamson of the B&DHA, dated 27 October 1993.[242] The letter concerned cardiac catheterisation services for adult patients from Southmead Hospital. It had been prompted by the case of such a patient who had decided to tell his story to the *'Bristol Evening Post'*. The letter commented on the need to avoid 'sudden crisis directives' from the UBHT concerning matters such as the cancellation of all non-emergency and all non-long-term-waiter patients who were not on the long-term waiting list.

177 Mr Roger Baird[243] commented on this letter in the following exchange:

> 'Q. Is it the fact that whether the decision is right or wrong, a shortage of money has led to a lack of treatment?
>
> 'A. Yes. There were always pressures on the cardiac catheterisation budget. There were always more people that could be investigated than there was the money to do it and they tried to increase the number that were done year on year, but there were often problems like this and we would always try to resolve them.'[244]

Increasing the number of anaesthetists and surgeons

178 Efforts made by the surgeons at the BRI to obtain additional operating sessions were affected in 1987 by the need to appoint a further consultant anaesthetist. Mr Gerald Keen, consultant cardiothoracic surgeon, wrote to Dr Robert Johnson[245] in November 1987:

> 'I believe that my anxieties concerning the consultant anaesthetist cover from July 1988 onwards stems from a chronic shortage of consultant availability in cardiac surgery. We have been dogged by this for many years, and it seems to me that this situation will not really improve following the commencement of our expanded service. There are two causes of this problem.
>
> 'In the first instance we are barely covered by consultant anaesthetist sessions and this is highlighted on Wednesday when the consultant anaesthetist is legally obliged to work a morning session only. To anybody with the faintest understanding of cardiac surgery and cardiac anaesthesia, it is clearly wrong that cardiac surgical patients should be attended by the anaesthetist in charge for the first half of a case only, and that the completion of the operation and perhaps the management of important immediate complications, should have no official consultant anaesthetist cover. The second cause and to an extent associated

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[242] WIT 0159 0086 Ms Evans

[243] Consultant general surgeon, BRI

[244] T29 p. 118 Mr Baird

[245] Consultant anaesthetist and Chairman of the Division of Anaesthesia at the BRI

> with the first problem, is the very heavy commitment of the consultant cardiac anaesthetists to other legitimate duties.
>
> 'Although we are completely covered for cardiac surgery on paper (excepting for Wednesday afternoon), these prolonged and often simultaneous absences of consultant anaesthetists gives us poor and often inadequate cover. Unhappily in my view the acquisition of another consultant anaesthetist will not really improve the situation, bearing in mind the proposed expansion of the service, for the new anaesthetist will undertake four sessions only in the operating theatre. At the same time, other consultant anaesthetists who are heavily overworked will quite understandably see the arrival of the new anaesthetist as an opportunity to reduce their own commitment to their contractual obligation. I did of course, set out most of these points in my recent letter to you, but your response, although helpful, gives me no indication that the service provided by your colleagues will be adequate in the future.
>
> 'As you know, James [Wisheart], Janardan [Dhasmana] and I have set out tentative proposals concerning our own work programme for the expanded service, but this can only happen with appropriate consultant cover. For the time being I do not propose to send any of this correspondence to the Regional Health Authority, but they may at some time in the future, need to be made aware of the under-provision of support for a service which they are now heavily financing.'[246]

179 As regards the need for cardiac surgeons, in October 1988 Mr Keen wrote to Dr Alastair Mason[247] at the SWRHA:

> 'With the further development and extension of cardiac surgical facilities in the South West region, certain consequences have been accepted by the Regional Health Authority. We have increased the nursing staff considerably and at the same time appointed two further consultant anaesthetists to support this development.
>
> 'When Mr J P Dhasmana was appointed in 1985, his appointment was partly proleptic to enable a further increase in work to take place, and as you know in 1986, we undertook a total of more than six hundred open and closed cardiac operations on adults and children. It was agreed at that time that this unit would eventually undertake a considerable number of those patients in the south west requiring cardiac surgery, and to achieve this, the need to appoint, a fourth cardiac surgeon at some time was appreciated. It was generally understood that once we had achieved a level of about seven hundred open heart operations per annum (in addition to about one hundred closed operations per annum), a total of eight hundred operations, the appointment of a fourth surgeon would become mandatory.

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[246] UBHT 0138 0018; letter from Mr Keen to Dr Johnson dated 23 November 1987

[247] Regional Medical Officer, SWRHA

> 'This topic was raised at the meeting of the South West Regional Cardiology Committee, held at Taunton on 6 October and after full discussion, it was agreed that the time to appoint this surgeon had now arrived. We are now operating on planned fifteen operations per week (apart from emergencies); that is approximately seven hundred and twenty five patients per annum. Whereas at the present time we are able to achieve this, it is only with the greatest difficulty, for the three surgeons in post, are working very hard and my two colleagues who also do paediatric cardiac surgery at the Children's Hospital, Mr J D Wisheart and Mr J P Dhasmana, are working all hours, day and night, and their weekends are rarely free.
>
> 'This really cannot continue, for even should these numbers be achieved during normal working periods, there is no way that this volume of work will be sustained during the summer, that is from the middle of May until the end of September, when one or other of the cardiac surgeons is away and at the same time, junior staff need to have their holidays staggered.
>
> 'It is anticipated that in the absence of a fourth surgeon, the volume of work undertaken will decrease to perhaps two thirds of its present level during that period, with consequent under-usage of our expensive, well equipped and well staffed cardiac surgical unit.
>
> 'With this in mind, it was recommended by the Committee that steps are taken to consider the appointment of a fourth cardiac surgeon, whose work would be primarily in adults, that the successful applicant would be in post by the late spring of 1989.
>
> 'Financial support for this fourth surgical appointment has been agreed in all planning documents for this expansion, prior to 1987, but as far as we can tell, any mention of this fourth appointment has not appeared on recent documents. I am sure that this discrepancy will come to light when you have had an opportunity to study the background of this request and I look forward to meeting you, together with my colleagues in the near future.'[248]

180 Mr Dhasmana wrote to Dr Mason in November 1988:

> 'I am writing to you to express my views on the above subject especially in reference to Mr Keen's earlier letter dated 11th October and your recent meeting with Mr Wisheart and Mr Keen on 11th November. …
>
> 'You are well aware that ours is a moderate sized Cardiac Surgical Unit which deals with both paediatric and adult cardiac surgery averaging about 520 cases per year over the past two years. During this period my own clinical work-load was not fully stretched due to lack of resources and it was a constant struggle for time, for theatre

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[248] UBHT 0174 0011 – 0012; letter from Mr Keen to Dr Mason dated 11 October 1988

space and also for medical and nursing manpower to look after my cases. It is only since the recent improvement in the staffing level and an extension in the cardiac surgical unit that I am able to achieve the target for which I was appointed three years ago. We are now hoping to achieve a target of around 700 cases a year in the extended Cardiac Unit.

'This figure I feel is just right for the present level of medical staff of three consultants, two senior registrars, one registrar and four SHO's. An almost similar figure was recommended by the Joint Cardiology Committee of Royal Colleges for the organisation of a Cardiac Surgical Unit (Brit Heart J 1980; 43:211-219). There are a number of units in this country which are managing an even higher number of operations per year with three consultants and supporting staff. Even units like Guy's and the Brompton Hospitals which deal with adult and paediatric cardiac surgery have been managing about 800–1000 operations a year with a similar number of consultant staff. The Brompton has only recently appointed a fourth surgeon. It appears that the secret lies in providing and increasing the support service rather than appointing a fourth surgeon alone in order to increase the number of operations. The fourth consultant would need theatre space and ITU beds. At the present time we are allocated 4–5 operations per consultant per week which in my mind is just right for a cardiac surgeon to maintain a high standard in the technical skill and the post-operative management. The above Joint Committee further emphasises "Facilities should be available for each surgeon and his team to perform four to six open heart operations a week with additional time for emergencies" in their recommendations for surgical staffing (page 214).

'I personally feel that the consultant appointment should not be made to cover leave and holidays of other colleagues. Locum appointment of a registrar or consultant during that period should see the work continued unabated. The present resources are utilised to the maximum by the three of us. In my mind there is no spare facility to accommodate the fourth person unless some of us agree to cut down on their own work.

'I agree that there is a threshold beyond which a fourth surgeon would be needed and we are approaching that figure when 700–750 open heart operations are performed a year. We should then combine this demand with further expansion of the unit here at BRI or the transfer of paediatric services to the Children's Hospital which would certainly make the way for a fourth cardiac surgeon to cover mainly the adult side. It would also be feasible to appoint a further surgeon if we have agreed in principle to establish a transplantation unit with increased resources.'[249]

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[249] UBHT 0174 0013; letter from Mr Dhasmana to Dr Mason dated 16 November 1988

181 On 5 July 1989, Mr Keen, Mr Wisheart and Mr Dhasmana wrote a proposal for the appointment of a fourth cardiac surgeon addressed to the planning authorities:

> 'STATEMENT OF NEED
>
> 'Cardiac surgical services in Bristol have developed in a step-by-step fashion during the last decade, increasing the number of open heart operations performed annually from 253 in 1980 to a predicted 675–700 in 1989. During this time, the numbers of surgical staff responsible for the work have increased as follows:- Consultants from 2 to 3, Registrars/Senior Registrars from 2 to 3, Senior House Officers from 3 to 4. During the planning processes, the initial target for the 1988 development was 600 cases, and it was agreed that three surgeons would be sufficient; in the light of experience and in the presence of a large outstanding demand in the region, this number was revised to 675; it was recognised that an additional surgeon would probably be needed, and this was formally accepted at a meeting at the SWRHA on 11.11.88 when the Region undertook to fund this appointment and a secretary.
>
> 'While the three surgeons have managed to sustain this heavy workload over the winter months of 1988/1989, it is not a load which could be carried indefinitely. In particular, it would almost certainly be impossible to maintain the volume of work during the holiday season, simply due to lack of sufficient surgical hands. Further, the high level of throughput has been made possible, partly by the presence throughout these winter months of three exceptionally experienced and competent registrars. We cannot expect to have junior staff of such experience and reliability as a general rule in the future. The exceptionally heavy load borne by consultant staff over the winter months has undoubtedly contributed to unsociable hours of working for the whole team, medical, technical and nursing, and this would be better avoided.
>
> 'The proposal is that four surgeons would undertake precisely the work done by the three at present in post, and the timetable of the proposed fourth surgeon is enclosed. Further development in cardiac surgical services will only take place after discussion with all parties involved and will not result directly from the proposed appointment.'[250]

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[250] UBHT 0174 0001; proposal dated 5 July 1989

182 The proposal[251] to appoint a fourth consultant cardiac surgeon was accepted and in 1989[252] Mr Jonathan Hutter was appointed to this position. When Mr Keen retired in 1990,[253] rather than being replaced directly with the appointment of another cardiac surgeon, the funding for his post was used ultimately to finance the position taken up by Professor Angelini in 1992. Dr Roylance explained:

> '… the plan when Mr Keen was retiring, is that we would appoint a Heart Foundation – I think it was the British Heart Foundation – funded Professor and we would use the resources, the salary of Mr Keen to appoint a supporting senior lecturer.
>
> 'It was an arrangement with the university we commonly pursued, and that is the university would pay for a Professor and we would pay for a consultant senior lecturer which was, the university felt, a minimum requirement for an academic unit. As a result of that deal, if you like, the university would have a whole time equivalent of one consultant for their academic purposes and the Trust would have a whole time equivalent for NHS work by each of us paying for an individual and having half their services shared.'[254]

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[251] UBHT 0143 0084 and UBHT 0143 0085; letter from Mrs Willis, B&WDHA to Dr Johnson dated 15 May 1989 with attached job description

[252] WIT 0096 0002 Mr Hutter

[253] WIT 0080 0145 Mr Keen

[254] T88 p. 74–5 Dr Roylance

Chapter 8 – Management and Culture of the UBH and the UBHT

The scope of this chapter

1 The focus of this chapter is the structure and culture of management at Bristol during the years of the Inquiry's Terms of Reference. The Inquiry also had access to authoritative expert evidence on the general managerial pattern in the NHS during the Inquiry period.

2 The chapter will chart the introduction of general management, the purchaser-provider split, the establishment of the United Bristol Healthcare (NHS) Trust (UBHT) and the development of clinical directorates at Bristol.

Dr Roylance's overview

3 Dr Roylance told the Inquiry that, over a period of years, there had been successive management changes designed, in his view, to address the mismatch between resources and demand in the NHS. He saw the introduction of general management to the NHS in the mid-1980s as one such change. In summarising his view of the changes over time, Dr Roylance said:

> 'The National Health Service is characterised by an accelerating gap between what is possible and what is affordable. Unless that fundamental issue is accepted and understood, nothing else makes a lot of sense.
>
> 'Over time, various initiatives to bridge that gap have been instituted. They include first of all, increased funding, and if there were time, I would demonstrate that the more money that is put into the Health Service, the bigger is the shortfall between what is considered possible and what is affordable.
>
> 'So although we all welcome increased funding, it will not bridge the gap.
>
> 'Then there was "Let us manage the Health Service (the Griffiths Report and so on) and make it more efficient, more effective and more business-like". As we have all seen, there is a tendency for that to divert money from healthcare into management. If you have what I call "professional managers" invited into the Health Service, it is not surprising that the amount of management is increased. In my judgment, in many Trusts, they are mostly managing management and not healthcare.
>
> 'Then there is the pious hope that evidence-based medicine would solve the problem and bridge the gap. That was fairly recent, five, six, seven years ago. In my view, all that does is sharpen the argument for more resources, because although

> there may be a slight delay, it will justify enormous expenditure on new developments.
>
> ‘There is the view, the very proper view, that the gap might be substantially reduced by health promotion … in my personal belief, until you separate health promotion – perhaps give it to local authorities as a responsibility – and recognise the Health Service as a disease service, you will not make any progress there …
>
> ‘Could I say that the last initiative – this is part of the background of management – was what I would describe as “concealment” of the shortfall. That is by the GP fund-holding system, where you give the GP the money and he does not send anyone to hospital until he can pay for it …
>
> ‘… a Chief Executive in a teaching hospital trust is constantly assailed with demands for more funds. These are not expressed in gentle terms … there are aggressive demands that patients are dying, the service is unacceptable. This comes in all the time.
>
> ‘In my last year as Chief Executive, the novel idea of clinical governance came in. It was a new idea and it followed the previous corporate governance which crudely could be said, “You must not put your hand in the till”, but clinical governance was a very new concept that the managing authority, the trust and the Chief Executives, should be responsible for the quality of clinical care.’[1]

General management

4 General management was introduced in Bristol in 1985. Dr Roylance was appointed as District General Manager (DGM) of the Bristol & Weston District Health Authority (B&WDHA) on 1 April 1985. He noted:

> ‘The creation of the post of District General Manager (“DGM”) was in response to the reorganisation of the NHS as recommended in the Griffiths Report. It was my responsibility as DGM to introduce the “general management function” in place of the then existing consensus management system.’[2]

He was ‘instructed … to produce a management structure for B&WDHA by 30 April 1985.’[3]

5 At this time the B&WDHA was divided into two ‘Units’, known as Central and South. The Bristol Royal Infirmary (BRI) and the Bristol Royal Hospital for Sick Children (BRHSC) were both part of the former (see Figure 1).[4] The BRI was itself a sub unit and the BRHSC and the maternity hospital were (together) another sub unit.

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[1] T25 p. 162–9 Dr Roylance

[2] WIT 0108 0004 Dr Roylance

[3] WIT 0038 0009 Ms Charlwood

[4] WIT 0106 0012 Mr Nix

Figure 1: Bristol and Weston District Health Authority unit structure

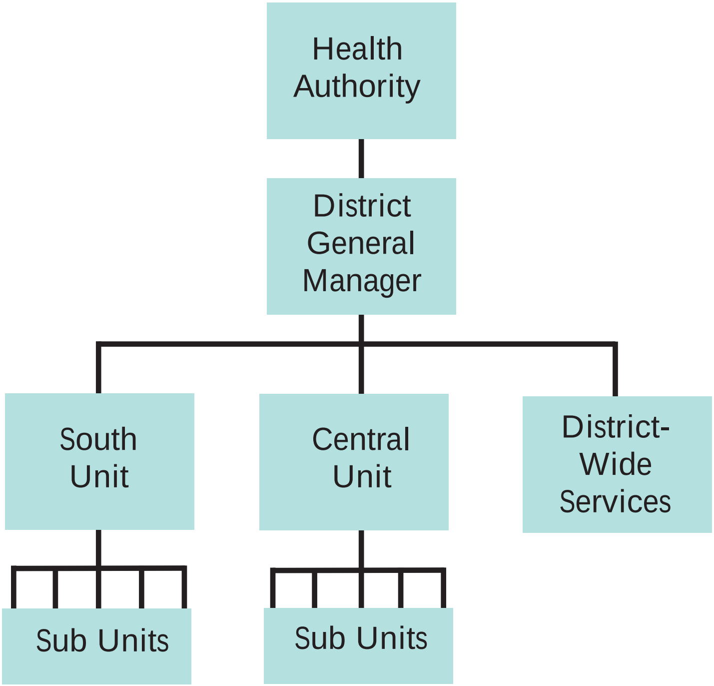
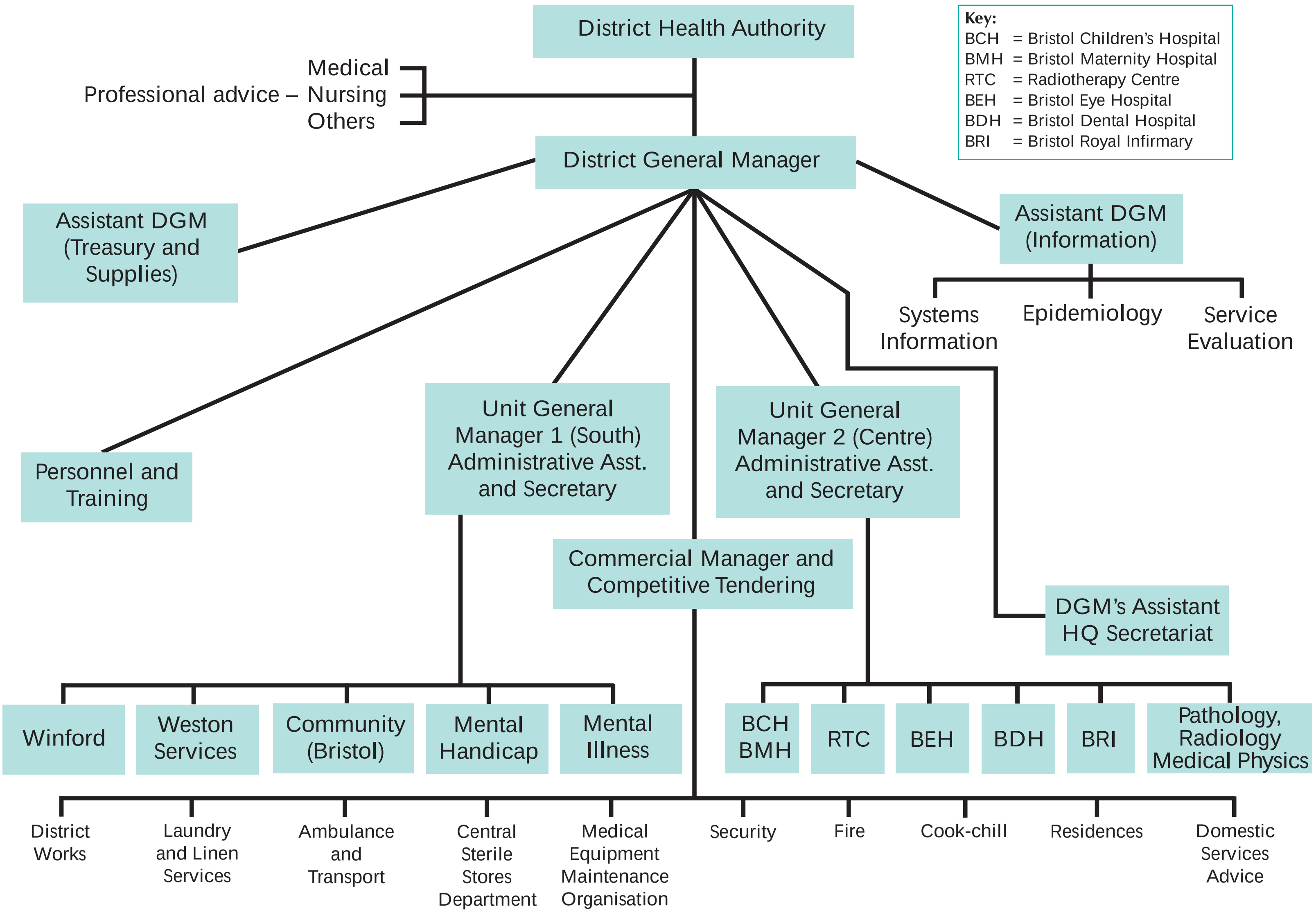


Figure 2: Management structure of B&WDHA, 1985[5]



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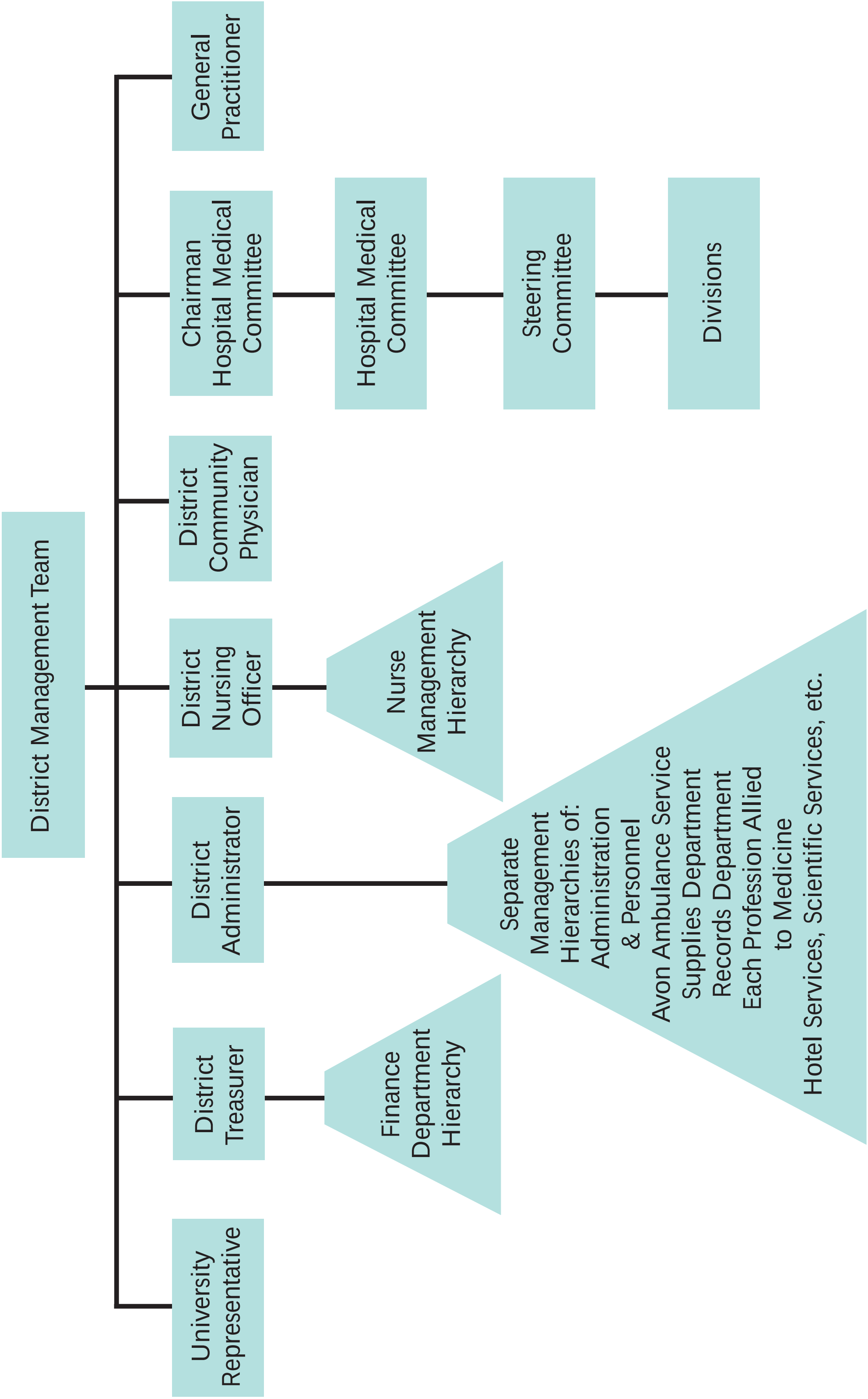
[5] WIT 0038 0067 Ms Charlwood

Figure 3: District Health Authority circa 1985[6]



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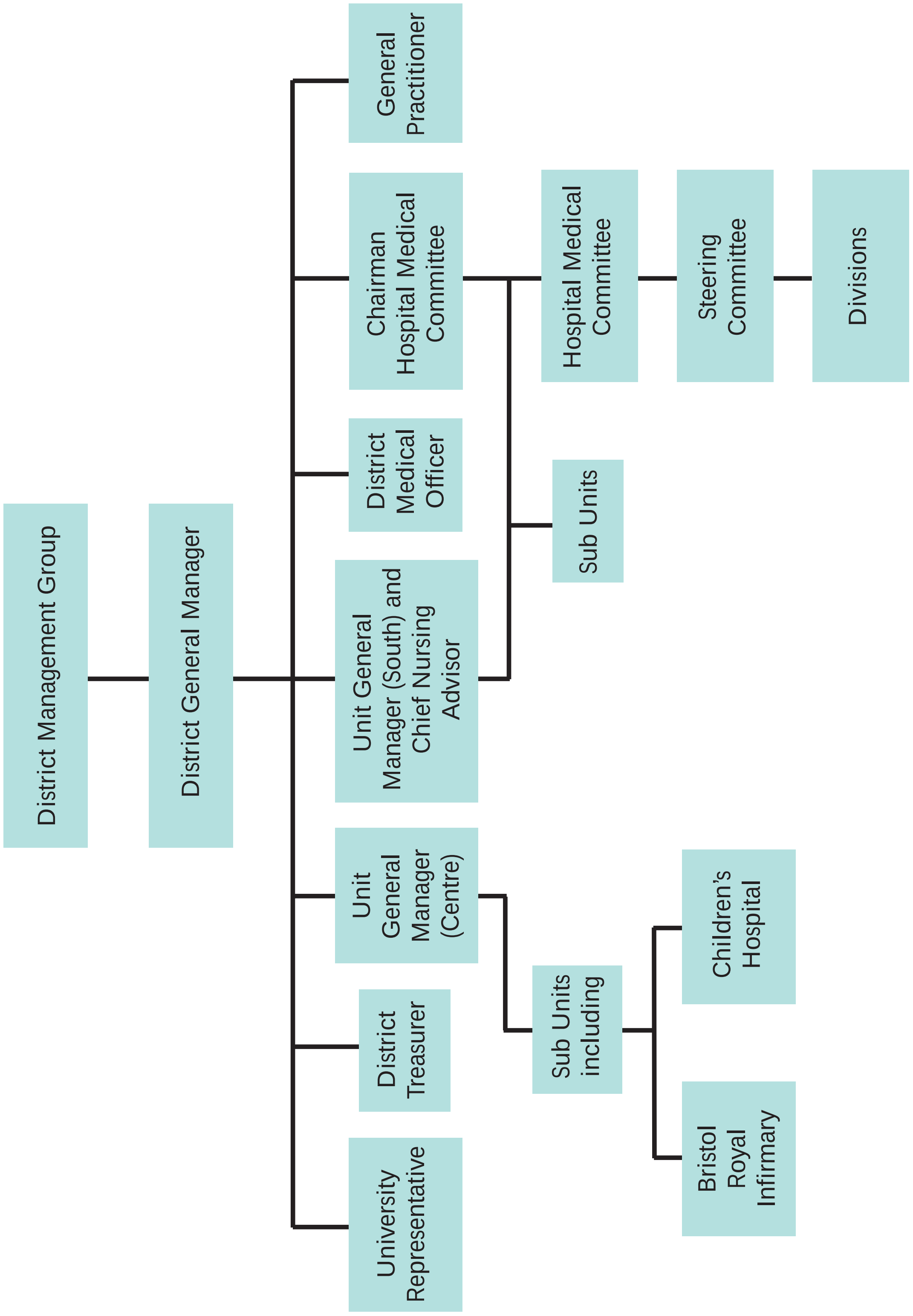
[6] WIT 0108 0040 Dr Roylance

Figure 4: District Health Authority circa 1987[7]



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[7] WIT 0108 0041 Dr Roylance

6 In May 1985 the B&WDHA approved the new general management structure.[8] In oral evidence, Dr Roylance explained the new organisation represented by general management, and his part in it:

> 'So in 1985, being appointed the first Director General Manager, I had two primary responsibilities; there were others, but the two primary responsibilities were to introduce the general management function, by which I mean getting rid of functional management, nurses being managed by nurses, physiotherapists by physiotherapists, administrators by administrators. It could be said at that time when I took up the District General Management role there were about nine different health services in the district coming together only at district level.
>
> 'In introducing the general management function, it was expressly required to delegate operational management decisions as near to the bedside as possible.
>
> 'To relate that to the financial issues that I have just mentioned, the district had been overspending annually by something of the order of a million pounds, which was at that time well over 1% of budget. Until that time, there had been various sources of what the Health Service calls non-recurring money which bailed out the districts at the end of each year and those sources had by then dried up. So in addition to introducing the general management function, it had the very real task of redressing the overspending and ensuring that the health district provided the best possible care from within the finite resources allocated to it.'

7 He added:

> '… It goes without saying that the business we were in was treating patients, was preventing ill health, was diagnosing and treating ill-health that occurred, and offering palliative care where curative care was not possible; that is the business we were in. I was taking it as read that in the reorganisation, that was directed to improving the quantity and quality of that patient care. But my appointment was contingent upon a particular form of management to achieve that, and so the answer to your question; what was the business we were in, what was the organisation to which I had been appointed the District General Manager? It was a healthcare organisation. Therefore, the responsibility of the organisation was my responsibility; that was patient care.'[9]

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[8] See also Chapter 5

[9] T24 p. 9–11 Dr Roylance

8 Mrs Margaret Maisey[10] described the reasoning behind the directorate system in oral evidence:

> 'A. The whole philosophy behind the introduction of Clinical Directors and directorates was to involve medical people in management. Even at the introduction of general management, medical management had stayed the same as it had since 1948, so far as I can make out. It was a separate entity. It managed itself. Clinical directorates was an effort to move those people into a management role, to understand why they could not have the money that they thought they ought to have; why management had to address the issues to satisfy the Department of Health, to whom we were all accountable, which I have to say, doctors did not always believe.
>
> 'Q. I understand one of the key features of the directorate system was that the Clinical Directors who were clinicians were going to be responsible for managing a directorate, they were going to be "in charge of their own show" to a large extent?
>
> 'A. That is right.'[11]

9 Mrs Maisey also described the personal effect of the changes:

> 'The effect on my own career was significant. For example, the introduction of General Management meant that if I was to influence policy and resourcing I had to give up my full-time vocational nursing career which I did when I became a Unit General Manager at the B&WDHA South Unit.'[12]

10 Mr Graham Nix, Director of Finance and Deputy Chief Executive, UBHT, described the effect of the introduction of general management as 'making the top of the pyramid sharper'[13] because:

> 'Prior to this, you would have actually had a district management team with a District Administrator, District Treasurer, public health doctor, and the Chairman of HMC would have actually managed the organisation as a team, working to the Health Authority, rather than in this situation, when Griffiths was making one person responsible for the organisation and its delivery.'[14]

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[10] Mrs Maisey's roles were: South Unit General Manager and District Nurse Adviser (1986–1989); Central Unit General Manager and District Nurse Adviser (1989–1991); UBHT Director of Operations and Trust Nurse Adviser (1991–1996); and UBHT Director of Nursing (1996–1997)

[11] T26 p. 53–4 Mrs Maisey

[12] WIT 0103 0002 Mrs Maisey, who also sets out at WIT 0103 0046 – 0057 a brief history of management in the NHS 1980–1992

[13] T22 p. 17 Mr Nix

[14] T22 p. 17 Mr Nix

11 Dr Roylance explained that, in the early days of general management, doctors were not part of the management structure (although Dr Roylance was himself a radiologist):

> '… we had not, at that time, incorporated the medical staff into the management structure. That was fairly standard throughout the Health Service, which first of all started to create a general management structure, but it did not include the doctors. We evolved this slowly because there was a considerable reluctance and anxiety on a number of the functional management, shall we say, professions allied to medicine, who, up until that time, had a district manager of their professional staff as a separate hierarchy within the trust, and it took time to determine how that could be changed into a professional advisory structure and the members of the profession to be incorporated appropriately into the sub units.'[15]

12 Miss Catherine Hawkins, South Western Regional Health Authority (SWRHA) Regional General Manager from August 1984 to December 1992, did not endorse the selection of Dr Roylance as DGM. She said:

> 'I think it is sufficient to say that he would not have been my first choice for the district management job in 1984 … John Roylance was a brilliant doctor and a very, very good Medical Director, but I did not see him as a General Manager in the true sense of management.'[16]

13 She went on to say:

> '… it was more difficult for him as a doctor managing doctors, and therefore, because he had been there for quite some time, it was very hard for him to appreciate the real role and function of a manager as opposed to being one of the colleagues in a set up of a teaching hospital, which is a very different climate to a non-teaching authority.
>
> '… he did not fully understand the role of a General Manager. He did the best he could, to the best of his ability, but he was not a trained manager in the real sense.'[17]

14 On the other hand, Dr Ian Baker, then District Medical Officer, thought:

> '… that John Roylance was a reassuring District General Manager of longstanding within the District, and I think that helped where other senior managers may have required support … Dr Roylance himself saw himself as a doctor and felt it was appropriate to lead healthcare, health services, provision as a doctor, to accept the

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[15] T24 p. 29 Dr Roylance

[16] T56 p. 21–2 Miss Hawkins

[17] T56 p. 123 Miss Hawkins

> general management challenge and position, and I think he viewed doctors as being in a similar position when it came to clinical divisions and directorates.'[18]

15 In the late 1980s, Dr Roylance was involved in a research project undertaken by Dr Sue Dopson[19] in relation to management matters. Dr Dopson provided the Inquiry with various notes and transcripts of interviews she conducted with Dr Roylance. One extract which discusses the power of his role illustrates Dr Roylance's view of himself as DGM:

> 'It's more in other people's minds than mine. I do my best to tell everybody that I haven't got power, they must do it, but I can actually bully anybody to do anything. I have enormous power which I'm not prepared to use except in very specific situations. I can hire and fire anybody, I don't need to ask anybody's permission for anything.'[20]

16 Dr Dopson commented:

> 'He exercises power primarily through influencing other people, not directly.'

She added later:

> 'He is comfortable with the power, "I believe democracy is a myth, it's based on the belief that the majority have some monopoly of wisdom and they usually haven't. The second thing is people think they understand and they don't."'[21]

17 In Judith Smith and Professor Christopher Ham's paper, commissioned by the Inquiry and entitled *'An Evaluative Commentary on Health Services Management at Bristol: Setting Key Evidence in a Wider Normative Context'* (the Ham/Smith paper), they commented on the fact that it was unusual that Dr Roylance was appointed General Manager. They wrote:

> 'The decision to appoint a doctor (Dr Roylance) as a district general manager was unusual as only 15 of 188 DGMs in England in 1986 came from a medical background (Ham, 1999). Even more unusual was the decision to appoint a doctor from a clinical background to this post. Most of the clinicians who became general manager were appointed at the unit level rather than to district posts; and the doctors who were appointed as DGMs tended to come from public health backgrounds or related posts.'[22]

18 Dr Roylance agreed that he was unusual in being a clinical consultant in general management. He explained that clinicians in general management tended to have a

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[18] T36 p. 38–9 Dr Baker

[19] Dr Dopson is a university Lecturer in Management Studies and a Fellow in Organisational Behaviour at Templeton College, Oxford University

[20] INQ 0027 0023; interview with Dr Roylance, 5 June 1987

[21] INQ 0027 0023; interview with Dr Roylance, 5 June 1987

[22] INQ 0038 0004; Ham/Smith paper

community physician background.[23] He had a wealth of experience in the district and had at one time been the Chair of the Hospital Medical Committee (HMC). He said:

> ‘I really had very intimate knowledge of the district at the time, how it had got there, what the past history was, what the aspirations of people were … I think I knew all the consultants personally. I knew a large number of other people personally, too.’[24]

19 Dr Roylance told the Inquiry that, before general management, the exercise of clinical freedom was independent of resources, and management had to use quite crude measures to try to prevent overspending. He said:

> ‘The exercise of clinical freedom … was entirely independent of resources and … management, up until that point, had to use quite crude measures to try and prevent the major overspending of a service, things like closing operating theatres, closing wards, so it was not possible to overspend, because there was a complete separation of the exercise of clinical freedom from the responsibility of staying within budget.
>
> ‘That is what the general management function was intended to address.’[25]

20 Dr Baker described the management chain in the era of general management, with particular reference to paediatric cardiac services. He said:

> ‘With the advent of District General Management in 1985 management of services was from the District General Manager, Dr J Roylance to the Unit General Manager of the Central Unit (initially Mr J Watson followed by Mrs M Maisey) to Sub Unit General Managers who existed separately for the BRI and BRHSC. Professional advice at District level was given by the Chair of the Hospital Medical Committee. He was fed advice by Chairs of the Clinical Divisions of which there was one for paediatric services and one for surgical services.’[26]

21 In his statement Mr James Wisheart, consultant cardiac surgeon and Medical Director UBHT (1992/94), set out a description of the managerial and medical advisory structures prior to 1990–1991.[27] In relation to management during this period, Mr Wisheart’s description was:

> ‘Within the management structure lines of responsibility were upward through more senior managers, through the General Manager and the District Management Group to the Health Authority. The medical structure was advisory and in

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[23] T24 p. 40–1 Dr Roylance

[24] T24 p. 43–4 Dr Roylance

[25] T24 p. 42 Dr Roylance

[26] WIT 0074 0010 Dr Baker

[27] WIT 0120 0011 – 0012 Mr Wisheart

> management terms did not have any executive responsibility. In practice, of course, the clinicians and the managers worked very closely together.'[28]

22 On the management side, communication was along the lines established by general management. On the clinical side, lines of communication would operate in various ways dependent on the circumstances, for instance outpatient clinics, ward rounds, formal and informal clinical meetings and, where necessary, clinico-pathological conferences.[29]

23 Dr Hyam Joffe, consultant cardiologist, thought that:

> 'Within the BCH [Bristol Children's Hospital] cardiac unit, communication among doctors and between doctors, nurses, radiographers and technologists was entirely satisfactory'[30] and 'Communication between consultant cardiologists at BCH and the consultant paediatric cardiac surgeons at BRI were effective and harmonious.'[31]

24 Mrs Fiona Thomas, Clinical Nurse Manager, in her written statement to the Inquiry, described the arrangement from the point of view of nurses:

> 'As staff nurse, 1986–1988, my reporting lines would have been first to the sister in charge and then to the In-Service Manager. I had very little or no contact with the managers during this time. I do not recall the managers visiting the Unit. The Unit was very much run by the surgeons.'[32]

25 Dr Stephen Jordan, consultant paediatric cardiologist, described the service as:

> '… consultant run and there was little perceived need for outside management involvement except in terms of nursing staff, technical staff and support services.'[33]

26 Dr Joffe described the organisation at the BRHSC when he joined in 1980:

> 'On my arrival in England in 1980, I was surprised to find that there was no hierarchical system among consultants. All consultants were considered equal in status, whether very senior or newly appointed, apart from a certain deference to age. This continued throughout the 1980s until the reforms of 1991, when those consultants appointed as Medical or Clinical Directors gained status and executive power, but only in managerial terms.'[34]

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[28] WIT 0120 0011 – 0013 Mr Wisheart

[29] WIT 0120 0013 – 0014 Mr Wisheart

[30] WIT 0097 0166 Dr Joffe

[31] WIT 0097 0167 Dr Joffe

[32] WIT 0114 0003 Fiona Thomas

[33] WIT 0099 0011 Dr Jordan

[34] WIT 0097 0138 Dr Joffe

27 As to medical and nursing staff, Dr Joffe said that they:

> '… contributed very little to management during the 1980s. Following the establishment of trust status in 1991, their involvement in managerial issues has been much greater.'[35]

28 On paediatric cardiac services in the 1980s, as a whole, he said:

> '… the medical and surgical elements were placed managerially into the departments of general paediatrics and general paediatric surgery, respectively.'[36]

The purchaser-provider split and the establishment of the UBHT

29 The Government's plan for the reorganisation of the Health Service was set out in the 1989 White Paper *'Working for Patients'*.[37] The main thrust of the change:

> '… lay in the creation of a competitive environment through the separation of purchaser and provider responsibilities and the establishment of self-governing NHS trusts and GP fundholders.'[38]

30 The UBHT formally came into existence on 1 April 1991. Thereafter, the UBHT was the 'provider' of healthcare services at the BRI and the BRHSC (and elsewhere) and the B&WDHA (later the Bristol & District Health Authority, B&DHA) was the purchaser of that healthcare.[39] Dr Roylance described his responsibility in these changes:

> 'In 1991 it was my responsibility as District General Manager to divide the District into a continuing District Health Authority, which became the purchasing authority for the District.'[40]

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[35] WIT 0097 0139 Dr Joffe

[36] WIT 0097 0139 Dr Joffe

[37] *'Working for Patients'*. London: HMSO, 1989. (Cm 555)

[38] INQ 0038 0006 – 0007; Ham/Smith paper

[39] See Chapter 6 for a further explanation of the purchaser-provider split

[40] WIT 0108 0005 Dr Roylance

31 Dr Roylance told the Inquiry that, in relation to cardiac services:

> 'The people who decided [what] the pattern of cardiac disease treatment should be … were the purchasing health authorities, not the providers and not the Trust Board.'[41]

He also said:

> 'The decision of whether cardiac services should be increased and that money should be allocated to it at the expense of the allocation of the same money to other services is the sole responsibility of the purchaser.'[42]

32 Ms Deborah Evans[43] explained the position in the District at the time of the purchaser-provider split:

> 'There were many challenges. I think that there was an enormous technical change in the Health Service at that time, which was to do with being able to track all the patients that were resident in a particular Health Authority and to follow them through hospital care and turn all of that into service agreements; but also, looking at the public health side of it, health authorities had a responsibility for the first time only to look at the needs of their local populations and not to be involved in running services. So I think the changes gave rise to an increased and more particular focus on local health needs from a public health point of view, which was helpful, and I think the other side of the separation from the provision of services meant that managers and clinicians had to go through a huge cultural change in getting used to huge organisations working together on the planning of healthcare.'[44]

33 Dr Roylance expressed himself a keen supporter of the purchaser-provider split.[45] However, Dr Roylance emphasised that a trust, as a provider unit, could not dictate what services the health authority should purchase. He said that at times this made strategic planning difficult. Dr Roylance mentioned the split site cardiac service in this context. He told the Inquiry:

> 'There is another strategic plan … and that was to rebuild and reprovide the Children's Hospital. We had to do that on no more than an understanding that the purchasers would continue to purchase children's services from us and indeed some children's services which are currently purchased from others.
>
> 'Q. … I was going to ask you, if it was the case that strategic planning meant no more than being able to respond to that which other people had determined and

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[41] T24 p. 152 Dr Roylance

[42] T24 p. 160 Dr Roylance

[43] Associate Director, and latterly Director, of Contracting for B&WDHA from April 1991, and Director of Contracting for B&DHA from October 1991

[44] T31 p. 23–4 Ms Evans

[45] T24 p. 165 Dr Roylance

their strategic plans, how on earth does one plan a major development such as the development that is just taking place?

‘A. I have to say, with difficulty, and I was very pleased that before I left, plans had reached an achievable position and the Children’s Hospital is being built, but I would not like to minimise the very substantial difficulties with that.

‘Q. So put another way, the planning for the future of the Trust and the hospitals within it may depend upon the reaction of other people, but on the other hand, the reaction of purchasers may to an extent be anticipated and plans placed, formed, on that basis?

‘A. I think that is right. …

‘Q. So there is scope for strategic planning, notwithstanding that whether the plans ultimately come to fruition may depend upon the co-operation of others who hold the purse strings?

‘A. If you strategically plan a new unit like the Children’s Hospital and then do not get contracts for it, I think somebody ought to have the situation discussed with them. I mean, what I am saying here is that the cardiac disease was a major cause of death and demand in the regional services is high and so on, and this is an issue that we are not meeting the demand for cardiac services and we were not committed to developing the service. Of course the Trust is and was committed to developing the service, but only as far as the purchasers were committed to buying that service.

‘Q. … it would no doubt be helpful, would it not, … for the Trust Board or the Trust to have a strategic plan, if it wished to do so, to encourage purchasers to behave so that investment and development of cardiac services might take place?

‘A. That is usurping the purchaser role. That is the provider saying that we, as providers, would like to provide this service.[46]

‘Q. … is there anything intrinsic in the system which means it is the usurpation of the purchaser’s role for the provider to encourage the purchaser to make a particular purchase and anticipate that he might do so?

‘A. Yes. In the decision of the purchaser to place contracts, there is a negotiation. The negotiations, by necessity, are specialty by specialty. What is needed is to influence the purchaser in their determination of the balance of resources they wish to put to each service. … What I think I am trying to say in great detail is that the provider trust has a very real and challenging problem of being in a position to provide whatever service the purchasers in their wisdom decide they need. But it

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[46] T24 p. 155–8 Dr Roylance

> is not the role of the provider as a trust. It may be as members of the public, but as a trust it is not their role to decide the pattern of care that the purchasers should provide. …
>
> ‘Q. … then the provider must necessarily anticipate to some extent the demands which a purchaser is likely to make upon it?
>
> ‘A. Yes, and it is for the directorate who are entering into that sort of conversation to advise the Trust Board what he believes the purchaser might buy.’[47]

Internal opposition to trust status

34 In the period 1989 to 1990 the UBH were considering the move to trust status. In the July 1990 ‘*Application for NHS Trust Status*’, the proposed intention of a move to trust status was summarised as follows:

> ‘The proposed United Bristol Healthcare Trust will take the new opportunities offered under the Act to involve local people more and to develop its services to provide not only the best health care for patients but also the best teaching for doctors, dentists and health care professionals of the future. We have chosen to express these aims of the Trust in the two words “Teaching Care”.’[48]

35 However, not all consultants and hospital staff supported a move to trust status. In fact a majority of the staff were suspicious of the potential change and whether there would be any associated benefits.[49] Mr Peter Durie[50] recalled:

> ‘… there was considerable concern by doctors in particular that somehow the creation of trusts was going to break up the NHS. Those of us who were putting in the application were absolutely convinced that was not so. We were totally committed to the National Health Service and still are, and did not see that this put the NHS at risk at all. We believed that over the months we would be able to persuade sufficient people that the risk they saw did not exist.’[51]

36 As early as 10 May 1989, at a meeting of the B&WDHA Steering Committee, there was discussion about obtaining the views of medical staff towards a move to trust status:

> ‘Dr Thomas advised that he intended to ballot all medical staff in the Bristol and Weston Health Authority to ascertain their views as to whether they wished to support the option of self-government for the UBH [United Bristol Hospitals]. Mr Wisheart considered that the information at present available was insufficient to allow for any informed opinion but that medical staff should still be balloted.’[52]

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[47] T24 p. 160–2 Dr Roylance

[48] UBHT 0060 0006; *‘Application for NHS Trust Status’*

[49] UBHT 0074 0253; *‘Draft Response to South West Region Consultation Exercise on the United Bristol Healthcare Trust Proposal’*

[50] Mr Durie was Chairman of B&WDHA from April 1986 to March 1990 and Chairman of the UBHT from April 1991 to June 1994

[51] T30 p. 56–7 Mr Durie

[52] UBHT 0113 0565; Steering Committee meeting, 10 May 1989

37 At the meeting of the B&WDHA on 18 September 1989:

> 'The Chairman invited Ms Betty Underwood and Mr John Vickery representing the Joint Trade Union Committee of Bristol and Weston staff to talk to the Authority about their views of the Government's White Paper on the future of the NHS.'[53]

38 Amongst the various concerns expressed by these representatives, was whether the views of staff would be heard in the making of major decisions. Mr Vickery said that:

> '... the Authority's staff wanted consultation on important matters. At the meetings with general management, the staff side was always passed information but normally there was no chance to influence decisions and he thanked the Authority, therefore, for the opportunity to put before it the Unions views on the White Paper. In developing the theme of consultation he used the analogy of schools where parents could be balloted as to whether they wished their children's school to become self-governing, whereas there was no such choice in the NHS White Paper. He concluded by saying that the Health Service existed for the benefit of the general public to provide health care at the point of need.'[54]

39 In the interim, the NHS required business plans to be put in place and that the DHAs prepare to separate the purchaser and provider functions. Dr Roylance introduced a paper on changes to the management structure to the B&WDHA at their meeting on 16 October 1989. The minutes of the meeting recorded:

> 'The Secretary of State had asked for business plans to be prepared by the end of March for Bristol health services and Weston health services. These would be the subject of informal consultation during preparation and formal consultation by the Regional Health Authority. It would be submitted to the Secretary of State with the results of consultation and the comments of the RHA.
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> 'Dr Roylance said that he had therefore created three management teams as set out in his paper. No substantive changes to any person's contract would be made until the end of March 1990 and all the changes had been achieved by secondments. Mr Durie said that as a Health Authority, all Members continued to hold the statutory obligations and duties to provide the best health care with the available resources. The White Paper would not be implemented until an Act of Parliament was passed in late 1990 or early 1991.
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> '… Mr Durie confirmed that the Chairman of the Hospital Medical Committee would remain the Authority's formal advisor. He explained that the instructions now being received from the NHS Management Board meant that the Authority would have to divide into the purchaser and provider roles. This was separate from any moves towards possible self-governing status for any part of the District's

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[53] UBHT 0249 0148; B&WDHA meeting, 18 September 1989

[54] UBHT 0249 0149; B&WDHA meeting, 18 September 1989

> services. When the business plans were complete, the Authority would assess whether it considered that self-governing was the correct future for its services.'[55]

40 At a later meeting of the B&WDHA in November 1989, it was noted that:

> 'Through the Dean of the Faculty of Medicine there were extremely good relations with the University and this would remain.'[56]

41 Professor Gordon Stirrat[57] agreed that great efforts were made to include the University in the move to trust status. He said:

> 'I know very well that the then Chairman of the authority, Mr Peter Durie, was extremely anxious to make sure that the University was on board as far as this was concerned. They worked very hard and worked hard with my predecessor as Dean and then subsequently myself to try to make sure that we were part of the application. So that really was my main direct contact.
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> '… I think Mr Durie did a very, very good job of putting the case for the Trust, and I think a great deal of credit goes to him for that, both in relation to my health service colleagues but particularly in the University.'[58]

42 At a meeting of the HMC on 20 December 1989, Mr Stephen Boardman, Director of Planning and Estates, and Mr Nix presented the Bristol Business Plan and discussed it in light of the forthcoming ballot of staff. In the minutes, Mr Boardman is recorded as saying:

> '… that the Business Plan was basically an application for a self-governing trust and that Bristol and Weston amongst many other districts had been invited to submit such applications by the end of March 1990. The alternative to non-acceptance of an application was to have a DHA managed provider unit.'[59]

43 Mr Boardman then went on to explain how the directors of a trust would be appointed:

> '… the Chairman of the Trust would be appointed by the Secretary of State and the five non-executive directors by the Regional Health Authority. The bill allowed for five executive directors who would be appointed by the Chief Executive and Chairman but four of them had to be from nursing, medical, finance and

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[55] UBHT 0249 0144; B&WDHA meeting, 16 October 1989

[56] HAA 0142 0091; B&WDHA meeting, 20 November 1989

[57] Professor of Obstetrics and Gynaecology at the University of Bristol and Honorary Consultant at the UBHT from 1982. He was also B&WDHA Chairman of the Division of Obstetrics and Gynaecology from 1988 to 1990, Dean of the Faculty of Medicine from 1991 to 1993, and Pro-Vice Chancellor from 1993 to 1997

[58] T69 p. 13–14 Professor Stirrat

[59] UBHT 0098 0366; HMC meeting, 20 December 1989

> management leaving only one director who could be appointed without a specific function.'[60]

44 According to Mr Durie, however, it was already known in Bristol who the executive directors would be prior to the inception of the Trust as a 'shadow trust' had been established. Mr Durie explained that:

> 'That was all part of the process of working up the Trust application. Part of it was to show credibility: that if we were given trust status, we had the competence to run this new Trust and those people had already shown their competence in the Health Authority so it was an evolutionary one.'[61]

45 In fact, in the executive summary of Bristol's '*Application for NHS Trust Status'*, much was made of the continuity in leadership:

> 'The style and structure of management in the Trust will be founded on continuing strong leadership.'[62]

46 Dr Stephen Jordan, consultant cardiologist, described the position within the hospital under the auspices of the 'shadow trust':

> '… starting April 1990, we had sort of shadow trusts. Everything was worked out in exactly the same way as it was going to be the following year but no money actually changed hands, if you like, and no one actually physically signed contracts and so on.
>
> 'For the year before that, that is the year beginning 1st April 1989, we were busy drawing up the shadow contract for the following year. We were instructed to do this on the basis of the workload for the previous two years and on the strict understanding that one thing that would not happen would be any … expansion of workload in relation to the new Trust status. I mean this was part of the general "aura" of the new status: that although it was going to sort of start off with the ability to change everything, the promise was it was not going to actually change suddenly and therefore it would be related directly to what was going on before.'[63]

47 Dr Roylance described the benefits of the purchaser-provider split as follows:

> 'When we were at District … we had a finite sum of money, which everybody, including me, agreed was woefully inadequate, and we had what people have described as an "infinite demand"… And this I tried to say is a fundamental challenge to the health service. You do not resolve it by pretending it was not there or wishing it was not there, you have to address it. I believe one of the major steps

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[60] UBHT 0098 0367; HMC meeting, 20 December 1989

[61] T30 p. 25 Mr Durie

[62] UBHT 0060 0011; *'Application for NHS Trust Status'*

[63] T79 p. 163–4 Dr Jordan

> which helped in addressing that issue was to separate the very difficult task of deciding what was necessary from the challenge of delivering what was decided. …'[64]

48 Dr Roylance emphasised his view that it was one of the functions of the purchaser to satisfy itself that the healthcare it was purchasing was producing a maximum benefit for the community.[65]

49 Dr Stephen Bolsin, consultant anaesthetist, wrote to Dr Roylance on 25 July 1990 after having read the '*Application for NHS Trust Status'*. The evidence as to the significance of a comment in the final paragraph of this letter is reviewed in Chapter 25. He was asked about this letter and his attitude towards a move to trust status in the course of his evidence to the Inquiry. He said:

> 'I think my attitude was that I was not necessarily sure that they were going to improve patient care and under those circumstances a change would not necessarily be for the better. I think I was reasonably ambivalent to trust status for the hospital.
>
> '… I think I had not been persuaded by any of the meetings that we had had as anaesthetists or doctors that trust status had advantages for us as clinicians involved in the delivery of patient care.'[66]

50 According to Dr Roylance he had many letters of this kind:

> '… a lot of people spoke to me, to try and evaluate what the impact of trust status was. This was such a letter. I had a lot of them, of people wanting to know whether trust status would make their aspirations more realistic or less realistic and I told them it would not affect that.'[67]

51 At a meeting of the HMC on 16 May 1990, Mr Durie was invited by the Chairman, Mr Christopher Dean Hart, to speak in favour of trust status, and Mr Geoffrey Mortimer, who was at that time the Chairman of the B&WDHA, was asked to state the case for remaining as a directly managed unit. Mr Durie explained why he and Mr Mortimer had been chosen to talk on the issue:

> 'Because Mr Dean Hart knew that I was in favour of what is now UBHT … because of the benefits … Mr Mortimer was the Chairman who took over from me … in 1990. He was strongly opposed to the whole concept of trusts anywhere … Therefore, Mr Dean Hart had somebody who was in favour and somebody who was vehemently against.'[68]

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[64] T25 p. 153–4 Dr Roylance
[65] T25 p. 21–2 Dr Roylance
[66] T80 p. 92 Dr Bolsin
[67] T88 p. 72 Dr Roylance
[68] T30 p. 21 Mr Durie

52 The minutes record that Mr Dean Hart said that:

> '… consultants in Avon had voted overwhelmingly against trust status on the information then available. Since that time further information had been forthcoming from the Department of Health and from those who had been asked to produce a business plan.'[69]

53 Amongst the reasons cited by Mr Durie in favour of trust status were the following:

> 'The size of the proposed Bristol Trust was such that it would make an easier working relationship with purchasers whilst it would also, through its board membership, have a direct relationship with teaching matters. With its non-executive members it would have a much stronger marketing base than other providers and these members would act as a sounding board for proposals from the executive members.
>
> '… the proposed management team for the Bristol Trust had a proven financial and managerial record and he felt that it was right to apply for trust status as early as possible as it was unlikely that the government would allow the first ones to fail.'[70]

54 However, Mr Mortimer was concerned that:

> '… Trusts were a moving target and the government had brought in more controls on them than envisaged in the White Paper and he believed that the capital freedom amounted to very little.'[71]

55 He believed that:

> '… the advantages of directly managed units were that they existed currently and were still evolving and that the purchaser/provider role in such units had been well proven in industry. The retention of the link at DHA and DGM level provided a means of ensuring the overall interests were given priority.' [72]

56 Mr Mortimer resigned shortly after this meeting, in September 1990. Dr Marie Thorne, Head of the School of Organisational Behaviour, Bristol Business School, in her paper *'Cultural Analysis of UBHT'*[73] wrote that this period of transition was characterised by the fact that:

> 'Insecurity, and anxiety increased but solidarity of the Trust group was reinforced by identifying a common enemy. Workloads increased through managing the conflict and attention was deflected from the primary aim.

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[69] UBHT 0098 0258; HMC meeting minutes, 16 May 1990

[70] UBHT 0098 0260; HMC meeting minutes, 16 May 1990

[71] UBHT 0098 0260; HMC meeting minutes, 16 May 1990

[72] UBHT 0098 0261; HMC meeting minutes, 16 May 1990

[73] UBHT 0296 0001 – 0008; *'Cultural Analysis of UBHT'*

> '… Chairman resigns and opposition becomes far more manageable.'[74]

57 When Dr Thorne was asked about this in her evidence to the Inquiry she said:

> 'The "common enemy" I suppose were the resisters, because my understanding was that the idea had been started that they would go for trust status and this was supported I think by the Chairman and the Regional Head of the South West Regional Health Authority, and therefore people were trying to go ahead with this …'[75]

58 According to Mr Boardman, the process of garnering support for the Trust was not just about identifying 'common enemies' but neutralising them. He said:

> '… the unit becoming a Trust was going through significant organisational change. Dr Roylance had to win over the stakeholders in that organisation, the key opinion formers who were the clinicians, and therefore he needed at the very least to keep important opponents neutral. One way to do that is by making sure that if an important opinion former is in an important department which looks like it is going to be swallowed by a larger one, to ensure that did not happen and to allow those opinion forming departments to stay with some degree of autonomy as clinical directorates. That is how I think Dr Roylance handled that significant organisational change …'[76]

59 A ballot of consultant medical staff was taken in January 1990:

> '… on the question: "With the present information, do you support any attempts to convert your hospitals into the whole or part of a self governing trust or trusts?" On an 88% response, 81% of Bristol consultants voted "No" against 11% "Yes". In a March 1990 ballot, general practitioners in Avon voted on effectively the same question and on an 81% response, 77% voted "No" with only 8% replying "Yes".
>
> 'There is little indication of any significant subsequent change in this balance of opinion within the Bristol section of the District.' [77]

60 These figures come from a July 1990 report of the B&WDHA Member Committee to Review Draft NHS Trust Applications. This Committee was appointed by the B&WDHA in April 1990 to review the proposals for trust status and make recommendations.[78]

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[74] UBHT 0296 0002; *'Cultural Analysis of UBHT'*

[75] T35 p. 95 Dr Thorne

[76] T33 p. 51–2 Mr Boardman

[77] HAA 0141 0045; report of Member Committee, 16 July 1990

[78] HAA 0141 0043; report of Member Committee, 16 July 1990

61 It was noted in the July 1990 report that the following were of concern:

> 'Absence of a clear strategy for the future in the proposal is a source of concern to many people, particularly those who feel that their specific service interests do not appear to be in the forefront of the sponsor's thinking … whilst the University clinical professors have noted that "there is very little mention of teaching and almost none of research in the Trust documents". There is a feeling that the sponsors' objectives have not been thought through beyond the achievement of independence and corresponding concern as to where this may lead.'[79]

62 The report noted that:

> '… the Committee heard a near-unanimous view that the Bristol Provider Unit is not ready for Trust status against an April 1991 timetable.'[80]

63 In a later ballot in around October 1990, of the 131 votes 66 were still in favour of remaining as a directly managed provider unit.[81] Mr Durie believed this attitude still prevailed as:

> '… in the papers there was a lot of very wild statements about the freedom of trusts and what the trusts would do. There was comment about trusts would cut the amount of money paid to nurses and everybody else.
>
> '… Doctors … they are very busy people. Their main concern is treating patients. They were not involved or wishing to be greatly involved in the real pros and cons, and if they were reacting to what they read in the press, I am not surprised if they were coming out against it.' [82]

64 However, the B&WDHA '*Draft Response to South West Region Consultation Exercise on the United Bristol Healthcare Trust Proposal*' came to the following conclusion:

> 'The Authority supports the proposal to establish an NHS Trust for UBHT services and recommends the Regional Health Authority to commend to the Secretary of State that such a Trust to be established to commence on 1st April 1991.'[83]

65 The paper also concluded that:

> '… whilst management need to have due regard to continuing anxieties expressed by staff, the ballots should not be regarded as the sole reason for refusing Trust status. In particular, the Authority is not convinced that the Trust issue, for many

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[79] HAA 0141 0046; report of Member Committee, 16 July 1990

[80] HAA 0141 0047; report of Member Committee, 16 July 1990

[81] UBHT 0074 0266; October 1990 Ballot

[82] T30 p. 58–9 Mr Durie

[83] UBHT 0074 0257; *'Draft Response to South West Region Consultation Exercise on the United Bristol Healthcare Trust Proposal'*

> staff, is clearly understood and separated from more general views about NHS reform.' [84]

66 Other conclusions of the Authority about the proposal to become a trust included the following:

> '1. An NHS Trust is the most beneficial environment within which to manage the new contractual arrangements, and offers the greatest opportunity of delivering benefits to patients.
>
> '2. There are financial, personnel and other management benefits which arise out of Trust status. Although these advantages are difficult to predict, and individually may be marginal, they could, taken together, be significant.
>
> '3. The Health Authority has full confidence in the ability of its managers to manage an NHS Trust.'[85]

67 The Trust eventually came into being, despite reluctance on the part of many of the consultant staff. Mr Roger Baird, consultant general surgeon, said:

> '… if you are the Chief Executive or whatever and you work out how it has to happen, obviously you listen in a reasonable way to what other people say, but in the end, are responsible for it. …
>
> 'I suspect he [Dr Roylance] worked out with his management team what the best deal was going to be for us, and then he had to sell it to us.'[86]

68 Further, Mr Baird said:

> 'The great thing about John Roylance was that at least we all knew where we stood. Quite honestly, most of the clinicians just wanted to get on, and still do, with treating patients. If they trusted him, as we did, and he said this was the way to go, then with one or two exceptions, which he was able to deal with, he was able to get his own way.'[87]

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[84] UBHT 0074 0255; *'Draft Response to South West Region Consultation Exercise on the United Bristol Healthcare Trust Proposal'*

[85] UBHT 0074 0256; *'Draft Response to South West Region Consultation Exercise on the United Bristol Healthcare Trust Proposal'*

[86] T29 p. 47 Mr Baird

[87] T29 p. 53–4 Mr Baird

The development of the clinical directorate structure

69 By 1989 a clinical directorate management structure was beginning to develop in Bristol, in response to national encouragement[88] and the impending introduction of the purchaser-provider split and NHS trusts as the providers of acute healthcare.

70 In the Ham/Smith paper, the reason behind the adoption of the clinical directorate structure was explained:

> ‘The principle behind the clinical directorate model is that these “semi-autonomous units”, based on a medical specialty or group of specialties, enable full budgetary and clinical decision making to be combined in a single entity … The model was believed to offer the most appropriate way of building on the principles of the Griffiths Report in relation to devolution and accountability, and to offer a way of properly engaging medical and other professional staff in the management of NHS trusts.’[89]

71 The paper went on to describe what was happening at the time in the national context:

> ‘In the early 1990s, some large NHS Trusts elected to have as many as sixteen clinical directorates (Disken et al., 1990), the rationale for this being to maximise the involvement of senior medical staff in the management of the Trust. In these cases, directorates were usually grouped into collectives of directorates sharing a general manager and other administrative functions. The more usual number of directorates, however, was between six and ten, the reason being that most organisations felt they could not afford the management costs associated with a greater number of directorates, along with concerns about coordination and control.’[90]

72 In conclusion, Ham and Smith said that the UBHT had gone further in emphasising the involvement of clinicians in management in two ways:

> ‘First, the approach adopted was one of maximum delegation to directorates from an early stage in their evolution. And second, the central management of the trust was kept light to give the directorates as much scope as possible to take on their new responsibilities.’[91]

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[88] T24 p. 45 Dr Roylance

[89] INQ 0038 0011; Ham/Smith paper

[90] INQ 0038 0012; Ham/Smith paper

[91] INQ 0038 0023; Ham/Smith paper

73 In due course, with the introduction of the purchaser-provider split and with the institution of the UBHT, the clinical directorates came to acquire a key role in the managerial structure of the UBHT.

74 As to the local view, Dr Roylance said:

> ‘In the 2 years of preparation before the establishment of Trust status, a number of further management changes were made. The most significant of these was the creation of some 12 Clinical Directorates, each managed by a Clinical Director, who was a consultant, and a General Manager … The aim was for the Clinical Director to be “in charge of” the doctors and for the General Manager to be responsible for everyone else, and to ensure that the necessary administration and support services were in place for the Directorate to run efficiently.’[92]

75 The change from general management to trust status with clinical directorates took place with many of those who had held responsibility in the general management structure remaining in management positions. It was said by Ham and Smith in their paper that:

> ‘The management arrangements put in place for the shadow trust, and subsequently the NHS trust, built on those that had gone before, and there was continuity of personnel between the pre and post trust structures. The main change implemented during this period was the further development of a clinical directorate approach as part of the changes to management arrangements that stemmed from the introduction of management budgeting and resource management across the NHS as a whole.’[93]

76 The view of the purchasing DHA was given by Ms Evans in her written statement:

> ‘Prior to UBHT becoming operational in April 1991, a management system of clinical directorates was proposed. This was an approach which became almost universal across acute Trusts in the NHS, and may have stemmed from a widely publicised initiative to involve clinicians in management at Guy’s Hospital, London (described in *“Managing Clinical Activity in the NHS”,* C Ham and DJ Hunter, Kings Fund 1988).’[94]

77 This clinical directorate system was a significant change in that it deliberately drew clinicians into management. The UBHT had a system involving some large directorates with sub-directorates within them:

> ‘... from the point of view of a purchasing Health Authority, this directorate system provided us with clear managerial and clinical points of contact.’[95]

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[92] WIT 0108 0006 Dr Roylance

[93] INQ 0038 0007; Ham/Smith paper

[94] WIT 0159 0010 Ms Evans

[95] WIT 0159 0010 Ms Evans

78 Dr Thorne's evidence emphasised that the clinical directorates were intended to be one of only three formal layers of organisational structure in the Trust. The others were the Trust Board and the individual ward level. She described the changes as follows:

> 'The commitment to put patients first was reflected in the way that the changes in organisation structure were described – as an inversion of the normal managerial hierarchy. The staff at HQ were presented at the bottom of the hierarchy acting as a support to the other layers, whilst patients were placed at the top with all the front line staff who "served their needs". This was an attempt to signal that the senior managers saw the delivery of healthcare as the most important part of the organisation's work. The organisation structure was reduced to three formal layers: Trust Board; Clinical Directorate; and ward level. This was to create clear lines of accountability, improve the speed of decision making and communication and to speed up the rate of change.'[96]

79 Mr Durie was asked about the directorate system:

> 'Q. Let us take the most important manager in the directorate, the General Manager of a directorate; their objectives would be met, therefore, by the Clinical Director in conversation with the General Manager, against a background of the ethos set by the Trust Board. Is that a fair summary?
>
> 'A. I am not sure. Why I am saying that is that I would not be directly involved in that process, so I am guessing exactly what the Chief Executive and the Personnel Director and Clinical Directors decided they would do. They would be meeting monthly and I would expect them to be talking about this objective-setting at some of those monthly meetings.
>
> 'Q. So you cannot tell me exactly what went on, but that is what you would have expected?
>
> 'A. I would have expected that it was not done in isolation at Clinical Director level: there would be input certainly from personnel and probably from the Chief Executive as well.
>
> 'Q. So the key concept in the actual running of the Trust was the clinical directorate system?
>
> 'A. They were essentially – yes. By having the clinical directorates, they were the people treating patients and providing the healthcare.
>
> 'Q. And the Clinical Director was given this new role as I think in your analogy, which Mr Wisheart says is a reasonable analogy, but like all analogies not perfect,

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[96] WIT 0171 0006 – 0007 Dr Thorne

they were the Chairmen of the directorate and the General Manager was the Chief Executive of the directorate?

‘A. Yes.

‘Q. So the leadership qualities of the Clinical Director, managerial and leadership qualities, would be very important to the success of a directorate?

‘A. Correct.

‘Q. How did the Trust satisfy itself that the Clinical Directors or assistant Clinical Directors had the necessary leadership as opposed to clinical qualities?

‘A. The Chairman of the Hospital Medical Committee and the Medical Director, who quite often were the same person, and Dr Roylance as Chief Executive with his medical knowledge and background, knew well the strengths and weaknesses of the various consultants in all the specialties. It was important initially to try to ensure that the person who became the Clinical Director was somebody who was respected by his peers.

‘You also try to ensure that that individual was also ready to be numerate and likely to be a good leader, so there were really three factors all interwoven in deciding who should the right person be.

‘Q. That decision was Dr Roylance’s decision?

‘A. He made the final decision, but in fact again the process came about from a lot of talking and discussion with the people concerned who knew what was happening in that area.

‘Q. Did you as Chairman or the Non-Executive Directors have any role in the appointing of Clinical Directors, in the selection of them?

‘A. No. I say “no”; as Chairman you are overall responsible for everything, but I do not remember – I cannot recall now being involved in discussions, although I might have been. If there was a discussion about should it have been A or B in a certain specialty, I could have been brought in on that discussion informally, but I do not recall it.

‘Q. To what extent is it fair to say that the Clinical Directors of the Trust in 1991 were all existing senior clinicians at the – let us take the Bristol Royal Infirmary – at the Bristol Royal Infirmary with whom Dr Roylance had worked closely for a number of years?

‘A. The answer is, “yes”; because he had been there a long time, the answer to the second half is “yes”, too.

> 'Q. There was no Clinical Director who did not fall into that description?
>
> 'A. Not initially. I think it is worth enlarging why not. There was considerable suspicion among consultants in particular about the move to Trust status. I think they had some reason, because there had been very wild remarks being made politically about what might happen in Trusts and the freedom they might have.
>
> 'That being so, it was important to try to ensure that the Clinical Directors had the confidence of those working under them.'[97]

80 Professor John Vann Jones[98] compared the relative positions before and after the institution of the UBHT. He stated:

> 'The new Directorate structure gave some financial freedom to Directorates, to determine how their resources would be utilised, and to determine their own priorities for developing services, benefiting directly from cost savings and efficiencies within the Directorate …
>
> 'Before the advent of Trusts it was necessary to put forward a case for any development. This was very cumbersome and slow because it had to be considered at area or regional level, and it had to be fitted into area or regional policy. The concept of Trusts produced a little more flexibility. For example Clinical Directors identified their own priorities.'[99]

81 Ham and Smith in their paper argued that:

> 'The board took an approach of delegating authority as far as possible, confirming the clinical directorates as the core units of management in the trust.[100] For this purpose, the trust was divided into thirteen clinical directorates, the clinical director of each directorate was a medical consultant, and this role was seen as that of a "non-executive chairman of the directorate" ... The trust board sought to delegate to directorates the authority they needed to manage their services, wishing to avoid becoming bogged down in operational detail and hence having time to focus on major issues.'[101]

82 Mr Wisheart described the directorate system after 1991 in his statement:

> 'The Directorates or, perhaps, the sub-directorates were "the functional units of the Trust", inasmuch as they provided an identifiable package of service to the patient, or for the purpose of contracting. The Clinical Directors and the Associate Clinical Director had the main role of leadership within this framework together with their

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[97] T30 p. 29–32 Mr Durie

[98] Consultant cardiologist, BRI; Professor Vann Jones was the Clinical Director for General Medicine from 1 October 1989 until 30 September 1993

[99] WIT 0115 0002 Professor Vann Jones

[100] INQ 0038 0008; Ham/Smith paper citing WIT 0086 0006 Mr Durie

[101] INQ 0038 0008; Ham/Smith paper citing WIT 0086 0006 Mr Durie

> Directorate General Manager and Nurse. Their duties included management responsibilities for which they were formally responsible to the Chief Executive. Clinical Directors initially were usually senior doctors but, in principle, could have been from any discipline, medical, nursing or the professions allied to medicine. The Clinical Directors exercised leadership in the management of the Directorate including the organisation of its clinical work. However the Clinical Director was not responsible for the manner in which consultant colleagues exercised their clinical freedom and responsibility in relation to the care of their individual patients.
>
> 'Within each Directorate or sub-directorate the executive group of three would meet as required and in addition it was usual for there to be a larger meeting of the staff working within that Directorate. In cardiac surgery, this larger meeting was called the Cardiac Surgical Board. It was a more formal expression of the teamwork that had existed before and … included at least representatives for all the groups working within the Directorate. This board, therefore, gave the non-medical voices a stronger say than they had before.'[102]

83 Mr Boardman told the Inquiry that he thought that 13 (the initial number of directorates) was too many :

> 'Through my subsequent experience with the NHS management executive, and as a specialist management consultant, it was clear that many Trusts operate with fewer directorates. In my opinion 13 was too many and consequently Dr Roylance did not appear to have proper control over them. He almost encouraged directorates to be loosely affiliated to the Trust. For example, each directorate formulated its own business plan with little central direction, and essentially all 13 plans were then bundled together. There was no real overall corporate strategy/planning … UBHT always delivered financially (Dr Roylance was known to run a tight ship and thus UBHT appeared to be well managed), but in other aspects the plan was not coherent.'[103]

84 Mr Boardman went on to say in his supplementary statement to the Inquiry:

> '… I should now like to say that with hindsight I realise it would have been possible to structure the organisation with a smaller number of clinical directorates. I remain of the view that overall there was no real overall corporate strategy or planning and in this sense, Dr Roylance did not appear to have control over the clinical directorates.'[104]

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[102] WIT 0120 0016 Mr Wisheart

[103] WIT 0079 0007 Mr Boardman

[104] WIT 0079 0281 Mr Boardman

85 Dr Roylance rejected this criticism. He said:

> 'It is not true to say there was any difficulty because of numbers in supporting and developing 13 Clinical Directors and their General Managers.'[105]

86 Further, when asked if he could have had fewer directorates within the UBHT, Dr Roylance said:

> 'No. If there had been an anxiety about numbers, the only managerial step I could have taken would have been to put an intervening level of management and put an assistant chief executive managing six seats, so to speak. There was no way I could put together two directorates and pretend they had a single interest.'[106]

87 When Mr Boardman was asked whether a smaller number of clinical directorates would have been better, he replied:

> 'That is a value judgement. I am not saying it would be better. I am saying there were other ways of doing it, and there are benefits but also non-financial costs to doing it with a smaller number. I think with a smaller number, some of the coordination would have been easier … it is not for me to say which is better or worse, but rather that there are other ways of organising and you have to weigh up the costs and benefits of that way of organising.'[107]

88 Mr Robert McKinlay, Chairman of the UBHT Board 1994–1996, agreed with Mr Boardman 'that coordination would be a problem with such a large number of directorates'.[108]

89 Bristol traditionally had had small central management with devolved management units. Ham and Smith in their paper described Bristol in the era of general management thus:

> '… a structure of two main units and eleven sub-units was preferred to a structure of say five units … BWHA apparently preferred to have a smaller general management core (the district general manager and two unit general managers [UGMs]) and a greater number of devolved sub-units of management.'[109]

90 One of the reasons advanced to explain why Dr Roylance did not find it difficult to support and develop the 13 clinical directorates was that all of the responsibility for

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[105] T24 p. 67 Dr Roylance

[106] T26 p. 12 Dr Roylance

[107] T33 p. 49 Mr Boardman

[108] WIT 0079 0279 Mr McKinlay

[109] INQ 0038 0005; Ham/Smith paper

running the directorates rested with the clinical directors and their general managers. One of the general managers, Mrs Rachel Ferris, recounted:

> 'My experience led me to believe that it was accepted in management circles that Dr Roylance was known for saying "don't give me your problems, give me your solutions." All my peers were told that responsibility for dealing with issues must be pushed back to the Directorates. My perception was that if this did not happen, then it was seen as a failure on the part of the Manager … I saw Mrs Maisey's role as controlling the General Managers in order that Dr Roylance could get on with other things …'[110]

91 Ms Evans explained that the clinical directorate structure at the UBHT was more fully developed in the period 1991–1995 than in some other trusts. The reasons for this, she felt, were:

> 'Two things, really: one is in terms of a system whereby clinicians were the Clinical Directors responsible for a specialty or group of specialties, and were thereby very much involved in the management of those specialties, but also very much involved in the dialogue with purchasing health authorities about what the Trust should be providing and how that might work …
>
> 'The second one would be something about the implications of a clinical directorate structure for the management of a trust, and, in the UBHT's case, being such a large trust with so many specialties, that led to a fairly federal structure of clinical directorates … it made good sense to have strong local management at directorate level.'[111]

92 There were regular meetings between the various levels of management. This was reported in the Ham/Smith paper as follows:

> 'The general managers in the clinical directorates, who were accountable directly to the chief executive, met regularly with the director of operations/chief nursing adviser in the executive management group. The trust's executive directors met in the executive directors group … on a weekly basis.'[112]

93 Further, 'The director of operations did take on a key role on behalf of the chief executive in working alongside directorate general managers.'[113]

94 As for the clinical directors, they:

> '… met on a monthly basis with the chief executive and medical director in the clinical policy board/management board. The involvement of the clinical directors

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[110] WIT 0089 0032 Mrs Ferris

[111] T31 p. 12–13 Ms Evans

[112] INQ 0038 0008; Ham/Smith paper

[113] INQ 0038 0013; Ham/Smith paper

> in the mainstream management of the trust appears to have been dependent on the role of the chief executive as go-between and lynchpin between the directorates and the central management.'[114]

95 Mrs Ferris, as the General Manager of Cardiac Services from November 1994, described how she saw the lines of accountability:

> 'Within cardiac services, I perceived that I was working very closely with the Clinical Director, the relationship with the Clinical Director was such that … we considered ourselves to be sort of a unit; we worked together very closely, so I was obviously accountable to the Clinical Director, but it was not like that in terms of our general work. I did not see a line management relationship between me and the Clinical Director of cardiac services. I perceived us as a unit that worked closely together. Beyond that, I saw myself as accountable to Margaret Maisey, and I saw the Clinical Director as accountable to John Roylance.'[115]

96 As for other groups, physiotherapists were responsible through their professional head to the Trust's Director of Nursing who was also responsible at Trust level for the Professions Allied to Medicine. Perfusionists were responsible to both the surgeons and, particularly, to the anaesthetists.[116]

97 Mr Wisheart's view was that, from the time of setting up the Trust, there were defined lines of responsibility and accountability from the Associate Clinical Director to the Clinical Director to the Chief Executive. This included management of the framework structure within which patient care was provided but did not include details of how an individual patient was cared for nor how any individual consultant exercised their clinical duties. In relation to accountability, Mr Wisheart was of the view that:

> '... in the period 1990–95 accountability increased for doctors in relation to their management responsibilities. Each consultant was responsible to the Associate Clinical Director, who in turn was responsible to the Clinical Director, the Chief Executive, etc. Each doctor became more conscious of their obligation to openly review their clinical work within the audit process, but there was no *routine* requirement to report the findings of audit outside the audit group.'[117]

98 Dr Roylance described the development of the system of devolved management:

> 'In the many discussions about the interrelationship between the Directorate General Manager and the Clinical Director, the suggestion emerged – I remember who made it – that we should not argue about who was accountable to whom; that was a sterile conversation; we should put them in the managerial bubble and say

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[114] INQ 0038 0017; Ham/Smith paper
[115] T27 p. 16–17 Mrs Ferris
[116] WIT 0120 0021 Mr Wisheart
[117] WIT 0120 0026 Mr Wisheart (emphasis in original)

> between them, they would manage the directorate. That is how it started. The bubble was accountable to me.
>
> 'As time went on, over the next three years or so, it became clearer that the Clinical Director would be accountable to me and the Manager would support the Clinical Director, so that was an evolutionary thing, but it was in order to overcome considerable anxieties. You will remember that for the very first time we were introducing consultants into the general management function.'[118]

The role of clinical director

99 Dr Roylance told the Inquiry that:

> '… the Clinical Director was responsible for everything that happened in his directorate. He had a substantial amount of support, but in terms of accountability, he or she was accountable to me for the proper conduct of affairs within the directorate. So the accountability line was quite clear.'[119]

100 Professor Vann Jones was one of several clinicians to give evidence of the burden which being a clinical director placed on a consultant. He said:

> '… I still had to take care of my heavy clinical load, both in cardiology and in general medicine, as well as maintaining my research and teaching commitments. No help was forthcoming from the Trust for the additional load of Clinical Director.'[120]

101 Mr Baird, who was at one time Clinical Director for Surgery, was also asked about the responsibilities that came with being a clinical director:

> 'Q. Clinical Directors had relief, did they, from their clinical duties in terms of not having to do sessions per week – some sessions?
>
> 'A. Well, most of them did what they did before and just worked a bit harder. I mean, some of them gave up something …
>
> 'Q. So in 1989–90 the rule, rather than the exception, was for people such as yourself to work in effectively your own time and for nothing?
>
> 'A. I can only speak for myself, because I know that other people, even Associate Clinical Directors within my directorate, accepted extra sessions to do that work, but I chose not to and it did not bother me much … Traditionally, we have, if the week is considered 11 half days, which is what it is in contract terms, perhaps about half of that is fixed and the other half is flexible for things like emergency

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[118] T24 p. 49–50 Dr Roylance

[119] T24 p. 74 Dr Roylance

[120] WIT 0115 0003 Professor Vann Jones

> duties, administration, teaching, research and so on. I used to fit my work as Clinical Director into that time. And even if I was, for example, as I was this morning, at a fixed clinical session, you can still pop in and keep things going in-between times. You can keep the kettle boiling, you know.
>
> ‘Q. So what you are describing is a situation in which people, because they were working for the greater good, would carry out a full clinical load and do whatever work they may have had as Clinical Director on top?
>
> ‘A. Yes.’[121]

102 However, Dr Roylance outlined measures designed to ease the burden on clinical directors. He said:

> ‘There was a national agreement that doctors assuming such roles as Clinical Director could either be paid two additional sessions’ salary in respect of the out-of-hours work, the extra work they were going to do, or that money could be used to employ a locum to do part of the incumbent’s work. So the national agreement was that for a job like Clinical Director, across the week there were two additional sessions of work that could and would be funded. I do not remember about individuals, but I do know that some Clinical Directors accepted the additional pay and put in the additional hours; some used the money for a locum to take some of the burden from their shoulders, and some declined either and said they would take it all in their stride. But the choice was theirs.’[122]

103 The clinical directors met monthly as the ‘Management Board’. Its function was explained by Dr Roylance:

> ‘It was not an Executive Committee that itself made decisions. In the general management philosophy, the General Manager or in this case the Clinical Director who was assuming the General Manager function had to retain personal responsibility for the decisions that were made and it was not possible to let them fudge it and say “Nothing to do with me, the Management Board made the decision”.
>
> ‘… doctors up to that stage actually made policy and we had to slowly develop the idea that it was the Trust Board that agreed policy, on the advice of the management, through the Management Board, and the professions through professional advisers, so that it was a properly made decision, but this was a communication function in which I made sure that at least once a month I would meet them all together and we would discuss issues and they would discuss issues from their point of view and, as I say, resolve issues which transcended the directorate structure.’[123]

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[121] T29 p. 61–3 Mr Baird
[122] T24 p. 91 Dr Roylance
[123] T24 p. 63–4 Dr Roylance

104 Some of the clinicians chosen to be clinical directors or associate clinical directors had little in the way of managerial experience. One such person was Mr Janardan Dhasmana, consultant cardiac surgeon, who was the Associate Clinical Director of the Associate Directorate of Cardiac Services from January 1993 to September 1994. Both Mrs Ferris, the General Manager for Cardiac Services, and Mrs Fiona Thomas, the Clinical Nurse Manager for Cardiac Services, recalled his problems in chairing meetings. Mrs Fiona Thomas said:

> 'He was not quite sure when to stop people from talking and how to stop arguments.'[124]

105 Mrs Ferris said that he:

> '… found it difficult to chair meetings and to ensure that decisions got made. This was particularly so where there was open conflict or even hostility in meetings.'[125]

106 In her oral evidence to the Inquiry, Mrs Ferris said:

> 'My recollection is that Mr Dhasmana deferred on a number of occasions to Mr Wisheart. Mr Wisheart was very experienced at managing meetings; he was very good at managing meetings. He often allowed Mr Wisheart to do that, because he found it difficult.'[126]

107 Both Mrs Ferris and Mrs Fiona Thomas said Mr Wisheart would intervene at these moments and that Mr Dhasmana would defer to him. Mr Dhasmana explained that this was because he:

> '… had no such earlier experience and had asked Mr Wisheart for his advice and help … Mr Wisheart did not take over as a chairman but tried to play an elder statesman's role in order to resolve differing views after a prolonged discussion.'[127]

108 Mrs Ferris also felt that Mr Dhasmana did not fully comprehend all the issues facing her as a general manager. She said:

> 'I expected to be able to discuss with my Clinical Director, the strategy and planning issues and the decisions that needed to be made before meetings took place. I found that it was not possible to do this with Mr Dhasmana. I also felt that he found it difficult to understand some of the concepts with which I, as General Manager, had to work. This essentially involved working within the existing system for the benefit of the services that we were offering to patients. I needed to focus on

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[124] WIT 0114 0008 Fiona Thomas

[125] WIT 0089 0017 Mrs Ferris

[126] T27 p. 75 Mrs Ferris

[127] WIT 0114 0043 Mr Dhasmana

> what was required of us under contracts, targets and other budget matters, but Mr Dhasmana found these issues difficult to understand.'[128]

109 Mr Dhasmana, on his appointment to the post of Associate Clinical Director, attended a course on 'Management skills for the newly appointed consultant'. He was not provided with a job description or written guidelines to assist him in carrying out his new managerial responsibilities. Mrs Ferris said she found it:

> '… surprising he was not given any guidance in how he should be effective in the Associate Clinical Director role. The course he attended would not have given him anything like that, although I am aware that the role of the Associate Clinical Directors, and indeed the Clinical Directors, was still very much evolving and developing and in fact, the Clinical Director roles did differ from directorate to directorate, depending on the style of the directorate, the style of the clinicians … but I would be concerned that he had not received any guidance.'[129]

110 Professor Vann Jones, although he had managerial experience as the Clinical Director for General Medicine from 1 October 1989 to 30 September 1993, was reluctant to serve when asked to become the Clinical Director for Cardiac Services. He said:

> 'During 1993 the Chief Executive of the new Trust (formed 1 April 1991) had started to discuss the possibility of creating disease based Directorates. The first two to be considered were cardiac services and gastroenterology. In the absence of an obvious alternative candidate I reluctantly agreed to become Clinical Director of Cardiac Services. Again, I was the first Clinical Director of a new Directorate. I started in mid October 1993 and continued until the spring of 1996.
>
> 'In its initial stages, the Directorate of Cardiac Services was little more than a concept … I and my General Manager, Lesley Salmon, had to try to establish what form the new Directorate of Cardiac Services would take.'[130]

111 Mrs Ferris was also critical of the lack of guidance she was given when she became General Manager of the Directorate of Cardiac Services in 1994. She said:

> 'I took up the post of General Manager, Cardiac Services on 7 November 1994. When I had been appointed to previous posts, I had asked my immediate manager for an indication of the key priorities and issues for the new job. In this new post, I asked Mrs Maisey, Director of Operations, for advice about the immediate priorities for the Directorate. My recollection is that I was told that the most important thing was to get the paediatric cardiac surgical services transferred to the Children's Hospital. I understood this to mean that I would need to give priority to completing the enabling work for the physical transfer of the paediatric cardiac surgical service. Apart from this, I had little guidance from executive level about the

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[128] WIT 0089 0018 Mrs Ferris

[129] T27 p. 67–8 Mrs Ferris

[130] WIT 0115 0002 Professor Vann Jones

> forward strategy or objectives for the Directorate, or generally what was expected of me as the newly appointed General Manager for Cardiac Services.'[131]

112 When Dr Roylance was asked about Mrs Ferris' feeling that there was a lack of guidance, he said that she may have felt this way because she was promoted before she was ready for that level of responsibility. He said:

> 'One could say that we may have been guilty of promoting her before she was ready … If you read her account carefully you will see that she was counselled and advised by her predecessor … and she had been in the Trust a long time and had been to management development meetings, she knew that her job by that time was to support and make effective her Clinical Director. If she was somebody who had a culture of wanting everything neat and tidy with a policy and a protocol all written and her authority all defined, you can see that appointing her to a directorate that did not exist, which had to be developed and so on, may be for a time, quite unsettling.'[132]

The relationship between the clinical directors and the general manager – the 'managerial bubble'

113 The key managerial relationship in each directorate was that between the general manager and the clinical director. Dr Roylance's concept of how the clinical director and the general manager should work together evolved over time, from the 'managerial bubble' to the clinical director being accountable to him, with the general manager supporting the clinical director.

114 Dr Roylance explained further the reasons for this evolution:

> '… each partnership of Clinical Director and General Manager … formed a working relationship which was based upon their individual expertise and abilities, and their willingness to undertake tasks. They developed the role together. Slowly, as I think was predictable, and probably directorate by directorate, they found it easier to converse and to be understood by others if it was absolutely clear that the Clinical Director took final responsibility and the General Manager's responsibility was to make them successful.'[133]

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[131] WIT 0089 0004 Mrs Ferris

[132] T25 p. 141–2 Dr Roylance

[133] T24 p. 57 Dr Roylance

115 Miss Lesley Salmon, Associate General Manager of Cardiac Services 1991–1993 and General Manager, Directorate of Cardiac Services 1993/94, gave her view of lines of responsibility:

> ‘Q. To whom were General Managers accountable?
>
> ‘A. I think the use of the word “accountable” is interesting. I felt that I was managerially responsible as a General Manager to John Roylance, but I had some accountability to the Clinical Director for the directorate in terms of the way I worked and what I did.
>
> ‘Q. You use the word “responsible”. Can I take you to WIT 0170 0004, Kathy Orchard’s statement that we looked at already, briefly, paragraph 9.
>
> ‘By all means take a moment to read the whole paragraph. The passage I am focusing on is the last sentence. [134]
>
> ‘Do you agree or disagree with that paragraph?
>
> ‘A. It is interesting, actually. I did see myself as being directly responsible to John Roylance. Whether I saw the Clinical Director being directly responsible to Dr Roylance, I am not sure.
>
> ‘Q. Who did you see the Clinical Director as being responsible to?
>
> ‘A. To some extent, to the Medical Director, but I suppose in the fact that the Clinical Director was to some extent a management position, albeit not a direct line management responsibility, that he did have some responsibility to Dr Roylance as Chief Executive.
>
> ‘Q. The Panel have heard the analogy quoted of the Clinical Director being akin to the Chairman and the General Manager being akin to the Chief Executive.
>
> ‘Normally a Chief Executive would be responsible to the Chairman of a Board. To what extent do you think that analogy held good when you were a General Manager?
>
> ‘A. I do not think it was that clear. I was quite clear that I was accountable for the quality of the work that I did to the Clinical Director, and to a large extent, he did guide and direct my work, although it was more of a partnership than perhaps otherwise. But I was also clear that I was responsible to the Chief Executive as a manager.’ [135]

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[134] ‘Directorate General Managers and Clinical Directors were responsible individually to Dr Roylance as Chief Executive and then to the Board’

[135] T31 p. 127–8 Miss Salmon

116 In her statement and in response to questions, Miss Salmon indicated that she encountered practical difficulties, particularly with one part of the team: 'There was a degree of tension between myself and … the head of the perfusionists … he did not feel that I should be managing the team' although she 'was not aware of any difficulty with the actual clinical delivery of the service.'[136]

117 Miss Salmon described the position of the general manager in terms of relationships with those higher in the hierarchy of management:

> 'Q. The second point is actually at WIT 0109 0014, the last sentence in paragraph 55, where you talk about the culture at the time was one in which personal relationships with an individual Executive Director was possibly more important than hierarchical relationships.
>
> 'Perhaps you could provide me with some explanation of that sentence?
>
> 'A. It was my view at that time that, particularly with Dr Roylance and perhaps with other executive directors, that because you were a General Manager did not necessarily mean that you were somebody whose opinion would be particularly listened to or respected, but that there were individual managers who did have good relationships and who did have, so to speak, the ear of the Chief Executive.
>
> 'Q. So are you saying, to use a colloquialism, your face fitted or it did not?
>
> 'A. I do not think it was so much a case of your face fitting, but there were individual people who, for whatever reason, but I could not explain to you because I do not know myself, had a good working relationship with Dr Roylance. I do not believe that I was one of those individuals.'[137]

How did cardiac services fit into the managerial structure?

118 Initially, from when the directorates were first set up in the run-up to trust status, adult cardiology was part of the Directorate of Medicine, paediatric cardiology was part of the Directorate of Children's Services, and cardiac surgery (including paediatric cardiac open-heart surgery) was part of the Directorate of Surgery.[138] This remained the case until 1993, when the Associate Directorate of Cardiac Services was introduced in a move to structure the care provided in relation to patient groups rather than professional groups.[139]

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[136] T31 p. 159 Miss Salmon

[137] T31 p. 159–60 Miss Salmon

[138] T24 p. 68 Dr Roylance

[139] T24 p. 71 Dr Roylance

119 Mr Wisheart explained briefly the management structure surrounding cardiac surgery. He said:

> 'As far as cardiac surgery was concerned all open-heart surgery, both adult and paediatric, lay within one directorate, initially the Directorate of Surgery and from 1993 the Directorate of Cardiac Services. Cardiac surgery was a sub-directorate within those larger Directorates and as a sub-directorate had its own manager, its own finance and its own facilities. It was run by a Board whose executive members were the associate clinical director, the directorate nurse and the directorate general manager.'[140]

120 Initially Mr Wisheart was the Associate Clinical Director of Cardiac Surgery. In 1993 he relinquished this role as:

> '… there [were] issues of workload and there [were] issues as to whether, as Medical Director, I had to make choices or decisions which might have involved cardiac surgery in relation to other directorates. I think it would have been then an invidious position to be in. It is better that cardiac surgery should have a lead and a spokesperson who can speak independently on behalf of cardiac surgery, not fettered by the wider responsibilities.'[141]

121 Mr Wisheart summed up the role of a clinical director as being 'to deliver the service, remain in the black and to maintain the quality.'[142]

122 Mr Dhasmana assumed the role of Associate Clinical Director of Cardiac Surgery in January 1993.[143]

123 Closed-heart surgery for children and paediatric cardiology lay within the Directorate of Children's Services which was based in the BRHSC. It had its own management, finance and facilities. However, care of patients took place freely across directorate boundaries, as required by clinical need.[144]

124 Dr Joffe served as Clinical Director of Children's Services from April 1991 to December 1994. This included the Associate Directorate of Paediatric Cardiology.

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[140] WIT 0120 0050 Mr Wisheart

[141] T40 p. 133 Mr Wisheart

[142] T41 p. 4 Mr Wisheart

[143] T86 p. 144 Mr Dhasmana

[144] WIT 0120 0050 Mr Wisheart

125 So far as cardiology was concerned, after 1991, Dr Joffe indicated that it:

> '… was separated from general paediatrics managerially and became an associate directorate in its own right, within the Directorate of Children's Services. As an associate directorate, the unit attained additional support from one of the assistant general managers. These positions were often held by former senior nurses who were able to bring their clinical experience and understanding into this role.'[145]

126 Dr Joffe said that:

> 'Clinical Directors worked closely, and very successfully, with the general managers (Mr Ian Barrington, in our case) whose role was to oversee the day to day activities of the Directorate and/or hospital. This arrangement promoted greater cohesion and a sense of purpose among the staff at all levels.'[146]

127 As described by Ms Evans, the management of cardiology and cardiac services together was an issue which Avon Health Authority (Avon HA), 'regarded as important because it felt that an integrated directorate could have a direct bearing on clinical decision making for certain parents.'[147] *'Hospital and Community Health Services in Bristol and District Purchasing Intentions for 1993/94'* stated that in respect to Children's Services, 'Cardiology and cardiac services will be purchased together as for adults'[148] and 'To improve the delivery of service, we intend to stimulate providers to manage these as a unified cardiac service by purchasing them as such.' [149]

128 From 1 April 1994, the Directorate of Cardiac Services came into being. The innovative feature of this new directorate was that it was disease-based rather than professional-based. Professor Vann Jones was the first Clinical Director and Miss Salmon was General Manager.[150] For 12 months previously, adult cardiology and cardiac surgery had been combined as an Associate Directorate of Cardiac Services.[151] In 1994 they came together in a directorate. This led Dr Roylance to explain that the title of Directorate of Cardiac Services was something of a misnomer, since the Directorate was intended only to embrace adult cardiac services.
Dr Roylance said:

> '… paediatric cardiac surgery was, as soon as we could, moved to the Children's Hospital to a paediatric environment, and a little time before that, adult cardiac surgery was merged managerially with adult cardiology. The Directorate of Cardiac Services, strictly speaking, should have been called the Directorate of Adult

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[145] WIT 0097 0139 Dr Joffe
[146] WIT 0097 0142 Dr Joffe
[147] WIT 0159 0022 Ms Evans
[148] WIT 0074 1417 Dr Baker
[149] WIT 0074 1422 Dr Baker
[150] T24 p. 70 Dr Roylance
[151] UBHT 0007 0128; Executive Committee meeting minutes, 13 May 1994

> Cardiac Services, and was, shall I say, independent of the moves in paediatric services.'[152]

129 Professor Vann Jones explained the difficulties encountered in establishing a disease-based directorate:

> 'In its initial stages, the Directorate of Cardiac Services was little more than a concept. The paediatric cardiologists were part of the Children's Directorate, the cardiac surgeons part of the Directorate of Surgery, and the adult cardiologists members of the Directorate of Medicine of which, of course, I had just ceased to be Clinical Director. I and my General Manager, Lesley Salmon, had to try to establish what form the new Directorate of Cardiac Services would take, e.g. would it include the cardiac anaesthetists and/or the cardiac radiologists, or would they remain with the Directorates of Anaesthetics and Radiology respectively, etc?'[153]

130 Professor Vann Jones went on:

> 'My role in these early stages of the Cardiac Services Directorate was to determine who should be in the Directorate so that in due course the appropriate budget could be allocated and the Directorate could then decide its own priorities. Paediatric Cardiology was primarily the responsibility of the Children's Hospital and in any event paediatric cardiology was never envisaged to be part of the Adult Cardiology Service.'[154]

131 Initially, when the Associate Directorate of Cardiac Services had been proposed, a steering group was to be appointed which would consist of a cardiologist, a cardiac surgeon, a cardiac radiologist and a cardiac anaesthetist. This group was to elect its own Chairman to act as Associate Clinical Director.[155]

132 Once the Directorate had been established, Professor Vann Jones established the Cardiac Services Management Board. The individuals who had examined the proposal to form the new Directorate were invited by Professor Vann Jones:

> '… to help us in our task of establishing new and effective working relationships within cardiac services.'[156]

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[152] T24 p. 69–70 Dr Roylance

[153] WIT 0115 0002 Professor Vann Jones

[154] WIT 0115 0020 Professor Vann Jones

[155] UBHT 0081 0240; Directorate of Surgery paper, 16 March 1993

[156] UBHT 0084 0181; letter from Professor Vann Jones dated 18 October 1993

133 At the inaugural meeting of this Board, there were cardiac surgeons, anaesthetists, radiologists and cardiologists. The membership:

> '… was felt to be correct at present, recognising that it could change if required in the future.'[157]

134 Whilst all of these groups contributed to the Management Board, it does not appear that all were within the Cardiac Services Directorate. Mr Dhasmana said:

> 'The clinical service in the paediatric cardiac service was provided by medical, nursing and support teams of perfusionists, technicians, physiotherapists, counsellors and social workers at both hospitals. Each of these teams had their own organisational structures and chains of command … Clinically the chain of command and accountability came under the umbrella of the Associate Directorate of Cardiac Surgery and the Directorate of Cardiac Surgery since 1994.'[158]

135 In 1995 paediatric cardiac surgery was separated from general paediatric surgery and joined with paediatric cardiology to become the Associate Directorate of Cardiac Services in the BRHSC, with the budget re-allocated accordingly.[159]

136 Accordingly, throughout most of the period when there were clinical directorates, until 1995, cardiology, cardiac surgery, and paediatric cardiac surgery had been maintained as distinct entities under different directorates. It was not until 1995 that they were brought together (see Figure 5).

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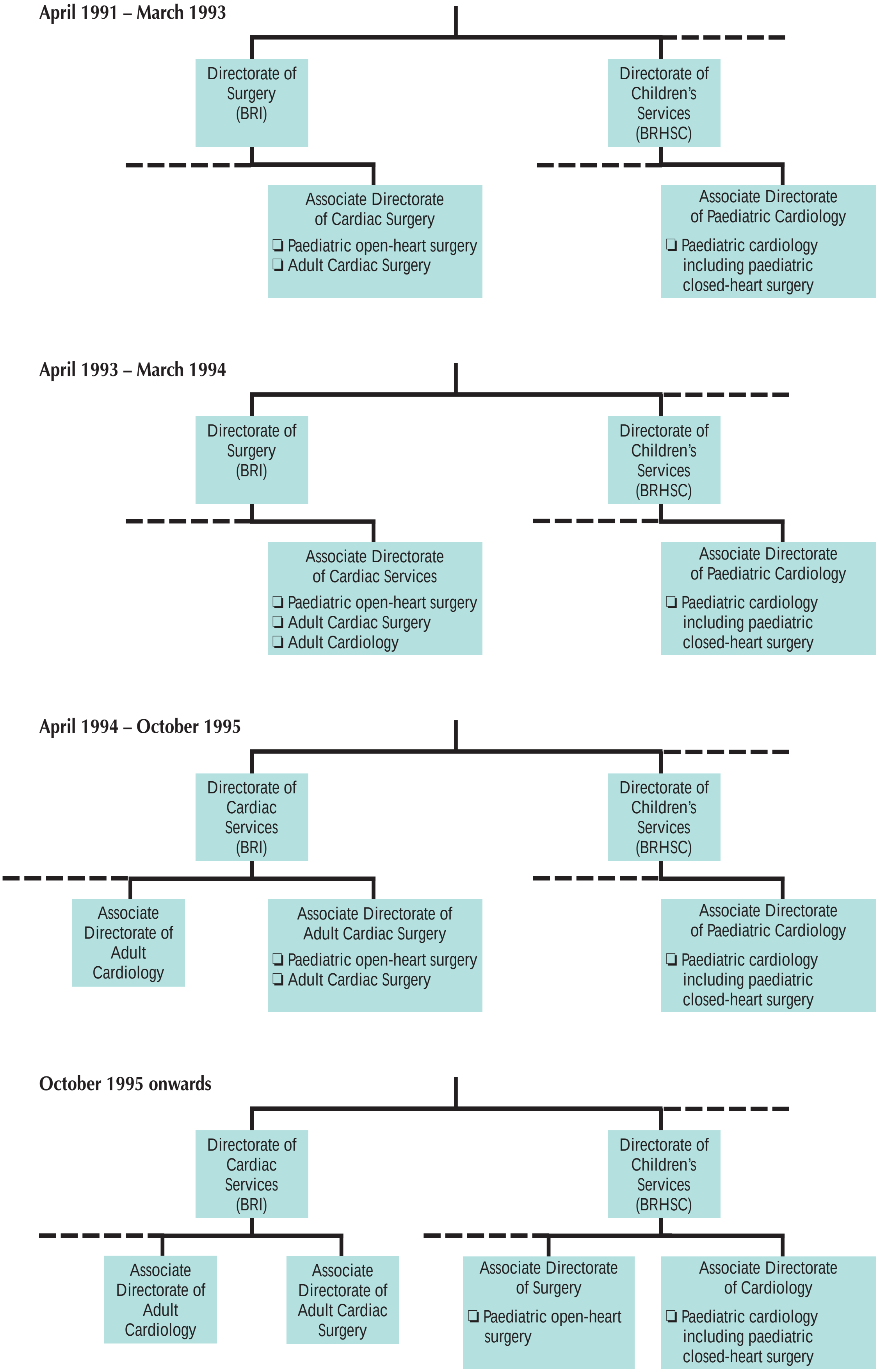
[157] UBHT 0084 0177; Cardiac Services Management Board minutes, 25 October 1993

[158] WIT 0084 0042 Mr Dhasmana

[159] WIT 0097 0139 Dr Joffe

Figure 5: How the paediatric cardiac service fitted into the clinical directorates system



Dr Roylance's key management concepts

137 Dr Roylance told the Inquiry that 'healthcare is led by consultants'.[160] They were self-teaching and self-correcting.[161] Dr Roylance explained that it was 'impossible' for managers to interfere.[162] It was 'a fact' that only clinicians could identify defects in the performance of other clinicians.[163]

138 Dr Roylance saw the role of management as being to 'provide and co-ordinate the facilities which would allow the consultants to exercise clinical freedom'.[164]

139 Dr Roylance explained some of the difficulties in managing consultants in the following passage:

> '… anybody who wishes to manage consultants should do their apprenticeship in the voluntary sector where none of the staff are paid and they can all please themselves. Unlike consultants in that area, I am told it is much easier to get rid of them without an industrial tribunal, but consultants are not manageable. Some people say … it is like "herding cats".'[165]

Therefore, he said:

> '… one has to adopt a leadership style and one has to free up their abilities and recognise their culture.'[166]

140 Dr Roylance's management philosophy attached importance to the following:

a) Management 'by values' and not 'by objectives'. At a meeting of the UBHT Executive Committee on 21 May 1993, Dr Roylance tabled a discussion paper on Trust values. He said that:

> 'UBHT had delegated responsibility to operational level and had pursued a policy of management by values and not by objectives. For this style to achieve continued success, the Trust Board needed to reinforce its values. Dr Roylance asked the Board to reflect what values should explicitly be presented to the workforce.'[167]

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[160] T24 p. 14 Dr Roylance
[161] T24 p. 14 Dr Roylance
[162] T24 p. 14 Dr Roylance
[163] T24 p. 17 Dr Roylance
[164] WIT 0108 0018 Dr Roylance
[165] T25 p. 168 Dr Roylance
[166] T25 p. 168 Dr Roylance
[167] UBHT 0006 0202; Executive Committee meeting, 21 May 1993

b) Delegating responsibility to operational level. Dr Roylance's oral evidence to the Inquiry included the following exchange:

> 'Q. … the clinician at the bedside made the decision which he or she thought was in the best interests of the patient?
>
> 'A. Yes.
>
> 'Q. And management felt that it could not, and should not, interfere?
>
> 'A. And does not, in any part of the Health Service.'[168]

Bristol's management culture

Oral culture

141 Dr Roylance saw his role as that of a communicator. He said:

> 'I spent the whole of my time in communication. I did little else, because in my position it was the passage of information of one sort or another that was my role. So that I spent the whole of my time communicating, not just a bit of it; I spent my time going around assisting managers, assisting, when we had them, clinical directors, commercial managers. I spent a lot of my time improving their chances of success by talking to them, counselling them, by holding countless training [courses] and of course the very structured committee arrangements and Working Party arrangements of this Trust.'[169]

142 Dr Roylance said that he hoped that the description of the process of management at the Trust as an 'oral culture' was a:

> '… fairly accurate description. What it means is that people talk to each other. I think that is very important, and I think it is a highly efficient and highly effective way of managing, that people should talk to each other.'[170]

143 Dr Roylance saw himself as someone who encouraged people to think twice before 'they diverted their efforts to a non-contributory consumption of paper' but at the same time as someone who 'did not excuse anybody for not writing down that which ought to be written down.'[171]

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[168] T24 p. 15 Dr Roylance

[169] T24 p. 34 Dr Roylance

[170] T24 p. 30 Dr Roylance

[171] T24 p. 32 Dr Roylance

144 Dr Thorne wrote a paper for a UBHT Executive Group Workshop on 3 June 1992, entitled '*Cultural Analysis of UBHT'.* In this paper, Dr Thorne referred to the oral culture. She said:

> '… the organisation at Executive Director level is primarily an oral culture – consequently to produce great reams of written material at this stage is counter cultural. The counter cultural nature of that material would give it greater meaning and "embeddedness" than I might want to convey. At UBHT if it is written down it is either very important or ignored.'[172]

Club culture

145 Dr Thorne's paper also referred to a perceived 'club culture' at the UBHT. She wrote:

> 'UBHT sees itself as a "family or club", you are either a UBHT type of person or you are not. Thus people who fit may do very well and progress rapidly on merit, those who do not either move sideways, down or out … Where and how people move is a key indicator of their ability, presence and status. However, the "in"/"out" distinction is not a lifelong category and it is possible for anyone to "shoot themselves in the foot" through incompetence, failure to follow the cultural imperatives, or by breaking an unwritten rule of cultural conduct … It is not appropriate to challenge the message and strategy publicly because it is translated as questioning loyalty. Loyalty to the Chief Executive is a critical cultural attribute – hence disloyalty is viewed with severe disapprobation.'[173]

146 Mr Boardman described a club culture in similar terms. He said:

> 'Dr Roylance actively tried to create a "club culture" for both the immediate executive team and the wider cadre of general managers. This was done explicitly, often using one of the models cited in Charles Handy's management textbook *("The Gods of Management")*. This helped create a culture where:
>
> '(i) you were either a UBHT "type" or not;
>
> '(ii) progress appeared to depend on your "fit" within the club rather than performance;
>
> '(iii) to challenge policy or strategy was perceived as disloyalty;
>
> '(iv) people who transgressed the club's unwritten rules were required to be "put back in their box" until they conformed once more.'[174]

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[172] UBHT 0296 0001; *'Cultural Analysis of UBHT'*

[173] UBHT 0296 0004; *'Cultural Analysis of UBHT'*

[174] WIT 0079 0014 Mr Boardman

147 According to Mr Boardman, this ‘club culture’ did not create a self-assessing or critical environment. He said:

> ‘I think the general culture of the organisation would not have encouraged whistle-blowers … I think this goes back to the club culture, where whistle blowing is a manifestation of disloyalty, because what you are saying to the organisation is, “we are not doing as well as we could be”. I think to say “we are not doing as well as we could be” is disloyalty. It is a message which club cultures do not wish to hear.’[175]

148 Dr Roylance was asked about steps taken to protect whistleblowers from victimisation. He replied:

> ‘I do not know what sort of victimisation you might imagine. I made absolutely certain that management would prevent victimisation.’[176]

Light touch from the centre

149 Dr Thorne’s paper highlighted a decentralised management style employed by the UBHT’s management. She wrote:

> ‘… the core of the leadership style is centred on a belief that it is not the manager’s job to solve problems but to present them back to the individual to sort out for him or herself.’[177]

150 Dr Roylance, for his part, said that this was ‘overstating it.’[178] He told the Inquiry that when people went to him with problems, he would:

> ‘… spend a very considerable time ensuring that they got themselves into a position to see the right solution, to make the right decision, and then to implement it. And I would give them my full authority and support for them to do it. What I knew would be unhelpful would be for them to unload the decision on to me and for me to assume the role of unit or sub-unit general manager and solve the problem. Of course I could solve the problem; that is why I was in the position I was in.’[179]

The role of the UBHT Medical Director

151 The first Medical Director of the UBHT was Mr Christopher Dean Hart,[180] since he was, at the time of the formation of the UBHT, the Chairman of the HMC.

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[175] T33 p. 84 Mr Boardman

[176] T25 p. 80 Dr Roylance

[177] UBHT 0296 0007; *‘Cultural Analysis of UBHT’*

[178] T24 p. 37 Dr Roylance

[179] T24 p. 38 Dr Roylance

[180] Mr Dean Hart was Medical Director from 1991 to 1992

152 Dr Roylance said in his statement that:

> 'At UBHT the role of the Medical Director was probably rather different to that in many smaller trusts. Although the post was designated as one of the executive directors, his role was, in many ways, non-executive and advisory. The Medical Director's position within the organisation was not one of authority or of command, but was advisory: he headed the medical advisory structure and was responsible for giving medical advice to the Trust Board.'[181]

153 Dr Roylance explained that the Medical Director had no line management role.[182] He said that the Medical Director:

> '… was elected by the medical staff as a Chairman of the Medical Committee, and he was appointed by the Board to Medical Director because he was Chairman of the Medical Committee, I have to say. It was not a coincidence; the Board wanted the Chairman of the Medical Committee as their Medical Director; unlike the other executive directors, he did not get paid as a Medical Director because he was a consultant. He was paid the national two-session allowance which we have been talking about, the two sessions, but he was not paid as a Medical Director, which is why I keep saying he was very much like a Non-Executive Director.'[183]

154 Mr Wisheart, himself a former Medical Director of the UBHT,[184] said that he felt that the role of Medical Director lay somewhere between an executive and a non-executive director. He said:

> 'There was no one who was directly responsible to him and his initial remit … was simply that he was to advise the Board on medical matters.'[185]

155 Dr Roylance described the role of the Medical Director and how it differed from that in other trusts. He said:

> 'The Medical Director advised me, as Chief Executive, and the Trust Board on medical issues. I met formally with him at Trust Board meetings and at HMC meetings on a monthly basis, and at weekly meetings of the Group of Executive Directors. I also saw him frequently on an informal basis. I believe that the structure of trusts which we were required to adopt was designed with organisations in mind that were very much smaller than UBHT. Thus, at UBHT the role of the Medical Director was probably rather different to that in many smaller trusts. Although the post was designated as one of the executive directors, his role was, in many ways, non-executive and advisory … he headed the medical advisory structure and was responsible for giving medical advice to the Trust Board.'[186]

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[181] WIT 0108 0009 Dr Roylance

[182] T25 p. 123 Dr Roylance

[183] T25 p. 124 Dr Roylance

[184] Mr Wisheart was Medical Director from 1992 to 1994

[185] WIT 0120 0018 Mr Wisheart

[186] WIT 0108 0009 Dr Roylance

156 Mr Baird, who was the Acting Medical Director at the UBHT from November 1996 until March 1997, described the primary role of the Medical Director in 1999 (i.e. after the period of the Inquiry's Terms of Reference) as being:

> '… in partnership with the Director of Nursing … to lead on professional issues in the group of Executive Directors, in Clinical Committees of the Board and the Trust Board itself.
>
> '… A major responsibility of the Medical Director is to assist and support clinical directors in their management of consultant staff, particularly in the areas of performance, health and conduct. This is an important but time-consuming aspect of the role. Links with Clinical Directors are fostered at monthly meetings, at reviews of their job plans, and when the Clinical Directors take up and leave office. The requirement for regular advice is growing.'[187]

157 Mr Wisheart said that as Medical Director it was his obligation to liaise with clinical directorates, all consultant staff, the Chairman of the HMC, executive directors and medical staffing personnel. As such, he was accessible to all those people and that particular part of his role evolved as other issues developed that were not part of his role when he first took up the post.[188]

158 Mr Wisheart succeeded Mr Dean Hart as Chairman of the HMC and Medical Director in April 1992. However, once Mr Wisheart's two-year term as Chairman of the HMC had ended, he remained as Medical Director, and the two posts were split. He explained this change in the following terms:

> 'When the [UBHT] was set up its policy was that the Chairman of the Hospital Medical Committee should be the Medical Director. When my appointment as Chairman of the Hospital Medical Committee began I was invited by the Trust to be the Medical Director. When my two-year term as Chairman of the Hospital Medical Committee finished it was clear that the job of Medical Director had developed to the point where one person could not realistically do both tasks. For that functional reason the two jobs were separated and I continued as Medical Director.'[189]

159 Dr Gabriel Laszlo became Chairman of the HMC and was welcomed at a meeting of the Trust Board on 14 January 1994. The minutes of that meeting record:

> 'The Chairman also welcomed Dr Gabriel Laszlo who would take over as Chairman of the [HMC] from the beginning of April. Until now the roles of Chairman of the [HMC] and Medical Director had been combined, but over the three years since becoming a Trust it had become evident that, with clinical commitments, the combination of the two roles was becoming untenable.'[190]

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[187] WIT 0075 0002 Mr Baird

[188] T40 p. 41–2 Mr Wisheart

[189] WIT 0120 0019 Mr Wisheart

[190] UBHT 0020 0007; minutes of meeting, 14 January 1994

160 Mr Wisheart was asked about the use of the word ‘untenable’. He said:

> ‘The combination of the two roles, together with one’s clinical commitments, had become too heavy, yes. But I think he believed that that would probably apply to any active clinician who also had the chairmanship of the Medical Committee and the Medical Directorship to carry out.‘[191]

161 Professor Gordon Stirrat had raised the issue of workload with Mr Wisheart in the later part of the period covered by the Inquiry’s Terms of Reference. Mr Wisheart told the Inquiry that he was:

> ‘… satisfied that I could cope with those responsibilities which I had accepted at that particular time. I do not regard myself as being in any way different from a significant number of my colleagues who worked equally hard in one area of their professional life or another. I just happened to choose to do my work where it was rather visible within the Trust and within the NHS.’[192]

162 Counsel to the Inquiry put it to Mr Wisheart that, in contrast to the two sessions per week he was allocated in order to discharge his duties as Medical Director, the current (at the time of his giving evidence) Medical Director had seven sessions per week. Mr Wisheart explained that the obligations of the Medical Director had increased during his period of office:

> ‘… when I began as Medical Director it would have been very difficult to identify what work I had to do as Medical Director that was different from my work as Chairman of the Medical Committee, but by the end of the two years in 1994, a whole portion of work had developed which had not existed two years earlier.’[193]

163 On the arrival of Mr Hugh Ross at the UBHT as Chief Executive in 1995, Mr Wisheart was asked to devote more time to the responsibilities he had as Medical Director. Mr Ross said that he:

> ‘… found that the then Medical Director Mr James Wisheart was assigned only two sessions per week for the Medical Director’s role which I felt was inadequate time to devote to the job of Medical Director at UBHT. Not only that, but at that time the Medical Director was not supported by Associate Directors to share the considerable load.’[194]

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[191] T40 p. 40 Mr Wisheart

[192] T40 p. 72 Mr Wisheart

[193] T40 p. 71 Mr Wisheart

[194] WIT 0128 0004 Mr Ross

164 However, Mr Ross acknowledged that throughout the NHS, there was no standard model for the role of medical director. He said:

> ‘From the start of trust status, some trusts had full time Medical Directors right from the start; other trusts, like the one I ran in Leicester, had a Medical Director who only devoted two sessions to the job and I supported that Medical Director with other people to share the load. A whole variety of models were in place.’[195]

165 Mr Ross explained that he was of the view that:

> ‘It is important for Medical Directors to continue with some medical and clinical responsibilities in order to keep their feet on the ground … and make sure they stay in touch with clinical practice, but I think it is fair to say that a trust the size of UBHT could easily have justified a Medical Director working the majority of their time on Medical Director duties, if not full time, such was the load.’[196]

166 In contrast to the clinical directors who had no extra assistance to enable them to carry out their role, the Medical Director did have support staff to assist him with the extra workload beyond his clinical commitments. Mr Wisheart said he:

> ‘… had an additional person at Trust headquarters who helped me with all my work as Chairman of the Medical Committee and Medical Director.’[197]

Mrs Margaret Maisey’s dual role

167 Mrs Maisey was both Director of Operations and Chief Nurse Adviser of the UBHT from its inception on 1 April 1991 until mid-1996 when she became the Director of Nursing. She then held this post until she left the UBHT in September 1997.

168 Mrs Maisey held a position of some significance within the UBHT. She said:

> ‘… certainly I had influence, I had John Roylance’s ear when I wanted it, I could speak to the Board if need arose. I do not think it ever did, particularly, but I did have influence, and I could make sure that works went up the road and, I do not know, did the work they said they would do and had not got round to doing. I could make some of these departments, lean on them to do things.’[198]

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[195] T19 p. 35 Mr Ross
[196] T19 p. 36 Mr Ross
[197] T40 p. 39 Mr Wisheart
[198] T26 p. 158 Mrs Maisey

169 Mr Durie was asked about Mrs Maisey's relationship with Dr Roylance in the following exchange:

> 'Q. So it was known throughout the Trust that Mrs Maisey was, to put it in legal language, Dr Roylance's "agent"?
>
> 'A. I think I understand that in legal language. If I do, yes.
>
> 'Q. It might be more colloquially put in terms of her being Dr Roylance's "eyes and ears" throughout the Trust?
>
> 'A. Not only eyes and ears. She was also a doer.
>
> 'Q. When Mrs Maisey would express a view about a matter, the person to whom the view was expressed would believe or would understand that the view Mrs Maisey expressed was liable to be Dr Roylance's view also.
>
> 'A. That is right.'[199]

170 An article in *'Private Eye'* dated 18 June 1993 described Mrs Maisey as 'Dr Roylance's sidekick'.[200] Mrs Ferris described Mrs Maisey as playing:

> '… a very particular role for the Chief Executive … She herself, I think, on many occasions, described herself as the Rottweiler of the Trust, so I think her own view was consistent with that.'[201]

171 Ms Janet Maher, General Manager UBHT,[202] described Mrs Maisey's power or influence as being due to her closeness to Dr Roylance. According to Ms Maher, Mrs Maisey had:

> '… a very strong power base and was seen as being strongly linked with Dr Roylance. I believe that some General Managers were frightened of her, although I do not believe she meant to be frightening to them. I would say that she always had the best interests of staff and patients at heart.'[203]

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[199] T30 p. 38–9 Mr Durie

[200] SLD 0002 0007; *'Private Eye'*

[201] T27 p. 83–4 Mrs Ferris

[202] Ms Janet Maher held several positions in Bristol. From 1989 she was the shadow General Manager of what was to become the Directorate of Medicine at the BRI. From 1991 she was the General Manager for the Directorate of Medicine. In April 1993 she became the General Manager for the Directorate of Surgery. In March 1998 she was appointed General Manager at the BRI responsible for Medicine, Surgery, Anaesthesia, Bristol General Hospital and Keynsham Hospital. She held this post until she left the NHS in March 1999

[203] WIT 0153 0010 Ms Maher

Mrs Maisey as Director of Operations

172 Dr Thorne told the Inquiry that Mrs Maisey's role, as Director of Operations, was different from that which she had carried out as a Unit General Manager in the pre-trust days. She said:

> '… as far as I understood it to be, she was Director of Operations and sort of Chief Nursing Adviser, in a professional capacity, which was why she was on the Board as the chief kind of Nurse Adviser. … she had moved from having this enormous kind of hierarchical management role as a General Manager to having a Board level role where she was actually supporting people and fire fighting, beetling around, trying to help people, solve problems, identify issues before they became very problematic.'[204]

173 Mrs Maisey had little guidance about what was expected of her in her role as Director of Operations. In her evidence to the Inquiry she said:

> 'I think what you have to remember is that there had never been a Director of Operations before in the Health Service to my knowledge … these titles were new … We did not have a hang up with titles in UBHT; we were concerned that the things that needed to be done got done.'[205]

174 Mrs Maisey was asked:

> 'What would you say were the main areas of responsibility, the main three or four areas that defined your role as Director of Operations as it subsequently developed?'

She replied:

> 'Quite a lot of my time was spent with individual General Managers and/or Clinical Directors, discussing how they were going to develop their directorates. Sometimes that was about geographical moves, sometimes it was about financial problems, sometimes it was about staffing, all sorts of things, some of which they would have had experience with, and some of which they might not have.'[206]

175 Ham and Smith in their paper discussed Mrs Maisey's role in relation to general managers:

> 'The general managers in the clinical directorates, who were accountable directly to the chief executive, met regularly with the director of operations/chief nursing adviser [Mrs Maisey] in the executive management group.'[207]

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[204] T35 p. 108 Dr Thorne

[205] T26 p. 52 Mrs Maisey

[206] T26 p. 75 Mrs Maisey

[207] INQ 0038 0008; Ham/Smith paper

176 Further they argued:

> ‘The director of operations did take on a key role on behalf of the Chief Executive in working alongside directorate general managers but the evidence suggests that the way in which this role was performed was not always viewed positively.’[208]

177 Ms Maher recalled Mrs Maisey’s role as follows:

> ‘The Director of Operations was there to support General Managers but not to manage them as such. I would say that Margaret Maisey, as Director of Operations, had a lot of influence and power, but no direct management responsibility for the General Managers of the Directorate … General Managers of Clinical Directorates met with Margaret Maisey as the Director of Operations once a month.’[209]

178 Dr Roylance explained that at these meetings, Mrs Maisey gave the general managers ‘a great deal of managerial support’.[210]

179 However, Mrs Ferris said:

> ‘I felt unable to talk to Mrs Maisey or Dr Roylance because there was a history of lack of support or guidance. Although I attended the monthly General Managers’ meetings and the weekly Management Development Group, I did not feel able to be open or to confide in my immediate colleagues and managers. It seemed to me that managers would watch to see who was “in favour” and those who were not were avoided. I felt that there was a culture of fear and blame.’[211]

180 Further, she said:

> ‘The Director of Operations had a personal management style of “management by fear” rather than encouragement. Although I challenged her on a number of occasions, I felt I did so to my own detriment.’[212]

181 When Mrs Ferris was asked to elaborate on these comments in her evidence to the Inquiry, she said:

> ‘The General Managers were in fear of the action that would be taken by Mrs Maisey if they did not fit into the perceptions or requirements that she had of them, which I think is different to being worried and performing well in their post, in that they are worried about what would happen. There was a real fear of the arbitrary way in which some managers were in favour and some managers were out of favour.’[213]

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[208] INQ 0038 0013; Ham/Smith paper
[209] WIT 0153 0003 – 0004 Ms Maher
[210] T24 p. 60 Dr Roylance
[211] WIT 0089 0025 Mrs Ferris
[212] WIT 0089 0034 Mrs Ferris
[213] T27 p. 81 Mrs Ferris

182 When Mrs Maisey was asked about Mrs Ferris' perception of her style of management, she said:

> 'Of all the management styles that I might have considered adopting, it is not one that I would want to be labelled as, and I cannot conceive that the team with which I worked would not have put me right if they thought that that was how I was being perceived. There was an openness and a frankness and an honesty and a preparedness to "say it as it feels" about our team working … particularly amongst the executive group. They would have given it to me straight, if they thought that is how I was comporting myself.'[214]

183 Miss Salmon said she felt she had:

> '… very little influence or authority as either an Associate General Manager or a General Manager with [Margaret Maisey] or [Dr Roylance]. The culture at the time was one in which personal relationships with an individual executive director [were] possibly more important than hierarchical relationships.'[215]

184 Mrs Ferris felt that there was no support provided to general managers and that:

> '… the attitude of Mrs Maisey and Dr Roylance when asked to help deal with particular problems, was either to ignore them, or to make the manager feel inadequate for having raised them, or to respond aggressively. My experience was that Mrs Maisey's approach was particularly aggressive.'[216]

185 Mrs Maisey confirmed that it was not usual to set objectives for the general managers of the clinical directorates. She said:

> 'I did not see it as essential that Clinical Directors set objectives for their General Managers. If their General Managers wanted objectives then it might be that the Clinical Director could help them, but I cannot conceive of the Clinical Directors that I can think of now, of any who would feel that they ought to sit down and work out themselves the objectives of General Managers. I think they would probably be happy to be involved in a debate with the General Managers about objectives that the General Managers themselves had set in the same way that I would.'[217]

186 Some, such as Ms Sheena Disley, did not see Mrs Maisey as having a significant input in their day-to-day activities. Sister Disley was asked what impact Mrs Maisey had in her capacity of Nurse Adviser to the Trust from 1991, on her work as a ward sister. She replied, 'I think we were a fairly self-contained unit. Clearly we knew who she was, clearly I think she was not a significant presence on the unit at that time.'[218]

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[214] T26 p. 89 Mrs Maisey

[215] WIT 0109 0014 Miss Salmon

[216] WIT 0089 0035 Mrs Ferris

[217] T26 p. 85 Mrs Maisey

[218] T32 p. 100–1 Ms Disley

Mrs Maisey's nursing responsibilities

187 Mrs Maisey was appointed Unit General Manager of the South Unit in the B&WDHA in 1985 and took up post 'early in 1986'. She also assumed the role of Nurse Adviser to the Health Authority.

188 Mrs Maisey explained the change which the introduction of general management brought about to the management of nurses:

> 'When general management came in, it swept away all those nurse managers. Most specifically, it swept away … 17,000 nursing officers in England and Wales … They were replaced with … General Managers, most of whom were not nurses and many of whom have never managed nurses. But the nursing officers used to monitor everybody.'[219]

189 The introduction of general management meant that nurses were managed not by nurses, but by general managers.

190 When the UBHT came into being, it was required to have a nurse as one of its executive directors.

191 Mrs Liz Jenkins, the Assistant General Secretary of the Royal College of Nursing (RCN), agreed that it was important to have someone with a nursing role at trust board level.[220]

192 When Mrs Jenkins was asked what she saw as the purpose and function of a director of nursing, she replied:

> 'I have to say, it will depend on what their job was, and there were all sorts of hybrid jobs. Some Directors of Nursing had responsibility for the budget, for the nursing and the accountability for that; others did not … Some had personnel functions added to their jobs. So there were many different jobs during that period of time [1984–1995] that were described as or incorporated the person who sat as the "nurse" on the Board.
>
> 'My own personal view is that whether you had the management of nursing and the finance for it in your power or not, you were on that Board to provide the best possible nursing advice for the benefit of patients to that Board and that therefore, my own view is that you would have a strong responsibility for ensuring that patient care within your domain was as safe and as good as it possibly could be, given the financial constraints that you would have.'[221]

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[219] T26 p. 152–3 Mrs Maisey

[220] T34 p. 54 Mrs Jenkins. The NHS Trusts (Membership and Procedure) Regulations 1990, SI 1990 No. 2024 state at Reg. 4(i)(c): 'The executive directors of an NHS Trust shall include … a registered nurse or a registered midwife …'

[221] T34 p. 53–4 Mrs Jenkins

193 She went on to say:

> '… the nursing role on a Trust Board has a responsibility for ensuring that the other colleagues on that Trust Board understand the issues of patient care and that they therefore ensure that they are not making decisions that conflict with patient care or safety.'[222]

194 However, it was not entirely clear what the ambit of the nursing director's responsibilities should be. Dr Roylance said:

> 'You will recognise that if you introduce the general management function, then there is no managerial role for a District Nurse, because nurses are managed by General Managers. When we became a Trust, along with other trusts – large trusts – there was a problem of what an appropriate role would be for the nursing director, the Director of Nursing, on the Trust Board, because … by definition she could not manage nursing. That and the general management function could not co-exist.'[223]

195 Dr Roylance added:

> 'A number of solutions were produced across the country on how to develop a role for the Director of Nursing, so when we became a Trust, which is after we created directorates, we agreed … that an appropriate role for her would be a Director of Operations.'[224]

196 Mrs Maisey explained her role in these terms:

> 'The title of Director of Operations and Chief Nurse Adviser … meant that as each Directorate had its own Nurse Adviser, I became the focal point for the Trust as a whole for these Nurse Advisers. This was the main change in my nursing role from before 1991. I was not Director of Nursing. Director of Operations was a new role to provide support and guidance to the General Managers in setting up their new Directorates and to manage the Trust's support services such as catering, maintenance and capital building works, patient information, information technology and complaints.'[225]

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[222] T34 p. 54 Mrs Jenkins

[223] T24 p. 48–9 Dr Roylance

[224] T24 p. 49 Dr Roylance

[225] WIT 0103 0022 Mrs Maisey

197 Thus within each clinical directorate there was a nurse advisor who could be approached for advice by any nurse within that directorate. If a matter needed to go further, Mrs Maisey was 'the professional link to the Department and to the policy making bodies for the profession.' [226] Mrs Maisey said:

> 'In all the different roles I had, I always expected to be approached if there were problems with nurses, whatever the problems were. I would always expect to be involved, assuming they were serious and unsolvable by any obvious route.'[227]

198 Ham and Smith in their paper outlined a drawback of Mrs Maisey's having this dual role:

> 'The responsibility given to the director of operations/chief nursing adviser by the chief executive meant that de facto she acted as a third deputy to the chief executive. A further consequence of this was that the operational aspects of the director of operations/chief nursing adviser role were significant and to some degree took time away from the role of chief nursing adviser.'[228]

199 The Inquiry heard evidence of a perception among ward nurses that Mrs Maisey was seen as an inaccessible figure. Ms Sheena Disley, a ward sister at the UBHT, said in her witness statement:

> 'I think I saw Margaret Maisey twice in all: I didn't feel she was someone I could confide in or expect to act on the problems I may have had.'[229]

200 Sister Disley's oral evidence included this exchange:

> 'Q. Was it the case that you did not feel you could confide in Mrs Maisey because she was in a separate building, or was it that you did not feel you could confide in her because she was not the type of person you could confide in, or both?
>
> 'A. I think because she was obviously very thinly spread about a large area, we saw less of her. I think it is difficult to confide in somebody that you are not familiar with, you do not have a relationship with them.
>
> 'Q. … You would have liked more support from higher up the nursing chain?
>
> 'A. I think as a group of nurses, as a hospital full of nurses, I sometimes felt that we lacked direction, that we lacked a clear leader, and I think ... since Lindsay Scott has been in post,[230] that there is a much more significant voice for nurses now … There have been arenas for nurses to meet Lindsay Scott and for nurses to identify

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[226] T26 p. 162 Mrs Maisey

[227] T26 p. 95 Mrs Maisey

[228] INQ 0038 0023; Ham/Smith paper

[229] WIT 0085 0004 Ms Disley

[230] Ms Lindsay Scott, the Director of Nursing at the UBHT from 1997 to date

> their concerns about where they work, about what is happening in the Trust. She has also been very active in the development of the nursing strategy.'[231]

201 However, according to Mrs Fiona Thomas,[232] there was not often any call for her to seek out the help or assistance of Mrs Maisey in the latter's nursing role:

> 'My responsibility was to the Associate General Manager, and to … the Clinical Director. And we were very much kept in that sort of remit. We did not really need to go elsewhere, apart from certain bits and pieces, so there was very little time I needed to actually think that I needed to have a Director of Nursing at that time.'[233]

202 When Mr Ross assumed the role of Chief Executive in 1995, Mrs Maisey's role changed. From 1996, she was the Director of Nursing rather than Director of Operations and Trust Nurse Adviser. Mr Ross himself assumed a lot of the responsibility that Mrs Maisey had previously had as Director of Operations. According to Mrs Maisey, this difference in roles meant that she:

> '… got more involved in the nursing issues of the day … I got more involved with the College, the University, to which we had contracted out the basic nursing training. I was drawn into nursing policies and processes in a much more detailed way than I had been previously.'[234]

Mr Ross explained the rationale for his reorganisation of the role of the Nursing Director on the UBHT Board:

> 'I felt strongly the right standards of patient care could only be achieved with a contribution from a nursing professional. So the Director of Nursing's role now is essentially … around professional standards, care, development, teaching, training, a whole range of issues around standards of service and so on.'[235]

The role of the Trust Chairman

203 In 1994 the NHS published the '*Code of Accountability for NHS Boards*'.[236] This described the Chairman's role thus:

> 'The chairman is responsible for leading the board and for ensuring that it successfully discharges its overall responsibility for the organisation as a whole.

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[231] T32 p. 104–6 Ms Disley

[232] Fiona Thomas was Clinical Nurse Manager of Cardiac Surgery from November 1993 to December 1996. She is currently Clinical Nurse Manager of the Cardiothoracic Clinical Directorate

[233] T32 p. 22 Fiona Thomas

[234] T26 p. 154 Mrs Maisey

[235] T19 p. 41 Mr Ross

[236] Department of Health, April 1994

> ‘A complementary relationship between the chairman and the chief executive is important.’[237]

204 Mr Durie was Chairman of the B&WDHA from 1 April 1986 to 31 March 1990 and then Chairman of the UBHT from 1 April 1991 to 30 June 1994. In the period between his two chairmanships:

> ‘… I was no longer involved with the National Health Service, except I think I had the title … some funny title they dreamt up for people who helped work out applications for Trust status.’[238]

205 Thus, like Dr Roylance, Mrs Maisey and Mr Nix, in particular, his evidence straddles the management and culture at Bristol both before and after the inception of the UBHT. When Mr Durie took up his post as Chairman of the Health Authority the only guidance he received on what was expected of him was a briefing from his predecessor and a discussion with the Chairman of the RHA.[239]

206 Mr Durie, the first Chairman of the UBHT, described his view of the role:

> ‘The Chairman’s role was somewhat ill-defined, but my personal belief was that it was up to me to ensure that the hospital services under me provided the most effective healthcare to the greatest numbers within the financial limitations imposed. That said, as Chairman of the [B&WDHA] and latterly UBHT, I was keenly aware that it was not my function to take over from the full time executive or to provide parallel management. I saw myself more as Chairman first of the Health Authority and then of the Trust Board, responsible for ensuring that in addition to treating today’s patients, there was the organisation and the management structure to prepare clear plans for the future. In so complex and diverse an organisation, I thought it important to be known personally and also to be seen as approachable.’[240]

207 Dr Roylance shared Mr Durie’s view of the role of Chairman. Dr Roylance was asked:

> ‘Would the Chairman of the Trust qualify as senior management?’

He replied:

> ‘No, he is not a manager at all. The Chairman and Non-Executives set policy and supported management, which was performed by the Executive Directors. There was no question about that … the Trust Board set policy, and it was left to the managers to implement it. We were the managers. The Trust Board did not manage anything … the Trust Board was a policy making body. I headed the management

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[237] HOME 0004 0073 – 0074; ‘*Code of Accountability for NHS Boards*‘

[238] T30 p. 12 Mr Durie

[239] T30 p. 8–9 Mr Durie

[240] WIT 0086 0002 Mr Durie

> function to implement that policy. I did not expect the Trust Board to manage and they did not expect to.'[241]

208 Mr Robert McKinlay was Chairman of the Board from July 1994 to November 1996. He described the role in his written statement:

> '… the Chairman is on the scene much more frequently than the other Directors, and he or she becomes the bridge between the Executive team and the Board. The Chairman needs to know what is going on to a greater degree than the other non-executive directors, in order to give on the spot advice to the Executive team and guide the deliberations of the Board. In addition, on many occasions the Chairman is required to be the representative or spokesman for the Trust.'[242]

209 He went on to say that:

> 'To implement the policy of the Chairman having a good understanding of what is going on, the Chairman should attend as many committee meetings as possible, which was my practice. In addition, there should be regular meetings with Executive Directors. I would meet the Chief Executive at least once per fortnight on a planned basis, when he would bring issues to my notice and vice versa. I would meet with the other Executive Directors individually on a planned basis every 4–6 weeks. In practice, by being around in the Trust and attending meetings, I would meet the Executive team and the other non-Executive Directors frequently.'[243]

210 To stay informed as to what was going on in the wider hospital community, Mr McKinlay paid:

> '… regular visits to the various hospitals and services, both during the day and at night … These visits were invaluable in seeing how the doctors, nurses and administrators were facing up to the day to day challenges, and to put into perspective proposals for change, either physical or operational, which the Board was being asked to consider.'[244]

211 Dr Thorne was asked what the role of the Chairman was as she understood it from her work at the UBHT. She replied:

> 'I think the role of the Chairman was to take a strategic overview and to manage the work of the Board effectively. I think that means actually managing the cohesion of the Board and actually looking at the competencies of the constitution of the Board, because that is inordinately important, having the right balance of people. I think that is a very important role for a Chairman to play, and I think it is also about actually being in some senses a figurehead whom people recognise as a

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[241] T88 p. 104–5 Dr Roylance

[242] WIT 0102 0006 Mr McKinlay

[243] WIT 0102 0008 Mr McKinlay

[244] WIT 0102 0008 Mr McKinlay

> symbol of a kind of strategic level, but are almost dissociated from the executive role because I also think that is important. So they have to ensure the non-executives do not try to become operational, because that is the road to disaster.'[245]

The role of non-executive directors

212 Dr Roylance, in the course of his evidence to the Inquiry, explained the role that non-executive directors performed. He said:

> 'They were non-executive and they were meant to be the parallel of Non-Executive Directors of a commercial company whose primary responsibility is to shareholders and profit. The primary responsibility of the Non-Executive Directors was to patients, so it was their responsibility to do two things: bring lay information about the community and skills that they brought with them from their background. In other words, they were people with business experience to give us the benefit of a business approach to things, and they were very active.'[246]

213 In one of the NHS *'Working for Patients'*[247] documents entitled *'Self-governing Hospitals'*,[248] published in 1989, it was stated that: '… the board of directors will be responsible for determining the overall policies of the Trust, for monitoring their execution, and for maintaining the trust's financial viability.'[249]

214 The same document also said, '… All the non-executive members will be chosen for the personal contribution they can make to the effective management of the hospital and not to represent any interest group.'[250]

215 Mr McKinlay gave an extensive description of the role of the Trust Board and its Chairman in his statement to the Inquiry:

> 'The role of the Trust Board and its Chairman, while having structural similarities to the commercial model, is essentially different. An NHS Trust is required to provide the highest quality service possible to members of the public within the funds made available by HMG. There is no profit motive in the NHS. While the Board acts as stewards for HMG's funds, the "customers" are the members of the general public, who in the end are also the "shareholders". How the Board should act in relation to customer service will be discussed below, but it is worth noting that, unlike a commercial business, the supply of "customers" to the NHS is effectively unlimited and sub-division into "product streams" is at best of limited applicability in a large Trust like UBHT.

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[245] T35 p. 22 Dr Thorne

[246] T26 p. 1–2 Dr Roylance

[247] NHS Reforms, *'Working for Patients',* Working Papers, HMSO Cm 555

[248] Working Paper No 1, '*Self-governing Hospitals*', 1989

[249] HOME 0003 0042; Working Paper No 1, '*Self-governing Hospitals*', 1989

[250] HOME 0003 0042; Working Paper No 1, '*Self-governing Hospitals*', 1989

> ‘In a Trust the Chairman and non-Executive Directors need to work with the Executive team to find the right balance between financial control and responsibility, and “customer service”, ie the quality of treatment and care given to patients. In my view, high quality patient care is the paramount requirement, but the funds available are limited and have to be managed carefully. To find the right balance, the non-Executive Directors and Chairman need to work in a more positive, pro-active way than would be usual in a commercial business. They need to be Directors and sounding boards for the Executive team, giving them as broad a spectrum of advice as possible.
>
> ‘If we now turn to the practice rather than the principles, although I have said that the Trust Board should be pro-active, they are not there to run the Trust on a day-to-day basis; that is the task of the Executive team. Guided by the Chairman, the Board is there to set policies, both financial and operational; approve investments; appoint senior members of staff; assist in ensuring that sound systems for setting standards and measuring performance are in place; and to look to the future. They are also there to help resolve specific issues of any sort addressed to them by the Executive team.’[251]

216 Mr Durie explained that the Board’s non-executive directors would try to fulfil their roles on the basis of information provided to them at meetings and by observation as they went about the Trust. He recalled:

> ‘We were very concerned at trying to improve the patient care; we were not … looking at the clinical outcomes but we were very concerned about were they being properly looked after when they arrived at the hospital etc etc.’[252]

217 Mr Moger Woolley, who was appointed a non-executive director at the Trust’s inception, viewed his role as not ’… to run the day to day activities of the Trust. My role as a non-executive director of UBHT was to sit at the Board table and to question the executives on their roles and how they were carrying them out.’[253]

218 Mr Woolley went on:

> ‘I felt that the role I adopted, of stimulating debate and ensuring that matters were thought through, was appropriate for a non-executive director. I did not feel that it was necessary for my view to prevail.’[254]

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[251] WIT 0102 0006 – 0007 Mr McKinlay

[252] T30 p. 42 Mr Durie

[253] WIT 0357 0002 Mr Woolley

[254] WIT 0357 0002 Mr Woolley

219 Mr Louis Sherwood, a non-executive director from the Trust's inception until November 1998, felt:

> '… that we [the non-Executive Directors] were there to sharpen up the financial management of the Trust. That was the most substantial contribution that I could make as a Non-Executive Director with a broad, general business background. Many of the Board's papers were financial ones, and we spent a lot of time on financial issues.'[255]

220 Mrs Maisey outlined various tasks performed by the non-executive directors:

> '… they came to the committees; they each of them chaired one of the executive committees …The Capital and Services Development Committee and the Patient Care Committee and the various committees that we had were all chaired by one or other of the non-executives … they took roles according to their expertise and skills.'[256]

221 Mr Nix, in his statement, when citing the benefits of trust status, viewed the non-executive directors as having a more active role. He said a benefit of trust status was that 'the expertise of the non-executive directors will be used to direct care more appropriately. They will also take a leading role as laymen and women ensuring all patients are treated as individuals.'[257]

222 However, Ham and Smith in their paper described the non-executive directors as not wanting to get involved in details. They said:

> 'From the evidence available, it appears that the board focused mainly on high level issues and was not drawn into the detail of service delivery. Peter Durie … personally committed three days a week as chairman and this time was spent in meetings and walking around the hospitals and services for which the trust was responsible. He would meet the chief executive on a regular basis and he supported the delegation of authority to clinical directorates because "it ensured that the Trust Board did not get bogged down in detail. The Board could concentrate on major issues".'[258]

223 However, Mr Durie's successor, Mr McKinlay:

> '… acted to strengthen the management structure by forming board committees chaired by non-executives to "take on a more inquisitive role" … The changes which he introduced were intended to strengthen co-ordination and monitoring

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[255] WIT 0110 0002 Mr Sherwood

[256] T26 p. 119 Mrs Maisey

[257] WIT 0106 0016 Mr Nix

[258] INQ 0038 0018; Ham/Smith paper

> from the centre given his perception that existing arrangements were not adequate.'[259]

224 Mr Durie was asked about the ways in which non-executive directors monitored what was happening in the Trust:

> 'Q. The mechanism by which you and your non-executive colleagues would monitor the executive management of the organisation was what?
>
> 'A. … We would see ourselves undertaking that role by the results that were reported to us when we met formally as a Board, by us observing, as we went around the Trust in between Board meetings. Those were our two key ways of understanding that what was being done was satisfactory.'[260]

225 The Inquiry heard that shortly after he became Chairman Mr McKinlay made proposals about the reorganisation of some of the committees of the Trust: 'I made some proposals for revamping what had been Advisory Groups into board committees, with more what I thought were clearer terms of reference.'[261] He produced a document to Board members setting out his proposals, and setting out the Board's three Committees: the Patient Care Standards Committee, the Medical Audit Committee and the Audit Committee. These Committees are considered in greater detail in Chapter 18.

226 Of the Patient Care Standards Committee Mr McKinlay wrote:

> 'This committee would be expected to oversee *all* aspects of patient care. Provided we can establish a satisfactory set of definitions it would need to enter into the field of medical outcome inasmuch as this affects the performance of the Trust as a whole but steer clear of medical audit. I believe the answer lies in studying medical outcome on a statistical basis while leaving the underlying clinical factors to the Medical Audit Committee.'[262]

227 Mr McKinlay commented on this in his evidence to the Inquiry:

> 'I think there was a tightrope of a sort. There was no tradition or culture in UBHT that the Board or the committees of the Board should be involved on outcome, medical outcome, even on a statistical basis. I felt that that is something that should evolve. To be more specific, I thought that was something that was wrong. I thought the Board should have some knowledge of statistical outcome, but there was a tightrope to be trod to find a way of easing it into place.'[263]

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[259] INQ 0038 0019; Ham/Smith paper
[260] T30 p. 41 Mr Durie
[261] T76 p. 6 Mr McKinlay
[262] UBHT 0021 0700; Board paper, 18 January 1995 (emphasis in original)
[263] T76 p. 8–9 Mr McKinlay

228 The minutes of the meeting of the Patient Care Standards Committee on 7 November 1995 recorded Mr McKinlay asking, '… how the Trust could identify the relevant professional standards and compare local performance. He commented that few of the audits concerned outcome'.[264] Mr McKinlay was asked in evidence whether any answer was provided to that question, and he replied that it was not. His evidence included this exchange:

> 'Q. Did you ever form a view as to how that question could have been answered?
>
> 'A. I think the answer could have been that it was not the tradition or culture in UBHT to publish in any open way outcome results.
>
> 'Q. Did you understand that to be a less open approach than other comparable Health Service organisations?
>
> 'A. The people that I talked to within the Trust, which would be probably largely Dr Roylance, but some others, I gathered the impression that they felt they were not really any different from other trusts. But I did not have any independent way of verifying that.'[265]

229 Mr McKinlay was also asked how the non-executive directors kept abreast of the quality of care within the UBHT. He replied:

> 'I feel that a Board has to be aware of the measures by which its business will be judged … I think the Boards have to have the measures that allow them to be confident that is happening. I think in the Health Service medical outcome is a measure that the Board should take an interest in … I believe that quality within medical performance can only be provided by those who are the providers, the experts, but the Board should be able to assess as to whether the standards which they think are relevant are being met.'[266]

230 Mr McKinlay was questioned by Professor Jarman about the information available to him:

> 'Q. … you stated in your witness statement … that "the board and executive management required that the Trust provided a high quality, safe treatment and care" then later on … you say that "Standards against which questions could be posed and followed up did not exist in this systematic fashion". You have said a number of times that you thought there should be analytical data available to analyse problems. Did you see any of the … reports of the paediatric cardiac surgery of the BRI?
>
> 'A. No.

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[264] UBHT 0016 0007; minutes of meeting of Patient Care Standards Committee, 7 November 1995

[265] T76 p. 14 Mr McKinlay

[266] T76 p. 18–19 Mr McKinlay

> ‘Q. Reports of that type were freely available and you wanted reports of that type; did you request them?
>
> ‘A. No, I did not, I did not know that reports of this type were available. What I had asked for as an audit report did not have this kind of information in it … I primarily wanted a system put in place where standards were set and performance against those standards were measured. At the time when I was projecting that view in the Trust, we are talking about November 1995, I was not aware that there was a problem in mortality in paediatric cardiac surgery. I was putting forward something to me that was perfectly normal. …
>
> ‘I requested the audit report, I did not request this information because the audit report did not track you through to this information. This information, by the time I was asking for the audit report, was the content of the information that Hunter and de Leval had produced and which was produced by the Trust in January 1995 … January 1996.’[267]

231 Mr Sherwood recalled visiting various parts of the hospital in order to oversee what was happening:

> ‘As Board members we were all encouraged to visit and follow the activities of various departments. Apart from any personal interests, we were allocated to particular parts of the Trust by the Chairman. I took on responsibility for following medicine, radiology, obstetrics and gynaecology, and ENT. I visited these departments fairly regularly. We were encouraged to go everywhere in the Trust, but specifically asked to look at the areas to which we were allocated.’[268]

232 Dr Thorne, in her evidence to the Inquiry, explained her understanding of the role of the Trust Board. She said:

> ‘… the role of the Trust Board was to help in identifying what this vision would be, to help clarify the nature of the organisation, and to actually set the tone of the organisation itself. So [the Trust Board was] very interested in “What kind of Trust do we want to be?” so “We will be a Trust, but what kind of Trust do we want to be and therefore what are the implications of that?” as long as all the kind of fiduciary duties and all the other things which are absolutely and terrifically important.’[269]

233 According to Mr Durie, the Board:

> ‘… had the role of being aware of what was happening and having to make the decisions of where limited resource was to be applied and it also could be a facilitator of trying to help the clinical directorates as necessary.’[270]

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[267] T76 p. 88–90 Mr McKinlay

[268] WIT 0110 0003 Mr Sherwood

[269] T35 p. 20–1 Dr Thorne

[270] T30 p. 29 Mr Durie

234 The directors on the Trust Board also had guidance from the NHS on their responsibilities. In the wake of the 1989 '*Working for Patients'* White Paper, the NHS Management Executive released a paper entitled *'NHS Trusts: A working guide'*.[271] According to Sir Alan Langlands,[272] this guidance set out the roles and responsibilities of trust boards and 'set out the basis on which they would be monitored and held to account by the DoH.'[273]

235 Sir Alan explained the responsibility of members of a trust board in his evidence to the Inquiry. He said:

> 'They were expected to behave as part of a single National Health Service. If I can give you some examples, they were expected to pursue national priorities and planning guidance produced by the Department of Health; they were expected to work to comply with patient charter standards and during the period, I guess, 1992 to 1995, they were expected to operate a series of codes … each Trust was expected to establish a system of corporate governance, which of course now has echoes in the way in which we define clinical governance, which included audit committees and required them to have standing financial instructions to a certain format, required them to produce annual reports, required them to engage in quite a detailed system of internal and external audit.'[274]

236 The working guide, referred to above, explained the differences that would occur with the introduction of trusts:

> 'A key element of the changes is the introduction of NHS Trusts. They are hospitals and other units which are run by their own Boards of Directors; are independent of district and regional management; and have wide-ranging freedoms not available to units which remain under health authority control.
>
> 'Whilst remaining fully within the NHS, Trusts differ in one fundamental respect from directly managed units – they are operationally independent.'[275]

237 The working guide also discussed who would be on the board of directors and what the directors' responsibilities would be:

> 'Each Trust is run by a Board of Directors consisting of:
>
> - 'a non-executive chairman appointed by the Secretary of State;
> - 'up to five non-executive directors, two of whom are drawn from the local community and are appointed by the regional health authority, the remainder of

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[271] NHS Management Executive, *'NHS Trusts: A working guide'*, HMSO, 1990

[272] Chief Executive of the NHS Executive in England from April 1994 to 2000

[273] WIT 0335 0043 Sir Alan Langlands

[274] T65 p. 20 Sir Alan Langlands

[275] WIT 0335 0053 Sir Alan Langlands

whom are appointed by the Secretary of State. Where a Trust has a significant commitment to undergraduate medical teaching, one non-executive director is drawn from the relevant University;

- 'an equal number of executive directors, up to a maximum of five, including the chief executive, the director of finance, and, for the vast majority of Trusts, a medical director and a nursing director.'[276]

238 This guidance was reinforced in April 1994 in an NHS publication entitled *'Corporate Governance in the NHS: Code of Conduct, Code of Accountability'*.[277] This said:

> 'NHS boards comprise executive board members and part time non-executive board members under a part-time chairman appointed by the Secretary of State ... There is a clear division of responsibility between the chairman and the chief executive: the chairman's role and board functions are set out below; the chief executive is directly accountable to the chairman and non-executive members of the board for the operation of the organisation and for implementing the board's decisions. Boards are required to meet regularly and to retain full and effective control over the organisation; the chairman and non-executive board members are responsible for monitoring the executive management of the organisation and are responsible to the Secretary of State for the discharge of these responsibilities.'[278]

Pathways for expressing concerns

239 After the UBHT was established, there were in general terms two separate pathways which could be taken by those members of staff seeking to raise concerns about any aspect of the delivery of healthcare in the Trust: the professional advisory route, leading to the Chairman of the HMC and the 'three wise men'[279] on the one hand; and the management route through the clinical directors ending, ultimately, with the Chief Executive on the other.[280]

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[276] WIT 0335 0056 Sir Alan Langlands

[277] HOME 0004 0068 – 0075; *'Corporate Governance in the NHS: Code of Conduct, Code of Accountability'*, Department of Health, 1994

[278] HOME 0004 0073; *'Corporate Governance in the NHS: Code of Conduct, Code of Accountability'*, Department of Health, 1994

[279] A Health Circular issued in July 1982 (HC(82)13) had required all DHAs to introduce procedures to prevent harm to patients resulting from the physical or mental disability of medical staff employed by them. Dr Roylance explained to the Inquiry that in practical terms this included incidences of suspected incompetence of staff (see T25 p. 6). The Circular recommended that the HMC of each DHA set up a panel of members, the Special Professional Panel, from the senior medical staff. From this panel a small sub-committee would then be appointed to receive and take action on any report of incapacity. In Bristol, the panel comprised the Chairman elect, the Chairman and the past Chairman of the Medical Committee, and they became known as the 'three wise men' (see T25 p. 6–7)

[280] T25 p. 75 Dr Roylance

240 Dr Roylance was questioned about this in the course of his evidence:

> 'Q. Would you have expected a member of hospital staff, whether medical or non-medical, to have had other means of raising concerns about unacceptable practice before getting to the stage of going to the three wise men or one of them?
>
> 'A. There was a whole mosaic of routes that were available and were used and it is difficult to answer specifically unless I really hypothesise a situation … It would be very likely to be through their district professional adviser, and then to Margaret Maisey or me.'[281]

241 There was no formalised system governing with whom a particular concern or complaint should be raised. In Dr Roylance's view, such a system would have:

> '… constrained and restricted the opportunities of staff to choose an appropriate route to resolve a situation.'[282]

242 The evidence as to the raising of concerns about paediatric cardiac services in Bristol, and the possible alternative routes which were or could have been followed in raising such concerns, is dealt with fully from Chapter 20.

The relationship between academics at the University of Bristol Medical School and the UBHT clinicians

243 The UBHT is a teaching hospital trust and, as such, has close links with the academic departments of the Medical School at the University of Bristol.

244 Dr Roylance described these links, in some detail, in his statement:

> 'There has always been an extremely close and intimate relationship with the University of Bristol. All senior NHS medical staff carried honorary recognition as University Professors, lecturers or clinical teachers. All University clinical staff had formal honorary contracts with the District which were then transferred to the Trust on its inception. All appointments committees for senior medical staff included representatives of the University of Bristol and all appointments committees for senior University clinical staff included representatives of the District and subsequently of the Trust. University representatives were appointed to the District Health Authority and to the Trust Board. There were, in addition, innumerable standing and ad hoc committees with representation both of the NHS and the University.
>
> 'In particular, there were standing University liaison committees at regional and district level and I was a member for a time of each of these committees. With the creation of the Trust there was created a Joint Committee for Medical and Dental

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[281] T26 p. 24–5 Dr Roylance

[282] T25 p. 76 Dr Roylance

> Education and Research with representatives of both University and NHS and chaired by the University Deputy Vice-Chancellor who was a non-Executive Director of the Trust Board. From 1990 there was an increasing relationship with the University of the West of England, at first in relation to management, training and development, and later in the education of nurses and of the professions allied to medicine.
>
> 'Together with the Chairman of the Trust I met the Vice Chancellor of the University and the Clinical Dean at least 3 times a year to discuss matters of joint interest. I also instituted a monthly lunchtime meeting, together with the relevant senior managers of the Trust, with the Dean of the Faculty and senior members of the University. All operational matters of immediate joint interest were discussed, particularly those affecting the clinical experience afforded to medical students.'[283]

245 Mr Wisheart encapsulated the view of the UBHT towards the University when he said:

> 'It was always the view of the Trust that they should work closely with the Faculty of Medicine of the University of Bristol and that they had a lot of common responsibilities, so there were a number of committees and groups which met to try to encourage and nurture and promote that high degree of cooperation.'[284]

246 However, there was a certain tension in that the University would opt to appoint the best academic candidate without regard to the needs of the UBHT to provide the community with a certain service. Dr Roylance explained:

> 'The university always took the view that they wished to appoint the best applicant and were uneasy about specifying too narrowly the speciality of the potential Professor. So that, if I can explain it out of this, that when a Professor of Gastroenterology retired, … we finished up with his replacement Professor as an endocrinologist. That always produced a certain amount of stress on the NHS side because we had to continue to provide the gastroenterology and to establish an endocrinology service.
>
> 'There were issues, but the University (and quite properly) wanted the best academic and would not normally conform to our wish to narrow the speciality down in the advertisement.'[285]

247 Mr Boardman saw this conflict in needs as both a strength and weakness. He said:

> '… I think there is no doubt that having a medical school alongside the hospital adds the enormous strengths; you attract the top people in your field, there is no doubt about that. I think the weakness is that there are times when the core business, the core function of the hospital or the Health Service, has to be to deliver

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[283] WIT 0108 0013 Dr Roylance

[284] T40 p. 54 Mr Wisheart

[285] T88 p. 76 Dr Roylance

> services which meet the local needs of the local population. But at times there is a tension whether the requirements of the University may be to recruit a specialist Professor in a particular field whose discipline could be at the cutting edge of medicine, which is not actually in an area where the local purchasers particularly want or particularly need to buy a particular service.'[286]

248 Dr Thorne was asked what she thought Dr Roylance's emphasis would be if it came to a conflict between the needs of the Trust and those of the University:

> 'Q. So would it be fair to say that those coming from a university background would have other priorities of research and innovation, and Dr Roylance's was that the focus should be on the patient actually receiving the service?
>
> 'A. I think his accent was on actually enabling that tension to co-exist, because he had always seen himself very much as a teacher, was absolutely wedded to the commitment of development and therefore what he wanted to ensure was that unlike a district general hospital, UBHT should be actually at the forefront of changing services and encouraging people to question their practices but not overspend.' [287]

249 Within the remit of cardiac surgery, however, several of the surgeons recognised that there was little relationship between their discipline and the University of Bristol prior to the 1990s. Mr Jonathan Hutter, consultant surgeon, said that:

> '… there was no close relationship between the Department of Cardiac Surgery and the University of Bristol prior to about 1990.'[288]

250 Mr Dhasmana recalled that:

> 'Up to 1992 there was no direct administrative or managerial connection with the University of Bristol … The academic department of Cardiac Surgery was established in October of 1992 …'[289]

251 The Bristol Heart Institute, a collection of a number of academic departments of which cardiac surgery was one, was established in 1995 as a new organisation by Professor Gianni Angelini, Professor of Cardiac Surgery, University of Bristol.

252 At a meeting of the cardiac surgeons on 12 October 1995, the Bristol Heart Institute was discussed. The minutes of that meeting recorded:

> 'The establishment of the Bristol Heart Institute was welcomed as a positive development for the Cardiac Services Directorate. Mr Dhasmana asked for

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[286] T33 p. 66 Mr Boardman

[287] T35 p. 73–4 Dr Thorne

[288] WIT 0096 0038 Mr Hutter

[289] WIT 0084 0046 Mr Dhasmana

> clarification of the role of the clinical service within the Institute. Professor Angelini confirmed that the opportunity was available for the clinical service to be part of the Institute. However, as a formal management structure was not planned, a Management Board would not be identified.'[290]

253 Mrs Ferris, as the author of these minutes, described the atmosphere at the meeting in her oral evidence:

> '… these are very innocuous minutes which do not reflect that this was a very difficult meeting and the whole of item 1 about the Bristol Heart Institute represented a very difficult discussion about whether or not the Bristol Heart Institute was valuable to the cardiac services directorate, whether or not the cardiac services directorate could benefit from the Bristol Heart Institute. It focused on how the cardiac services directorate fitted into the Bristol Heart Institute and I know there was some concern from surgeons as to whether almost the Bristol Heart Institute would take over the cardiac services directorate, which is why there is the reference there to the formal management structure. There was the fear expressed that the creation of the Heart Institute would mean the cardiac services directorate would be absorbed into that and there would be a management structure with Professor Angelini as the person in charge of both the academic department of cardiac surgery and the clinical service.'[291]

254 When Mrs Ferris was asked who in particular feared Professor Angelini taking over, she replied:

> 'I recall Mr Hutter was very concerned about that. I think Mr Dhasmana to a lesser extent, and I think that whilst not sort of openly critical, I know that James Wisheart was very questioning of what this would actually mean. So it was a sort of, if you are looking for a division between surgeons, it was really Mr Bryan, Professor Angelini trying to reassure … Mr Hutter, Mr Wisheart and Mr Dhasmana that this Bristol Heart Institute was in fact an umbrella for the academic service and would not swamp, absorb or take over the cardiac services directorate.'[292]

255 However, Professor Angelini maintained in evidence that he had no intention of taking over clinical practice. He explained:

> 'The Bristol Heart Institute was conceived with the approval of the University. In fact, … the Bristol Heart Institute is a Research Centre within the University, nothing whatsoever to do with the NHS. It has two functions. One is to bring under the same umbrella all the cardiovascular research done in Bristol. This comprises as well as clinicians, biochemists, pharmacologists, physicians and so forth. It has an executive board made of various members, clinical and non-clinical, who meet once or twice a year. The purpose of this is to give strength to any proposal which

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[290] UBHT 0229 0005; meeting of cardiac surgeons, 12 October 1995

[291] T27 p. 115 Mrs Ferris

[292] T27 p. 116 Mrs Ferris

> comes from Bristol, because there is a large body of research groups working in that area. This is particularly relevant nowadays, because, for example, the MRC [Medical Research Council] would not consider any proposal from individual people.
>
> ‘As a second aspect, I wanted the Bristol Heart Institute to be a separate, if you like, entity in clinical terms and the reason was because I was very concerned as early as the end of 1994, that the performance of the adult cardiac surgery was substandard.
>
> ‘As a result of this, I did not want to incur the same problems as the paediatric, and somehow I wanted to distance myself from the rest of the Unit. As a demonstration of this, in 1994 and 1995 the Bristol Heart Institute produced an annual report which not only had research achievement, but also clinical results … It was the first time that institution, the Bristol institution, had produced data which was open to the general public.’[293]

256 Professor Angelini also explained that there are now several such Institutes within the University:

> ‘There is a Neurology Institute. There is now an Institute of Endocrine Neuroscience. These are created by the University. This institute was set up following a request from the then Dean of the Medical School for me to group all the cardiovascular research in Bristol. It was not even my idea in the first instance. There are many other Institutes within the UBHT, but it does not mean they are going to contract us to do the operation. We just have an honorary status with the Trust. We do the operation the same as any other NHS consultants.’[294]

257 The evidence as to the tensions apparent in the setting up of the Institute reflects evidence as to the nature of relationships between staff of various disciplines (and amongst those of the same discipline) engaged in paediatric cardiac surgical services.

The management of the UBHT under the leadership of Mr Ross

258 Mr Ross told the Inquiry that when he took up his post in succession to Dr Roylance, he discovered that Mrs Maisey was in large part responsible for day-to-day operational matters, rather than Dr Roylance. He said:

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[293] T61 p. 52–4 Professor Angelini

[294] T61 p. 57 Professor Angelini

> 'I felt that almost all of the day to day operational management of the Trust in terms of the business of the Trust had been devolved to the Director of Operations, which was a model, as I say, it is not unusual, but not one that I had previously worked with myself.'[295]

259 Mr Ross had heard the clinical directorates under Dr Roylance described as 'semi-detached'.[296] Dr Thorne, by contrast, thought the clinical directorates were 'quite well integrated'.[297] However, despite the 'semi-detached' description, when Mr Ross arrived at Bristol he found that the clinical director's role was one that he was familiar with from his earlier experience in the health service. He said:

> '[It] was a fairly standard Clinical Director role; there was no job description for the post that I could find and I set out to create one, but the role had been spelled out … quite carefully by my predecessor, because of his feelings about the importance of involving the senior doctors in the Trust fully in the management of the Trust … But it was a Clinical Director role, not unlike that I was familiar with elsewhere.'[298]

260 However, Mr Ross felt there was little central direction at the UBHT when he arrived. He said:

> 'I did feel, when I came to the Trust, that the devolution to the directorates had gone too far and that the overall performance of the organisation was not as tightly controlled and managed as it needed to be. As the new Chief Executive, I felt a little nervous about that, if I am frank, and have worked since then to try and get the right balance between the local ownership and responsibility that I talked about and the need to performance manage the whole organisation in a very tight and proactive manner, especially as the expectations placed upon the Trust by government grow greater with each year.'[299]

261 Mr Ross also encountered the 'club culture' at Bristol. He said:

> '… it certainly was a strong feeling when I arrived from General Managers that issues like promotion within the Trust and so on were not decided necessarily on objective grounds, based on individual reviews and performance reviews and so on, but on some less easily measurable factors and things like fit or, you know, whether you were in, those were the sorts of things they said to me they thought were more influential in deciding issues of promotion and so on than perhaps objective measurements of their success in doing their job.'[300]

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[295] T19 p. 13 Mr Ross
[296] T19 p. 22 Mr Ross
[297] T35 p. 111 Dr Thorne
[298] T19 p. 17–18 Mr Ross
[299] T19 p. 21 Mr Ross
[300] T19 p. 53 Mr Ross

262 Mr Ross explained that the oral culture fostered by Dr Roylance had been preserved under his own leadership of the UBHT. Mr Ross said:

> '… that is still the culture. The pace and complexity with which we work demands that many things are said once and done, and I think if we put everything in writing, the whole organisation would grind to a halt. So there is still an oral culture at director level to a large extent and I think it is fair to say that is what I inherited.'[301]

263 However, he added:

> '… I think if things get put in writing, it means they are important, and they need to be put into writing because they are important.'[302]

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[301] T19 p. 46 Mr Ross

[302] T19 p. 47 Mr Ross

Chapter 7 – Supra Regional Services

Summary and chronology

1 In 1983 it was agreed between the Department of Health and Social Security (DHSS), the regional health authorities (RHAs) and the Joint Consultants Committee (JCC) that new supra regional service (SRS) arrangements would be introduced. The arrangements came into force at the beginning of the financial year 1983/84 with neonatal and infant cardiac surgery (NICS) being included in the scheme from the start of the financial year 1984/85.

2 The Royal College of Surgeons of England (RCSE) and the Royal College of Physicians of London (RCP) set up a joint working party that reported on 1 September 1986 into the matter of proliferation.

3 In December 1987 the Welsh Office asked the RCP to set up a task force to review cardiac surgery and cardiology in Wales.

4 On 22 January 1988 the Supra Regional Services Advisory Group (SRSAG), for the first time, discussed the possible de-designation of the whole service.

5 In May 1988 the RCP reported the Welsh Office as saying, amongst other things, that South Wales was capable of sustaining its own cardiac service.

6 On 28 July 1992 it was agreed that the SRS for NICS should be de-designated with effect from April 1994.

The national framework

Introduction

7 The SRS was intended to support the national development of highly specialised services, which required particular clinical expertise or experience, might need particular facilities and equipment, and for which the demand was such that they could not economically be provided in each region. It was hoped that by providing a special funding system, dedicated to an individual service, proliferation in the development of these services could be limited.

8 The funds for the SRS were acquired by 'top-slicing' a levy each year from the funds allocated by Parliament for Hospital and Community Health Services. The levy had the effect of reducing (marginally) the overall amount available for RHAs to spend on local health services. The SRS funds were then administered directly by the Department (of Health and Social Security, from 1988 of Health), on the advice of the

SRSAG. The secretariat of the SRSAG liaised directly with the health authorities and later the trusts that provided services funded through this mechanism. The financial implications of SRS for Bristol are set out in Chapter 6.

9 The top-sliced amount was then used to provide secure funding direct from the Department to centres 'designated' to receive such funds as part of a designated service. It was as part of the SRS that, between 1984 and 1994, funds were made available for the designated service of NICS.

10 NICS related to children under 1 year of age only: 'infants' meant children under 1, and the term 'neonates' meant children under 1 month of age. Throughout the period of the Inquiry's Terms of Reference, the arrangements for organising and funding cardiac surgery for older children, those aged between 1 and 16, were the same as those which applied to the vast majority of children's and adult acute healthcare services. Thus, there were no special arrangements for funding paediatric cardiac surgery for children aged over 1. It was funded through the Regional Health Authority (RHA), until the provider-purchaser split took effect in 1991, after which they were provided in accordance with arrangements ('contracts') made between the provider unit and the District Health Authority (DHA) purchasers.

Rationale for supra regional funding

11 The concept of focused, specialised centres for, amongst other specialities, NICS, was something discussed within the medical profession from at least the 1960s.

12 Dr Norman Halliday (Medical Secretary, SRSAG 1983–1994) said in evidence:

> 'The reason for setting up the supra regional service and the reason for selecting any particular service was principally funding … But of course from the Department's point of view, we recognised that there was also a benefit in that. There was a benefit in that we could control the development of the services, which would be beneficial in terms of cost, but also beneficial in terms of benefits to the patients, because the experience worldwide was that the more a doctor does a particular form of treatment, the better are his results. So by controlling the development of these services, we would be giving benefits to the patients.'[1]

13 The process by which the system was gradually established began in earnest from 1974 onwards. It included the setting up of a Joint Working Party between the Department's Medical Policy Division (MPD) and representatives of the medical profession to consider how specialised clinical services should be delivered.[2]

14 This Working Party met regularly and, in 1983, the need for specialist services was agreed between the Department, the RHAs and the Joint Consultants' Committee (JCC) such that, consequently, SRS arrangements would be introduced. A view was

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[1] T13 p. 12 Dr Halliday

[2] WIT 0049 0002 Dr Halliday

taken that, in order to be economically viable and clinically effective, the small number of specialised health services (serving a population substantially larger than that of any one region) could not be funded through the usual mechanism.

15 In his formal written statement Dr Halliday stated that, in relation to designation:

> 'An essential criterion which was agreed with the medical profession during the protracted discussions leading to the establishment of the SRS arrangements was the requirement that a designated service should not be provided outside of designated units.'[3]

16 Dr Halliday defined the 'medical profession' as the JCC, the Royal Colleges and the British Medical Association (BMA).[4]

17 In oral evidence he also described his understanding of the role of advice from the Royal Colleges, in designating particular units as part of the SRS:

> 'I think you would have to ask the Royal Colleges what they were looking for, but what we would expect from the Royal Colleges is their expert opinion as to the facilities available in the unit, the staffing of the unit, the qualifications and experience of the staff, and in their opinion, the ability of that unit to provide that service.'[5]

18 In respect of proliferation, the SRS was able to nurture the chosen specialties, many of which were new forms of treatment or treatments for small groups in the population, thus allowing expertise to develop within the funded Centres. It appears to have had some success in limiting the spread of some specialised services, e.g. transplant surgery. Dr Halliday's view was that the overall supra regional system had 'proved to be a complete success'.[6] He said:

> 'If one can implement the arrangements effectively, you should have the services concentrated in a few centres.'[7]

However, paediatric cardiac surgery had already been provided in a number of units before the scheme began and proliferation in this area was always difficult to control.

19 The SRSAG knew that there were 'too many' units undertaking NICS, as Dr Halliday explained:

> '... the supra regional service arrangements were set up for any service that fitted the criteria. We took neonatal and infant cardiac surgery into the arrangements

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[3] WIT 0049 0013 Dr Halliday
[4] WIT 0049 0018 Dr Halliday
[5] T13 p. 18 Dr Halliday
[6] WIT 0049 0003 Dr Halliday
[7] T13 p. 14 Dr Halliday

> knowing that there were more units than we needed. We hoped we could bring about a rationalisation. That was not achieved. That is not a failure of the supra regional service funding arrangements, that is a failure of trying to change an established service, which had been in existence for decades, and, in the absence of any formal powers that will allow anyone to tell doctors what to do, I do not think it is in the interests of anyone to tell doctors what to do.'[8]

20 The Department had no binding powers to limit services only to designated centres and, indeed, recognised this. For example, on 27 October 1986 Mr Antony Hurst (Administrative Secretary of the SRSAG, 1983–1987) wrote to the South Western Regional Health Authority (SWRHA), indicating that the supra regional arrangements were:

> '… essentially funding arrangements, and we have no powers to determine referral practices which remain a clinical responsibility; HN(83)36 discourages health authorities from providing supra regional services in units that are not designated as supra regional centres, but this is not binding on clinicians.'[9]

The administration of supra regional services: Supra Regional Services Advisory Group (SRSAG)

21 As part of the SRS, an Advisory Group was established with Terms of Reference which included the duty:

> 'To advise the Secretary of State, through Chairmen of Regional Health Authorities, on the identification of services to be funded supra regionally and on the appropriate level of provision.' [10]

22 This advice was to cover which services should be funded, supra regionally, in the forthcoming year; which units should be designated to provide them; and what level of funds should be allocated to each designated unit. Authorities would then be notified of the Secretary of State's decision, reached in the light of the SRSAG's recommendations.[11]

23 The Inquiry heard evidence from Sir Graham Hart, Permanent Secretary at the Department of Health from March 1992 to November 1997, on the position of the SRSAG in the Departmental structure.

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[8] T13 p. 82 Dr Halliday

[9] UBHT 0062 0213; letter dated 27 October 1986 from Mr Hurst to SWRHA

[10] DOH 0002 0022; circular HN(83)36

[11] DOH 0002 0022; circular HN(83)36

24 He indicated that:

> ‘It was not technically part of anybody’s command. It was an advisory group, chaired by a regional chairman who actually stood outside the Departmental structure. It was outside people serviced by officials from within.’[12]

He went on to say: ‘I do not think it reported to any official in the Department; it reported unequivocally to ministers.’[13]

25 Sir Graham explained how there was interaction between the SRSAG and the NHS Management Executive (NHSME) and the wider Department.[14] He also described the process:

> ‘The Supra Regional Services Advisory Group would meet. They would consider papers. They would take decisions. Those decisions would, as it were, take the form of recommendations to ministers.
>
> ‘Officials in the Department on the policy side would then brief ministers, inform ministers, about those decisions … When there was something that needed to be decided or to be done of importance, then either Dr Halliday or one of his administrative colleagues, they would presumably agree between them who would handle it, would put a submission up the line which would go to ministers.’[15]

26 Later in his evidence, Sir Graham again dealt with the process:

> ‘… it [the SRSAG’s recommendation] would come with a submission from officials, saying “Here is a report from the Supra Regional Services Advisory Group”, I would expect, “This is what we think about it and here are the issues that you need to consider, you need to be aware”, you know, on the pro side, on the con side. “Will you please tell us your decision”.’[16]

27 The SRSAG was supported by a Secretariat provided by a Departmental doctor and an official. The Medical Secretary, Dr Halliday, was in post throughout the period 1983 to 1992.[17] He was a Senior Principal Medical Officer and reported to Dr Michael Abrams, Deputy Chief Medical Officer.

28 The Administrative Secretary held the grade of Principal. During the relevant period, Anthony Hurst 1983–1987, Alan Angilley 1987–1992 and Steven Owen 1992–1996 held the post.

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[12] T52 p. 7 Sir Graham Hart

[13] T52 p. 12 Sir Graham Hart

[14] T52 p. 11 Sir Graham Hart

[15] T52 p. 14 Sir Graham Hart

[16] T52 p. 17–18 Sir Graham Hart

[17] WIT 0049 0001; Dr Halliday continued as Secretary to SRSAG after he retired in 1992, until 1994

NICS as a supra regional service (SRS)

29 Numerous reports, papers and notes of meetings were written on the topic of NICS and will be referred to hereafter. For convenience, the following table sets out the principal documents:

Table 1: Principal documents

Date	Title	Author
1 February 1979	Cardiac Services for Children in England and Wales	Gray OP (British Paediatric Association) (University Hospital of Wales), Mann TP (British Paediatric Association) (Royal Alexandra Hospital), Simpkiss MJ (British Paediatric Association) (Poole General Hospital), Joseph MC (British Paediatric Cardiology Section) (Guy's Hospital), Jones RS (British Paediatric Cardiology Section) (Alder Hey Children's Hospital), Watson GH (British Paediatric Cardiology Section) (Royal Manchester Children's Hospital)
1 January 1980	Provision of Services for the Diagnosis and Treatment of Heart Disease in England and Wales	Joint Cardiology Committee of the Royal College of Physicians of London and the Royal College of Surgeons of England
1 January 1980	Second Report of a Joint Cardiology Committee of the Royal College of Physicians of London and the Royal College of Surgeons of England on Combined Cardiac Centres for Investigation and Treatment with a note on the Requirements of Cardiology in Hospitals Outside such a Centre	Royal College of Physicians of London, Royal College of Surgeons of England
1 December 1981	Report of the Working Party on Cardiothoracic Services in Wales	
December 1983	Supra Regional Services Circular HN (83)36	Department of Health and Social Security (DHSS)

Table 1: Principal documents (continued)

Date	Title	Author
4 October 1984	Minutes of the meeting of Consultants from the nine designated Supra Regional Centres called by the Department of Health & Social Security (DHSS) held on 4 October 1984 in Hannibal House, Elephant and Castle, London	DeGionvani JV (Birmingham), Dickinson D (Leeds), Hamilton D (Liverpool), Holden MP (Newcastle), Hunter S (Newcastle),Jones O (Guy's), Jordan S (Bristol), Keeton BR (Southampton), Lincoln C (Brompton), Macarthey F (Gt Ormond Street), Munro J (Southampton), Shinebourne EA (Brompton), Silove ED (Birmingham), Stark J (Gt Ormond Street), Tynan M (Guy's), Davidson J (Nursing Division), Hurst A (Health Services Division, Chairman, afternoon), McInnes D (Medical Division – Paediatric Services), O'Toole SM (Finance Division), Paterson NFC (Health Services Division), Prophet M (Medical Division, Chairman, morning), Sherriff JM (Health Services Division), Wilkinson JL (Liverpool), Walker D (Leeds)
5 December 1984	Minutes of the meeting of representatives of the designated Supra Regional Centres called by the DHSS held on 5 December 1984 in Hannibal House, Elephant and Castle, London	DeGionvani JV (Birmingham), Dickinson D (Leeds),Hamilton D (Liverpool), Hunter S (Newcastle), Joffe HS (Bristol), Jones O (Guy's), Keeton BR (Southampton), Lincoln C (Brompton), Macarthey F (Gt Ormond Street), Munro J (Southampton), Shinebourne EA (Brompton), Silove ED (Birmingham), Stark J (Gt Ormond Street), Tynan M (Guy's), Walker D (Leeds), Wilkinson JL (Liverpool), Wisheart J (Bristol), Hurst A (Health Services Division, Chairman), McInnes D (Medical Division – Paediatric Services), Staniforth M (Medical Division – Cardiac Services), Sherriff J (Health Services Division, Secretary), Roberts KD (Birmingham), Shaw D (Southampton)
1 June 1986	South Glamorgan Health Authority – Regional Cardiac Service for Wales – Paediatric Cardiac Facilities to be Provided at The University Hospital of Wales Cardiff – 'Approval in Principle' Submission June 1986	Harrhy G (South Glamorgan Health Authority)
1 September 1986	Report of a Joint Working Party of the Royal College of Physicians of London and the Royal College of Surgeons of England	Royal College of Physicians of London, Royal College of Surgeons of England
2 September 1986	Draft Copy – Paediatric Cardiac Services in Wales	Henderson A

Table 1: Principal documents (continued)

Date	Title	Author
2 September 1986	Note of meeting between the Welsh Office and South Glamorgan HA on 2 September 1986 at the Boardroom University Hospital Wales (UHW) Cardiff	McGlinn D (Welsh Office), George M (Welsh Office), Vass D (Welsh Office), Skone J (South Glamorgan HA), Thomas (South Glamorgan HA), Henderson A (South Glamorgan HA), Roberts KD (South Glamorgan HA), Williams R (South Glamorgan HA), Clay L (South Glamorgan HA), Wilson P (South Glamorgan HA), Abrorillo A (South Glamorgan HA)
20 October 1986	Note of meeting held by Medical Officers of the Welsh Office with South Glamorgan Health Authority on 20 October 1986	Crompton G (Welsh Office), Hine D (Welsh Office), George A (Welsh Office), Lloyd J (Welsh Office), Webb S (Welsh Office), Henderson A (South Glamorgan HA), Gray O (South Glamorgan HA), Hughes I (South Glamorgan HA),Skone J (South Glamorgan HA)
10 December 1986	Paediatric Cardiology and Paediatric Cardiac Surgery – A Situation Report	Lloyd J
Late 1986	Paediatric Cardiology Services for Wales – Report on Neonatal and Infant Cardiology and Cardiac Surgery	Welsh Office
22 January 1988	Paper SRS(88)2	SRSAG
May 1988	Royal College of Physicians Report on Advisory Group on Cardiac Services in South Wales	Royal College of Physicians of London
22 February 1989	Report of a visit on behalf of the Specialist Advisory Committee in Cardio-Thoracic Surgery to the Bristol Hospitals – Bristol Royal Infirmary and Frenchay	Ross B, Taylor K
1 July 1989	Interim Report of the Working Party on Neonatal and Infant Supra Regional Cardiac Surgical Units in England and Wales	Joint Working Party on Neonatal and Infant Supra Regional Cardiac Surgical Units
28 September 1989	Minute of meeting held on 28 September 1989 in Hannibal House, Elephant and Castle, London	SRSAG
1990	Paper – SRS (90) 6	SRSAG
1990	Paper – SRS (90) 15	SRSAG
26 July 1990	Minutes of the meeting held on 26 July 1990 at Hannibal House, Elephant and Castle, London	SRSAG
3 October 1990	Minutes of the meeting held on 3 October 1990 at Hannibal House, Elephant and Castle, London	SRSAG
1991	Draft SRS (91)	SRSAG
1992	SRSAG – Designation Issues – SRS 92(2)	SRSAG

Table 1: Principal documents (continued)

Date	Title	Author
4 February 1992	SRSAG Minutes of the meeting held on 4 February 1992 in Hannibal House, Elephant and Castle, London	Addicott G, Appleyard W, Carlisle M, Davenport P (Welsh Office), Davies M, Edwards P, English T,Ferguson J, Green M, Halliday N, Jones N, Kearns W, Kemp P, Kent H, Munday S, Owen S, Ross A, Shaw D, Shipton N, Sowerby M, Spence D, Spry C, Taylor A, Turnbull N, Winterton P
31 March 1992	Annual Report for the Period Ending 31 March 1992	SRSAG
1 June 1992	Report from the Working Party set up by the Royal College of Surgeons of England on NICS – Supra Regional Funding and Designation	RCSE
12 June 1992	Infant Cardiac Surgery and the Changing Practice of Paediatric Cardiology – The Case Against Supra Regional Designation	Department of Paediatric Cardiology – Guy's Hospital
28 July 1992	SRSAG Minutes of the meeting held on 28 July in Hannibal House, Elephant and Castle, London	Appleyard W, Carlisle M, Davenport P (Welsh Office), Edwards P, Ferguson J, Garlick J, Halliday N, Howell J, Jones N, Kearns W, Kemp P, Kent H, Owen S, Ross A, Shaw D, Shipman N, Sowler E (Scottish Office), Spry C
8 July 1994	Report of a visit on behalf of the Specialist Advisory Committee in Cardio-Thoracic Surgery to the Bristol Hospitals – Bristol Royal Infirmary and Frenchay	Dussek J, Hamilton D
13 July 1994	Bristol Royal Infirmary – Report to the Hospital Recognition Committee 13 July 1994	Kapila L, May P

30 Likewise, discussions regarding NICS as an SRS took place over several years and are also dealt with in the text hereafter. For convenience the following table sets out the principal meetings:

Table 2: Principal meetings

Date	Title	Author	Attendees
4 October 1984	Meeting of Consultants from the nine designated Supra Regional Centres called by the Department of Health & Social Security (DHSS) held on 4 October 1984 in Hannibal House, Elephant and Castle, London		DeGionvani JV (Birmingham), Dickinson D (Leeds), Hamilton D (Liverpool), Holden MP (Newcastle), Hunter S (Newcastle), Jones O (Guy's), Jordan S (Bristol), Keeton BR (Southampton), Lincoln C (Brompton), Macarthey F (Gt Ormond Street), Munro J (Southampton), Shinebourne EA (Brompton), Silove ED (Birmingham), Stark J (Gt Ormond Street), Tynan M (Guy's), Davidson J (Nursing Division), Hurst A (Health Services Division, Chairman, afternoon), McInnes D (Medical Division – Paediatric Services), O'Toole SM (Finance Division), Paterson NFC (Health Services Division), Prophet M (Medical Division, Chairman, morning), Sherriff JM (Health Services Division), Wilkinson JL (Liverpool), Walker D (Leeds)
5 December 1984	Meeting of Representatives of the Designated Supra Regional Centres called by the DHSS held on 5 December 1984 in Hannibal House, Elephant and Castle, London		DeGionvani JV (Birmingham), Dickinson D (Leeds), Hamilton D (Liverpool), Hunter S (Newcastle), Joffe HS (Bristol), Jones O (Guy's), Keeton BR (Southampton), Lincoln C (Brompton), Macarthey F (Gt Ormond Street), Munro J (Southampton), Shinebourne EA (Brompton), Silove ED (Birmingham), Stark J (Gt Ormond Street), Tynan M (Guy's), Walker D (Leeds), Wilkinson JL (Liverpool), Wisheart J (Bristol), Hurst A (Health Services Division, Chairman), McInnes D (Medical Division – Paediatric Services), Staniforth M (Medical Division – Cardiac Services), Sherriff J (Health Services Division, Secretary), Roberts (Birmingham), Shaw D (Southampton)

Table 2: Principal meetings (continued)

Date	Title	Author	Attendees
2 September 1986	Meeting between the Welsh Office and South Glamorgan HA on 2 September 1986 at the Boardroom, University Hospital Wales (UHW) Cardiff		McGlinn D (Welsh Office), George M (Welsh Office), Vass D (Welsh Office), Skone J (South Glamorgan HA), Thomas (South Glamorgan HA), Henderson A (South Glamorgan HA), Roberts (South Glamorgan HA), Williams R (South Glamorgan HA), Clay L (South Glamorgan HA), Wilson P (South Glamorgan HA), Abrorillo A (South Glamorgan HA)
8 September 1986	Meeting held by the Welsh Office on 8 October 1986 to Discuss a. Burns and Plastic Surgery Unit – Morriston Hospital, b. Paediatric Cardiac Development in UHW Cardiff		Crompton G, Hine D, George A, Ferguson D, Pritchard J, Vass D, Grist M, Gornall D, Harding G, Lloyd L, McGlinn D, Webb S
20 October 1986	Meeting held by Medical Officers of the Welsh Office with South Glamorgan Health Authority on 20 October 1986		Crompton G (Welsh Office), Hine D (Welsh Office), George A (Welsh Office), Lloyd J (Welsh Office), Webb S (Welsh Office), Henderson A (South Glamorgan HA), Gray O (South Glamorgan HA), Hughes I (South Glamorgan HA), Skone J (South Glamorgan HA)

Table 2: Principal meetings (continued)

Date	Title	Author	Attendees
21 January 1987	Welsh Medical Committee – Infant Cardiac Surgery and Paediatric Cardiology Services – Meeting held on 21 January 1987 at the Welsh Office		Owen D (Welsh Committee for Hospital Medical Services), Daley D (Welsh Committee for Hospital Medical Services), Broughton R (Welsh Committee for Hospital Medical Services), Davies R (Gwynedd DMC), Duthie H (University of Wales College of Medicine), Edwards A (Clwyd DMC), Edwards H (Welsh Medical Manpower Committee), Evans K (West Glamorgan DMC), Hayes T (Committee for Postgraduate Medical Education, Wales), Jones J (South Glamorgan DMC), Kilpatrick G (University of Wales College of Medicine), Lowther J (Gwent DMC), Palit A (Pembrokeshire DMC), Reynolds G (Welsh Committee for Community Medical Services), Watson M (General Medical Services Committee, (Wales), Crompton G (Welsh Office), George A (Welsh Office), Hine D (Welsh Office), Lloyd J (Welsh Office), Thomas D (Welsh Office), Thomas H (Welsh Office), Saunders M (Welsh Office), Henderson A (University Hospital of Wales), Williams R (Welsh Office), Butchart E (University Hospital of Wales), Verrier Jones E (South Glamorgan HA)
21 September 1988	Meeting of the Executive Committee of the Society of Cardiothoracic Surgeons of Great Britain and Ireland on 21 September 1988	Society of Cardiothoracic Surgeons of Great Britain and Ireland	Ross K, Smith GH, Bain W, Parker J, Cleland J, Williams WG, Monro J,Watson D, Ross B, Sethia B, Pepper J, Goldstraw P, Frost-Wellings S
12 May 1989	Meeting of the Executive of the Society of Cardiothoracic Surgeons of Great Britain and Ireland on 12 May 1989	Society of Cardiothoracic Surgeons of Great Britain and Ireland	Smith GH, Bain W, Cleland J, Williams W, Watson D, Ross B, Sethia B, Jeyasingham K, Matthews H, Hamilton D, Hilton C, Frost-Wellings S, Jones M
28 September 1989	Supra Regional Services Advisory Group (SRSAG) – meeting held on 28 September 1989 in Hannibal House, Elephant and Castle, London	Supra Regional Services Advisory Group	Angilley A, Barros S, Carlisle M, Davies M, Ferguson J, Grabham A, Greenwood R, Halliday N, Horsley S, Hunt T, Kenward D, Ledingham J, Malley R, Owen S, Revell D, Roy S, Sherriff J, Taylor A

Table 2: Principal meetings (continued)

Date	Title	Author	Attendees
20 September 1990	Meeting of the Executive of the Society of Cardiothoracic Surgeons of Great Britain and Ireland on 20 September 1990	Society of Cardiothoracic Surgeons of Great Britain and Ireland	Williams B, Matthews H, Smith G, Dussek J, Elliot M, Jeyasingham K, Lock T, Ross B, Frost-Wellings S, Robinson S
3 October 1990	SRSAG meeting held on 3 October 1990 in Hannibal House, Elephant and Castle, London	Supra Regional Services Advisory Group	Angilley A, Barros S, Carlisle M, Davies M, English T, Grabham A, Halliday N, Kenward D, Malley R, McGlinn D, Roy S, Shaw D, Sherriff J, Taylor A, Whiteley S (Department of Health), Winterton P
21 February 1991	Meeting of the Executive Committee of the Society of Cardiothoracic Surgeons of Great Britain and Ireland on 21 February 1991	Society of Cardiothoracic Surgeons of Great Britain and Ireland	Hamilton D, Williams W, Williams W, Matthews H, Smith G, Dussek J, Jeyasingham K, Ross B, Frost-Wellings S
4 February 1992	SRSAG meeting held on 4 February 1992 in Hannibal House, Elephant and Castle, London		Addicott G, Appleyard W, Carlisle M, Davenport P (Welsh Office), Davies M, Edwards P, English T, Ferguson J, Green M, Halliday N, Jones N, Kearns W, Kemp P, Kent H, Munday S, Owen S, Ross A, Shaw D, Shipton N, Sowerby M, Spence D, Spry C, Taylor A, Turnbull N, Winterton P
28 July 1992	SRSAG meeting held on 28 July in Hannibal House, Elephant and Castle, London		Appleyard W, Carlisle M, Davenport P (Welsh Office), Edwards P, Ferguson J, Garlick J, Halliday N, Howell J, Jones N, Kearns W, Kemp P, Kent H, Owen S, Ross A, Shaw D, Shipman N, Sowler E (Scottish Office), Spry C

31 The system of supra regional funding for designated services came into force at the beginning of the financial year 1983/84 and initially applied to four services but did not include NICS.[18] The Inquiry took evidence as to the inclusion of NICS as a designated service with effect from the following year, and the way in which Bristol came to be a designated centre.

32 In 1967 the Joint Cardiology Committee of the RCP of London and the RCSE prepared a report (for publication in 1968) on the need for special cardiac centres for diagnosis, treatment and research.[19]

33 In 1967 the British Paediatric Association (BPA) reported a need to concentrate operations to remedy congenital heart defects in young children in a few centres only.

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[18] DOH 0002 0022; circular HN(83)36

[19] *'British Heart Journal'*; 1968 40: 864–8

In 1979 the BPA followed up its 1967 Report with the recommendation that six NICS centres (including one in the South West) should be established.[20]

34 In 1980 the London Health Planning Consortium recommended three centres to be established in London.[21]

35 It was with this background that, in 1980, the Second Report of the Joint Cardiology Committee of the RCP and the RCSE was published.[22]

36 Amongst other things, the Report indicated that: the size of a supra regional centre should depend on the population served; diagnosis and treatment were intimately linked; it was to be expected that the greater the number of operations performed the less should be the rate of mortality; the number of units should be 'certainly under ten'; and that the selection of SRCs should be based on present workload, geographic location and quality of work.[23]

37 In 1982 the Regional Medical Officers suggested nine centres (being exactly those that were designated in 1984).[24]

38 In 1983 the SRSAG considered the provision of treatment for children born with congenital heart disease. At that time, two quite recent reports were available, from the BPA (1979) and the Joint Cardiology Committee of the RCP and the RCSE (1980).

39 The fundamental theme accepted and endorsed by the SRSAG was that provision should be concentrated into relatively few centres to ensure a high standard of diagnosis and treatment. It was also noted that there were too many small units receiving financial support that would be better directed towards developing the larger and more efficient ones.

40 At this time the SWRHA was of the view that '... Bristol is not necessarily large enough to fulfil the criteria of a catchment population of 5 million ...'[25]

41 This estimate was derived from estimates accepted by the SRSAG:

> 'The BPA estimated that the incidence of CHD [congenital heart disease] to be of the order of 7–8 per 1,000 live births. This figure has been accepted more recently by Macartney, Kernohan et al, the JCC [Joint Cardiology Committee of the RCP and the RCSE], and in a report of a joint working party of the Royal College of Surgeons and Royal College of Physicians.'[26]

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[20] BPCA 0001 0014; '*BPA Report'* 1967

[21] ES 0002 0007; *'London Health Planning Consortium Report';* 1980

[22] RCSE 0003 0017 – 0023; *'Second Report of the Joint Cardiology Committee'*; 1980

[23] RCSE 0003 0017 – 0023; *'Second Report of the Joint Cardiology Committee'*; 1980

[24] ES 0002 0007; minutes of a meeting of representatives of the designated SRCs, 5 December 1984

[25] HAA 0095 0071. This document appears to be dated 14 November 1983 – see HAA 0095 0073

[26] DOH 0002 0240; *'SRS Report'* (88)2

42 The SRSAG went on to note that:

> '… an estimation of need is dependent upon the birth rate, and it is not possible to forecast with any certainty whether it will move significantly in either direction, but it may be acceptable to suggest that only a marked swing will exert any real influence for planning purposes …'

43 Dr Barry Keeton, consultant paediatric cardiologist, Southampton General Hospital, and a member of the Inquiry's Expert Group, during his evidence to the Inquiry, described his recollection of the process behind the setting up of the SRS for NICS. He said:

> '... I recall that prior to the setting up, there were eight centres that had been nominated for supra regional designation, and then my next recollection is that the Regional Medical Officers commissioned a report. I had some personal knowledge of this because the lady who did it came round to visit me and I gave her some help in the data, the statistics from Southampton.
>
> 'Following that Regional Medical Office report, there were then 9 centres and that was the point at which Bristol was added on, I think in 1984, to the supra regional list.'[27]

44 Dr Keeton was also asked:

> 'Q. So your understanding was that the view of the profession, before the RMOs had their meeting, was that essentially Bristol was not a natural candidate for supra regional status and it became one following that meeting.
>
> 'A. Yes. It led to some correspondence between members of my group, my surgical colleagues and the Regional Medical Officer, … I can recall his letter very well, saying that he thought that centres were based around people's expertise and not around railway timetables and the geography was not an issue, but the centres should be designated according to their results.
>
> 'There were discussions then with the Supra Regional Services about audit results. I attended each year the meeting of the department of the Supra Regional Services Committee, and a member in each of the hospitals was there to present any problems that they had and what their results and things had been from the previous years, but I remember at those meetings we were calling then for the setting up of a country-wide audit on the results of paediatric cardiac surgery, but it never really got off the ground, it was never funded.

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[27] T51 p. 112 Dr Keeton

> ‘Q. This was back when?
>
> ‘A. It would be in the early days of supra regional funding. It must have been in the middle 1980s.’[28]

45 Dr Hyam Joffe, consultant cardiologist, also recollected that he ‘had a hand’[29] in Bristol being designated. He said:

> ‘When we knew that these centres were being designated, I believed it was important, if possible, for Bristol to provide one of these designated services, partly because of geographical reasons, partly because I believed the unit had the potential to become an outstanding unit; and I was, secondly, I suppose “appalled” is the word, at the fact that there had been no attempt by the people who were making the designations to visit Bristol and see the centre and find out what it had to offer. So I wrote a letter which was supported by Dr Jordan to the individual that I thought was the Chairman of this supra regional group.’[30]

46 Dr Joffe, Dr Stephen Jordan, consultant cardiologist, and Mr James Wisheart, consultant cardiac surgeon, wrote a memorandum[31] expressing their view that:

> ‘... Bristol has an irrefutable claim of recognition as a supra regional cardiac centre for neonates and infants ... Redirection of these [cardiac] patients to a centre elsewhere must result in a demise of meaningful paediatric cardiology in Bristol.’[32]

47 The memorandum pointed out that Bristol had historically provided a paediatric cardiac service to its catchment area:[33]

> ‘The paediatric cardiology service already functions as the de facto Regional and Supra Regional Centre (although not yet officially recognised as such), drawing 28% of new referrals to the unit from Avon, 48% from the rest of the SW Region and 24% from South Wales, North Wessex and elsewhere …
>
> ‘The long-term management of patients is supervised near their homes through a system of Consultant Cardiac Clinics developed over many years and probably more comprehensive than in any other paediatric cardiology service in England. Regular peripheral clinics are held in Bath, Swindon, Cheltenham, Gloucester, Taunton, Barnstaple, Exeter, Torquay, Plymouth and Truro. Close liaison exists with paediatricians in all these centres, who would resist any curtailment in the services they and their patients receive.’

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[28] T51 p. 113 Dr Keeton

[29] T90 p. 69 Dr Joffe

[30] T90 p. 69–70 Dr Joffe

[31] JDW 0001 0150 – 0152; memorandum on the designation of Bristol as a SRC in NICS, July 1982

[32] JDW 0001 0150 – 0152; memorandum on the designation of Bristol as a SRC in NICS, July 1982

[33] See Chapter 11 for further consideration of the Bristol catchment area

48 The clinicians' memorandum argued that it was:

> '... unrealistic to base any such decision simply on current surgical volume in infants, without taking cognisance of other important factors such as geographical position and communications, association with the University Department of Child Health, historical evolution and ties with paediatricians in the region and adjacent areas of other regions, anticipated expansion and development, and standards of associated paediatric and neonatal services.'[34]

49 The memorandum refers to, and apparently rehearses, arguments put forward in October 1981 favouring Bristol as an SRC including the following: (1) the service already functioned as a de facto supra regional centre; (2) there were two experienced and expert paediatric cardiologists and two experienced cardiac surgeons, one of whom had been specially trained in congenital heart disease surgery; (3) long-term management of patients near their homes through a system of consultant cardiac clinics; (4) the geographic position of Bristol with major rail connections and road services; (5) that the Bristol Royal Hospital for Sick Children (BRHSC) was 'ideally suited' to provide direct access to the expertise of a range of clinicians and healthcare workers.[35]

50 In relation to the geographical case for designation of Bristol, Dr Halliday was asked:

> 'Q. You say more than once, I think, in your statement, that there was evidence that the more operations a unit did, the better they got at it?
>
> 'A. Yes.
>
> 'Q. I am putting it very crudely, but that is the essential principle, is it not?
>
> 'A. Yes.
>
> 'Q. So one would expect the biggest centres to have better results?
>
> 'A. Yes.
>
> 'Q. If one factors that into the equation, it makes a bit of a difference in the geographical case, does it not? The geographical case depends upon, does it not – tell me if I am wrong – the results being equal in the two centres being compared?
>
> 'A. Yes, but if you are designating a service for the first time and you are endeavouring to cover the country, you may well have to identify a unit which at that moment in time is not performing as well as some of the other centres which

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[34] JDW 0001 0150; memorandum on the designation of Bristol as a SRC in NICS, July 1982

[35] JDW 0001 0150 – 0151; memorandum on the designation of Bristol as a SRC in NICS, July 1982

> may have been established for many years, but the intention is to develop that service, nurture that service.'[36]

51 A subsequent Departmental paper called *'Centres of Excellence and Supra Regional Units,'*[37] dated 12 September 1988, addressed to managers, identified that centres suitable for designation had to qualify as 'centres of excellence'. It added:

> 'Centres of Excellence: Units which might qualify for this title are those where a special expertise had been developed in a particular area of medicine'.[38]

52 Under the heading 'Overlaps Between Supra Regional Services and Other Centres of Excellence', the same paper said:

> 'All supra regional services will be provided in units which would fall within the "centres of excellence" definition.'[39]

53 There is no evidence in the documentation now available that Bristol was regarded, at the time of designation, as a centre of excellence in relation to NICS.

54 Sir Terence English,[40] who was a member of the Specialist Advisory Committee in Cardiothoracic Surgery between 1979 and 1987, was asked:

> 'Could it be said of Bristol that in 1983 there had been developed there a special expertise in neo natal and infant cardiac surgery?'

He answered: 'No.'[41]

55 In January 1987 Mr Eric Butchart, consultant cardiothoracic surgeon at the University Hospital of Wales in Cardiff, was of the opinion that Bristol was not a centre of excellence:

> '… the designation of sites as Supra Regional Centres relied partly upon them being existing centres of excellence, although Bristol had been exceptional in this respect, and had apparently been chosen for geographical considerations.'[42]

56 The view of Dr Halliday was:

> 'My division kept close contact with all the professions within the various specialties, and attending meetings of the Society of Cardiothoracic Surgeons (SCS)

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[36] T13 p. 31 Dr Halliday

[37] DOH 0002 0025 – 0027; DHSS Paper EL(88)P/153

[38] DOH 0002 0026; *'Centres of Excellence and Supra Regional Units',* 1988

[39] DOH 0002 0026; *'Centres of Excellence and Supra Regional Units',* 1988

[40] Currently the President of the British Cardiac Patients Association; previous appointments include the President of the Royal College of Surgeons of England between 1989 and 1992

[41] T17 p. 68 Sir Terence English

[42] WO 0001 0281; minutes of extraordinary meeting of the Welsh Medical Committee, 21 January 1987

> and the Royal College of Surgeons of England (RCSE) when dealing with paediatric cardiac surgery and cardiology, Bristol did not actually shine as a star, whereas many of the other units such as Birmingham, Harefield, Brompton, Guy's, GOS [Great Ormond Street], would stand out, so it did not seem to be one of the leading lights in this area.
>
> 'Q. "Shine as a star" in what sense?
>
> 'A. In terms of clinical work that was going on there, in terms of research, in terms of the results that they were getting.'[43]

57 The minimum workload for a centre to be viable, and maintaining sufficient expertise, was explored. Sir Terence said:

> 'Q. ... Just pausing there, the minimal viable workload for a centre; we spoke earlier of a surgeon needing to do 50 as a minimum operations per year. Is that open-heart operations?
>
> 'A. Open heart.
>
> 'Q. And that corresponds, does it, with the minimum viable workload?
>
> 'A. Yes. I think actually the figure that I had was 40 when this was calculated against the epidemiology of congenital heart disease within the UK and they were first thinking about it, but whether it is 40 or 50, it was considered desirable that that should be roughly the minimum number of open-heart operations performed by a single surgeon per year in the under one-year-old-age group and that there should be at least two surgeons in a unit.
>
> 'Q. Yes, that means the unit would have to do 80–100?
>
> 'A. Correct.
>
> 'Q. Just pausing there, Bristol never did, did it?
>
> 'A. No, you have just pointed out that the year before it was designated it had done three.
>
> 'Q. Or four?
>
> 'A. Or four, correct. But may I add that that, in my view, is not necessarily a reason for not designating a centre, because designation to me involves — the whole concept of supra regional designation was that it was a mechanism by which a particular service could be nurtured and strengthened and developed in certain

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[43] T13 p. 27–8 Dr Halliday

> parts of the country, to provide service. That was the whole history of the designation of prospective heart transplant units, so, whereas in certain instances — for example, I believe with Newcastle, which was the third unit to be designated for supra regional funding for heart transplantation, they had in fact done some cases beforehand from money which they got, I know not where, but they had done that to prove that they could do the work, but that was at a low level. But they were seeking the designation so that they could get the funding that would follow the designation so that they could develop a proper service, which is indeed what they did.'[44]

58 Dr Halliday's view as to numbers was similar:

> 'Q. ... Is what you are saying that the track record in terms of numbers of operations done was not really a justification for Bristol becoming a supra regional centre?
>
> 'A. Well, it certainly did not perform anything like on a par with the other units, no.
>
> 'Q. It is very difficult to see how three open-heart operations would justify that?
>
> 'A. Well, if you look at those figures again, you will see it actually goes ten, 11, three, and so on, so there might have been a good reason, a management reason, for only doing three that year.
>
> 'Q. But if one took ten, which was the highest it had been before 1984?
>
> 'A. If you take ten, then you would have to look at outstanding units such as Harefield, who only did about ten in those years.
>
> 'Q. What then did you mean by "weakness?"
>
> 'A. It was a small unit. They were not doing many operations.'[45]

59 Dr Halliday explained the case for designation as follows:

> '... Bristol was one of the units which the Royal College thought was a suitable unit for designation.'[46]

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[44] T17 p. 69–71 Sir Terence English

[45] T13 p. 27 Dr Halliday

[46] T13 p. 20 Dr Halliday

60 However, Dr Halliday characterised the case in favour of Bristol's designation as 'weak'. He said:

> 'In the case of the designation of the units, the Royal College of Surgeons was given all the evidence we had on all the units that were asking to be considered for designation.
>
> 'In the case of Bristol, the case was weak, but there was an important point and that was the geographical cover, because all the other units covered the country well, but the South West was deprived in terms of cardiac surgery, especially for neonatal and infants. So the Advisory Group was concerned to see that part was covered. Indeed, many of the professional reports identified that there was a need for cover in that area.'[47]

61 It was put to Dr Halliday that Bristol was designated for geographical reasons:

> 'So we have a unit which is doing a small number, and you say it may well correspond with Harefield at ten, but obviously not at three, a unit where the view was – I will come back to the evidence for that in a moment – that it was not a star; and the basis that you are telling me was decided by the Group to designate Bristol was geography?
>
> 'A. A main reason was the geography, yes.'[48]

62 Dr Halliday described the view of the SRSAG to the designation of Bristol:

> 'Q. So what you are saying is really: "Well, if the Advisory Group were looking at this as a matter of their own experience and the criteria, Bristol would not qualify, except on geography, and geography depends upon the quality being maintained and improved; we are assured by the Royal College of Surgeons that they are going to do their best to make sure that happens". Is that essentially it?
>
> 'A. That is essentially it.'[49]

63 Dr Halliday added:

> 'The weakness of the Bristol case was a factor, and I remember clearly that Terence English rang me and spoke to me about this before the decision was taken, and said – at that time, of course, he was not President of the College; I think he was actually President of the Society of Cardiac Surgeons – but he said if in fact the Advisory Group designated Bristol, then through the College they would endeavour to strengthen that unit.'[50]

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[47] T13 p. 26 Dr Halliday

[48] T13 p. 28 Dr Halliday

[49] T13 p. 33–4 Dr Halliday

[50] T13 p. 26 Dr Halliday. For Sir Terence's evidence on this point, see para 83

64 Dr Halliday's evidence included this exchange:

> 'Q. Was anything said by Sir Terence – he was then, I think, just Terence – as to what precisely the Royal Colleges proposed to do to encourage the change in referral patterns?
>
> 'A. No.
>
> 'Q. So really, it was left very vague?
>
> 'A. Yes, but we were in a situation where the Advisory Group was concerned to see the country covered. We had the South West, which was not being provided for; we had Wales, which was not within the supra regional service arrangements, they were separate. We always provided services through them. So ideally we would like to see that part of the country covered.
>
> 'The professional advice was that Bristol was a suitable unit. The Advisory Group could have decided, "Well, we do not accept professional advice" and not designated the unit, but given that there was a pressing need, we have all these patients travelling all the way to London, the Advisory Group, I think rightly at the time, decided to designate Bristol.'[51]

65 Sir Terence thought that the original decision to designate Bristol was correct:

> '… and there was nothing to suggest to those who were not intimately involved in 1984, and again in 1986, at the time of the first report, the first Working Party's report which I chaired, that Bristol did not have the capacity to develop in that way if the will were there. That was the reason for thinking it was reasonable to designate it in the first place and to continue it.'[52]

66 Sir Terence also confirmed that the process of development of the unit required close monitoring:

> 'Q. ... The question I put to you is: if that criterion [capacity to develop] were adopted, what would your view be about the proposition that it could only be justified as a variation from the existing criterion if the progress of development was very clearly, very tightly and very carefully monitored?
>
> 'A. I believe that is absolutely right, Chairman.'[53]

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[51] T13 p. 34–5 Dr Halliday

[52] T17 p. 76 Sir Terence English

[53] T17 p. 79 Sir Terence English

67 Thus it was that, on advice from the SRSAG, the Secretary of State recognised nine centres as SRCs for NICS – with effect from 1984–85 – and offered protected funding: *'Bristol Royal Infirmary/Children's Hospital'* was designated as such a unit.[54]

68 In selecting NICS as an SRS, the SRSAG drew a distinction between patients over and under 1 year of age. This created some practical difficulties and the matter was taken up by the SWRHA with Dr Halliday, as recorded in a letter of 21 March 1984 from Dr Marianne Pearce (then Specialist in Community Medicine at the SWRHA) to Dr Ian Baker (then Acting District Medical Officer, Bristol and Weston District Health Authority):

> 'I have informally discussed with Dr Halliday and Dr Alderslade the possibility of including infants selectively deferred for surgery after the first year. They were adamant that this could not be done because the numbers of children would then be so large as perhaps to make regional units viable. I know from previous conversations with our consultants that they regard this as being unreasonable as they are making a selective decision to defer infants. Both the DHSS doctors warn that if the age limit was put up for all units, as it would have to be, the service may be reclassified and not regarded as of supra regional status, as has happened with bone marrow transplant.'[55]

69 Dr Halliday's evidence to the Inquiry, on this point, was that the drawing of a distinction between patients under 1 year of age and those over 1, with the former but not the latter being included in the SRS arrangements, was 'somewhat artificial'.[56]

Developments in Wales until the designation of NICS as a supra regional service

70 The basis of any assessment of there being a likelihood of a sufficient number of NICS operations to reach the threshold which was described as the minimum to ensure that a unit would be reasonably viable depends on the size of the catchment area. The catchment area for Bristol would be larger if Wales was part of it. The Inquiry thus sought evidence as to whether developments in Wales, and aspirations for further development of a Welsh service, affected the position of Bristol.

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[54] References in the text hereafter to 'Bristol' refer to the Bristol Royal Infirmary/Bristol Royal Hospital for Sick Children

[55] HAA 0095 0069; letter from Dr Pearce to Dr Baker dated 21 March 1984

[56] WIT 0049 0015 Dr Halliday

The development of a paediatric cardiac service in Wales

71 Mr Peter Gregory, Director of the NHS in Wales since 1994, told the Inquiry that:

> 'In the late 1970s, partly as a consequence, I think, of the appointment of a new Chief Medical Officer, now Professor Gareth Crompton, it became evident to the Department [Welsh Office] that there was a need for a comprehensive review of services and policy towards the provision of cardiothoracic services [adult and paediatric] in Wales.'[57]

72 A Working Party into cardiothoracic services in Wales was set up in 1979. The Working Party reported to the Welsh Medical Committee. The genesis of the Working Party was explained by Mr Gregory as being due to:

> '... professional concern at the inadequacy of Cardiac Services in Wales in the light of proportionately higher morbidity and mortality in Wales ...'[58]

The *'Working Party Report'* of 1981

73 The Working Party reported in 1981. This was, of course, prior to the establishment of NICS as an SRS. The *'Report of the Working Party on Cardiothoracic Services in Wales' (the 'Working Party Report')* described the paediatric cardiac needs in Wales at that time as follows:

> 'Estimates of paediatric cardiac surgical need are broadly agreed in all major reports. These may be extrapolated to the All-Wales population as an annual need for 48 infant operations (24 of which would be open heart), and an additional 123 older paediatric operations after infancy (95 of which would be open heart), totalling 171. The corresponding figures for Wales excluding Clwyd and Gwynedd are 38 (19) and 97 (75), totalling 134 (94). The number of catheterisations required is identified as about double the number of operations, or a total of c. 350 for All-Wales (270 for Wales excluding Clwyd and Gwynedd).'[59]

74 The 1981 *'Working Party Report'* summarised the recommendations of the Joint Royal Colleges' second report on Combined Cardiac Centres in relation to suitable throughput and projected staffing of a paediatric cardiac surgical unit thus:

> 'The Joint Colleges' Report recognises that a paediatric surgeon should carry out at least 50 neonatal operations per year to retain the special expertise required for neonatal surgery, that two such surgeons are needed in the centre to provide cover, and thus that there should be a limited number (perhaps 10 in England and Wales) of supra regional centres specialising in neonatal surgery, but not divorced from the adult centres. A supra regional neonatal centre should have 2 or 3 paediatric

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[57] T10 p. 7 Mr Gregory

[58] WIT 0058 0010 Mr Gregory

[59] WO 0001 0044; '*Working Party Report* ', 1981

> cardiologists, and be closely associated with a Children's Department and an integral part of an adult cardiac or cardiothoracic unit.'[60]

75 The Working Party stated:

> 'It would appear likely that one such supra regional unit would in future be sited in Cardiff *or* in Bristol. However, it is unlikely to be developed in the near future. When it is developed, the choice of site will be influenced by the relative amount of paediatric work then being undertaken in each centre. The choice is thus unlikely to be Cardiff ... It is the view of the Working Group that the diversion elsewhere of paediatric cardiac services for Welsh children would be to the detriment of cardiac services as a whole in Wales. A paediatric unit should thus be developed in Wales.'[61]

76 To the extent that this recommendation was intended to embrace neonatal and infant work, it is inconsistent with the Royal Colleges' recommendations on throughput, since the need, in Wales, for open-heart infant operations, quoted above, was (at 24)[62] less than half the number recommended by the Royal Colleges.

77 The '*Working Party Report*' appeared to accept that the development of a neonatal service in Wales was desirable, although possibly a long-term aspiration. The Report stated:

> 'The need for some 150 post-infancy operations per year clearly justifies the provision of a paediatric cardiac service in the regional centre in Wales, even if complex neonatal problems continue to be referred elsewhere (e.g. to London) until a neonatal centre is established, and even if the needs of Clwyd and Gwynedd continue to be served as now by Liverpool. The need is clear and a paediatric unit is necessary in Wales now.'[63]

78 The Working Party concluded:

> 'For Wales a modest unit would require 2 surgeons with paediatric expertise,[64] and 2 paediatric cardiologists together with paediatric supporting staff. From the point of view of sharing expertise and resources it would best be part of the regional cardiac centre and closely associated with a paediatric department such as that of the University Hospital with other specialised paediatric services. Training in paediatric cardiology is recommended for all paediatric senior registrars and also for all cardiology senior registrars. A paediatric cardiac unit is therefore a highly desirable development for professional training. Continuing liaison between paediatric cardiologists and general paediatricians throughout the region is called

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[60] WO 0001 0044; *'Working Party Report',* 1981

[61] WO 0001 0044; *'Working Party Report',* 1981 (emphasis added)

[62] WO 0001 0044; *'Working Party Report',* 1981

[63] WO 0001 0044; *'Working Party Report',*1981

[64] This does not appear to envisage that the surgeons would be dedicated solely to operating on children

> for since most screening for heart disease will be carried out by general paediatricians. This would be better co-ordinated by locally based paediatric cardiologists than by paediatric cardiologists visiting from different regions (e.g. London) as at present.'[65]

79 The Working Party was urging that development occur swiftly, so that the prospects of securing a supra regional centre in Wales would be maximised. The Working Party ended its section on paediatric cardiac services thus:

> 'A PAEDIATRIC CARDIAC SERVICE IS NEEDED IN WALES NOW. THE OPTION OF DEVELOPING THIS INTO THE SUPRA REGIONAL NEONATAL SERVICE SHOULD NOT BE LOST.'[66]

80 The Working Party expanded on this need for such a service in Wales later in the Report:

> 'The paediatric cardiac surgical needs for Wales are for some 170 operations per year, or 134 if Clwyd and Gwynedd are excluded as being served by Liverpool as at present (cf. 40 at present undertaken in Cardiff). There is an urgent need to develop a paediatric cardiac unit as part of the cardiothoracic centre, though complex neonatal surgery will continue to be referred where possible to specialised units in London. It will then be possible to co-ordinate the paediatric services at least in South Wales (at present partly being served by a visiting consultant from London). A paediatric unit requires 2 cardiac surgeons with paediatric expertise and 2 paediatric cardiologists, with junior staff in rotation with paediatrics and cardiology. It must be on the same site as other paediatric specialties. This development also keeps open the otherwise endangered option of developing further into the supra regional neonatal cardiac centre which is likely to be sited in either Cardiff or Bristol.'[67]

81 In the event, Bristol was designated as a supra regional centre (SRC) for NICS, with effect from April 1984. There was no SRC for this service located in Wales at any time during the years of the Inquiry's Terms of Reference.

82 The actual numbers of open-heart operations performed on the under-1s at Bristol is shown in the following table, taken from a table of surgery for congenital heart disease, provided by the DoH:

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[65] WO 0001 0045; *'Working Party Report',* 1981

[66] WO 0001 0045; *'Working Party Report'*, 1981 (upper case in original)

[67] WO 0001 0053; *'Working Party Report',* 1981

Table 3: United Bristol Hospitals surgery for congenital heart disease performed under 1 year of age[1]

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991
Open-heart surgery	3	6	6	5	2	8	10	10	4	11	14	24	25	29	40	39	46
Palliative closed surgery	10	11	13	13	14	15	19	24	19	30	28	24	21	22	30	16	24
Definitive closed surgery	3	2	5	5	7	7	9	13	11	9	13	40	28	27	28	29	29
Total:	16	19	24	23	23	30	38	47	34	50	55	88	74	78	98	84	99

1. DOH 0004 0028; *'Table of Surgery for Congenital Heart Disease Performed under One Year of Age, 1975 to 1991'*

83 It was put to Sir Terence that Dr Halliday had indicated to the Inquiry that he felt that there was nothing that the SRSAG could do in relation to increasing the numbers of operations in Bristol and that encouragement was entirely a matter for the Royal Colleges. Sir Terence's original response was:

> 'I do not think that there was anything that the two colleges of physicians and surgeons could do, other than to draw attention to the problem.'[68]

He expanded on this answer in oral evidence to say:

> 'I do not think that there was any specific encouragement which either the Royal College of Physicians or the Royal College of Surgeons could have given to the BRI at that time to increase their throughput in paediatric neonatal and infant cardiac surgery.'[69]

84 Accordingly, the Inquiry explored this difference of view, and considered the operation of the SRS, and what mechanisms there were by which the SRSAG could and did monitor the position of Bristol, in order to see both if the numbers of operations conducted increased to the necessary extent, and if the outcomes improved such that Bristol could properly be regarded as a centre of excellence and thus appropriate for supra regional designation.

85 The consequence of Bristol not developing as had been hoped might be thought to have been that it would cease to be designated. On this, there was a difference of emphasis between Sir Michael Carlisle, Chairman of SRSAG from April 1989 to October 1994, and Dr Halliday:

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[68] T17 p. 97 Sir Terence English

[69] T17 p. 99 Sir Terence English

> ‘Q. Sir Michael, can I deal now with the issue of Bristol’s continued designation throughout the time that you were Chairman, until it became, with other units, de-designated? Can I ask you, please, to have on the screen, DOH 0002 0022? This goes right back to the start of the supra regional services, HN(83)(36) … that appears to say that every year one of the duties for the group to advise the Secretary of State about is whether the service should continue to be designated; is that correct?
>
> ‘A. That is correct.
>
> ‘Q. It also appears to say that once it has reached the decision that the service should be designated, it has each year to make a fresh decision as to whether each unit providing the service should be designated to provide it; is that correct?
>
> ‘A. I would take issue with that. I think “each unit should be designated” is incorrect. I think the service should continue to be designated, yes.[70]

86 Dr. Halliday, however, said:

> ‘A. … The procedure was that the Department each year would invite regional health authorities to submit bids for any service that they thought might warrant designation … We had before us the reports of the various professional groups …
>
> ‘These bids were all then submitted to the Royal Colleges for their opinion as to which of the units should be selected. So Bristol was one of the units which the Royal College thought was a suitable unit for designation.
>
> ‘Q. The Supra Regional Services Advisory Group had to agree of course?
>
> ‘A. Would have to agree?
>
> ‘Q. Well, they had to agree before there was any designation?
>
> ‘A. Yes, of course.
>
> ‘Q. Because it was not the Royal Colleges’ decision?
>
> ‘A. Of course not.
>
> ‘Q. It was the Secretary of State’s ultimately, and he would do it on the Advisory Group’s advice?
>
> ‘A. Yes.

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[70] T15 p. 45–6 Sir Michael Carlisle

> ‘Q. And the Advisory Group would take their input from the Royal Colleges fed through you?
>
> ‘A. Yes.’[71]

The SRS system in operation

Bristol in the SRS system 1984/85

87 In January 1984 the DHSS distributed the first in a series of annual papers explaining the Secretary of State’s decisions (made on advice from the SRSAG) on the future development of the SRS for the next financial year.[72] The SRSAG had asked the Department to initiate a study of the services provided in each NICS unit and the costs involved. This was to lead to later recommendations as to the protection of expenditure for 1984/85 and the setting of funding levels for 1985/86.[73]

88 On 5 December 1984 an inter-unit NICS liaison group meeting was held at the DHSS in London, at which there was:

> ‘A brief account by each of the nine centres about what difference (if any) the supra regional designation of the service has meant, what difficulties stand in the way of the service being improved, and what action might be taken to enable those improvements to happen.’[74]

89 It was also noted that:

> ‘When the question of designating neonatal and infant cardiac surgery as a supra regional service had been referred to the Advisory Group, there had been no hesitation in recommending that the service met the criteria laid out in Annex B to HN(83)36.’[75]

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[71] T13 p. 20–1 Dr Halliday

[72] HAA 0095 0023, HAA 0095 0024 – 0026; *‘Secretary of State Annual Report’*

[73] HAA 0095 0026, HAA 0095 0024 – 0026; *‘Decisions for 1984–85 Following Recommendations from the Supra Regional Services Advisory Group and Regional Chairmen’* (details of finance for the NICS service at Bristol are to be found in Chapter 6)

[74] ES 0002 0002; letter from A Hurst to Dr Silove dated 26 November 1984

[75] ES 0002 0007; minutes of meeting, 5 December 1984

90 The minutes of that meeting are available,[76] from which it can be seen that Dr Joffe and Mr Wisheart were present.[77] Each unit made a presentation to the meeting, the report from Bristol being:

> 'The children's hospital dealt with supra regional specialities of various kinds. The surgical work was carried out at the Bristol Royal Infirmary which treated only adults. Additional staff were needed since there was only one fully dedicated paediatric cardiac surgeon[78] and there was a shortage of nursing staff. A large amount of "soft" money had been used for the purchase of equipment; on the surgical side: the RHA was embarking on an extensive programme of expansion, and plans for the development of paediatric surgery lay within the development of cardiac surgery generally, which had obvious nursing and manpower implications.'[79]

91 In January 1985 the SRS system was in full operation and timetables had been set for the SRSAG's consideration both of future funding levels for existing designated services and of new applications for designation.[80] This included the requirement of an annual return to the Department from the centres on workload and expenditure (sent in June of each year). The Secretary of State's Decision Paper 1985/86 indicated, amongst other things, that Bristol's protected funding level for that year was the fifth highest of the nine centres.[81]

92 In February 1985 the RCP and RCSE published the Third Report of the Joint Cardiology Committee: *Provision of Services for the Diagnosis and Treatment of Heart Disease in England and Wales.*[82] It concluded, amongst other things, that SRCs were an appropriate means of dealing with NICS and funding should continue, but that nine centres were the 'absolute maximum'. The report indicated that 'no consideration should be given to the establishment of further [SRCs] unless there is a considerable increase in workload which, at present, seems highly unlikely.'[83]

93 On 4 October 1985 a meeting of consultants from the nine SRCs was again held at the DHSS. On this occasion Dr Jordan represented the Bristol SRC. His report on Bristol was:

> 'The Region have agreed to provide and equip a cardiac catheter laboratory and had tentatively accepted a new proposal for an additional cardiologist. There were no staff particularly dedicated to paediatric cardiology. They had acquired an

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[76] ES 0002 0007; minutes of meeting, 5 December 1984

[77] ES 0002 0006; minutes of meeting, 5 December 1984

[78] In fact, at that time, there was no fully dedicated paediatric cardiac surgeon at Bristol – see evidence of Dr Joffe T90 p. 84 and Mr Wisheart's comments on the meeting T94 p. 115–16

[79] ES 0002 0009; minutes of meeting, 5 December 1984

[80] DOH 0002 0248; *'Secretary of State Annual Report'*

[81] UBHT 0278 0521; *'Secretary of State Decision Paper'*,1985/86

[82] BCS 0001 0001 – 0006; *'Third Report of a Joint Cardiology Committee',* 1985

[83] BCS 0001 0005; *'Third Report of a Joint Cardiology Committee',* 1985

> ultrasound machine with doppler, and even in some of their peripheral clinics and [*sic*] access to ultrasound equipment.'[84]

94 Dr Jordan also stated that a major part of the cardiac work had been passed on to London units, because of organisational difficulties. There had been an increase in pressure to carry out coronary artery bypass grafts (CABGs) which had adversely affected the number of operations carried out on the under-1-year-olds and had resulted in longer waiting lists.[85]

Plans for a new Welsh Cardiac Unit and its effect on supra regional services (SRS)

95 Meanwhile, developments were taking place in Wales that might have been seen as jeopardising further the number of operations carried out on paediatric patients. They had their origin in January 1984, shortly before Bristol's designation as a supra regional centre took effect, when, according to Mr Gregory:

> '... the Secretary of State for Wales announced plans to provide a Regional Cardiac Centre for adults at the University Hospital of Wales site in Cardiff. The Working Group of the Project Team established by the Welsh Office and South Glamorgan Health Authority agreed that Paediatric Cardiac facilities should be provided immediately as part of the centre.'[86]

96 The Welsh Office had to give 'Approval in Principle' to the plans of the South Glamorgan Health Authority (South Glamorgan HA) for the new cardiac unit. The Health Authority made its submission for such approval in June 1986.[87]

97 The 'Approval in Principle' (AIP) document set out the aspirations of the South Glamorgan HA for a comprehensive paediatric cardiac service. It was, in effect, a proposal to the Welsh Office for support, that is, funding for a new service.

98 The South Glamorgan HA submitted that a 'comprehensive paediatric cardiac service' was needed in Cardiff.[88] Mr Gregory stated that:

> 'In referring to a comprehensive paediatric cardiac service the authority included provision for neonates and infants under 1 year.'[89]

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[84] ES 0002 0014; minutes of meeting, 4 October 1985

[85] ES 0002 0014; minutes of meeting, 4 October 1985

[86] WIT 0058 0006 Mr Gregory

[87] WIT 0058 0006 Mr Gregory

[88] WIT 0058 0006 Mr Gregory

[89] WIT 0058 0010 Mr Gregory

99 The submission described the then current (i.e. June 1986) paediatric cardiac facilities provided in Wales thus:

> 'Facilities in Wales for the investigation and surgical treatment of children with heart disease exist only in Cardiff and are scant. No beds are specifically allocated to paediatric cardiology, children being accommodated on general paediatric wards in the University Hospital of Wales as need arises. The cardiac catheter room facilities are shared with the adult cardiology workload. Paediatric cardiac surgery is subject to the same constraints as adult cardiac surgery. There is no full-time paediatric cardiologist; the service is at present provided by one consultant practising both adult and paediatric cardiology.'[90]

100 The AIP submission estimated the needs of a Welsh service as follows:

> 'The need to develop paediatric cardiac services in Wales is agreed. It is necessary for the clinical service to the patients in Wales, for the training of general paediatricians and of cardiologists in Wales, and to provide for expertise in managing congenital heart disease in adult life. The need is for a comprehensive service.
>
> *'The development of a less than comprehensive paediatric cardiac service would not in fact attract a paediatric cardiologist. A paediatric cardiologist will not be attracted without a full paediatric cardiac surgical provision, which necessarily requires a fully trained paediatric cardiac surgeon (including neonatal work). In practice therefore we have either a full paediatric cardiac provision or none.'*[91]

101 Thus the submission was for a full cardiac service, including neonatal and infant work. The main proposals that the Health Authority made were:

> 'The paediatric cardiac service should be established as soon as possible because of the urgency of the clinical need. This requires the appointment of a paediatric cardiologist (trained in general paediatric and neonatal work), a paediatric cardiac surgeon (trained in neonatal surgery) and a paediatric cardiac anaesthetist. Close teamwork is required and it is appropriate to take advantage of the unique opportunity for a linked appointment of well suited individuals. One of the present cardiologists should continue to fulfil part-time the role of a second paediatric cardiologist until he retires; this component of his work should then be taken on by a second paediatric cardiologist. One of the present cardiac surgeons will fulfil the role part-time of a second paediatric cardiac surgeon. The paediatric cardiac work will be shared between the newly appointed anaesthetist and one of the present anaesthetists, each of whom will carry out some other duties. This practical

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[90] WO 0001 0148; AIP

[91] WO 0001 0150; AIP (emphasis in original)

> compromise provides for less than 2 full-time paediatric cardiologists, at least in the short term, and less than 2 full-time paediatric cardiac surgeons, but is the appropriate provision, given the size of the catchment population.'[92]

102 It was not envisaged that the paediatric cardiac surgeon would be dedicated solely to paediatric work. This is demonstrated by this passage from the AIP submission:

> 'The paediatric cardiac surgeon will be fully trained in all aspects of his subject. He will also undertake some adult cardiac surgery, both as a contribution to the service and to ensure adequate continuing experience in relevant aspects of cardiac surgery (e.g. valve replacement).'[93]

103 At a national level, developments in surgery caused consideration of the SRS's strategy. The Decision Paper for 1986/87[94] highlighted the development whereby the number of patients under 1 year receiving surgery was rising slightly because of increasing medical preference for early surgery.

104 The SRSAG saw no need to change NICS provision 'over the next three years', but recognised the need for more work 'to refine the methodology used for costing the provision of the service.'[95]

105 In early 1986 Harefield Hospital applied for designation as an SRC for NICS. There were also two other possible applications for designation (from Leicester and Hammersmith Hospital) and, in April, the Department requested advice from the RCSE and RCP.

106 The Colleges set up a Joint Working Party under the chairmanship of Mr Terence English (consultant cardiothoracic surgeon). Mr English (later to be knighted and to become a member of the SRSAG from 1990–1992, when President of the RCSE) wrote to the nine centres on 16 June 1986, seeking information. The information sought concerned the total numbers of closed and open cardiac operations performed on neonates and infants up to the age of 1 year in the calendar years 1984 and 1985. Mr English ended his letter:

> 'I should stress that information on mortality is not being sought.'[96]

107 The *'Report of the Joint Working Party'*, dated 1 September 1986, deals with the situation in general, but had comments on some of the centres.[97] Among the recommendations were that the use of the designated SRC system continue (it was

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[92] WO 0001 0152; AIP

[93] WO 0001 0153; AIP

[94] UBHT 0278 0445; *'Supra Regional Services, 1986–87';* Secretary of State's Announcement

[95] UBHT 0278 0447; *'Supra Regional Services, 1986–87';* Secretary of State's Announcement

[96] RCSE 0002 0005; letter from Mr Terence English to NICS Centres, dated June 1986

[97] RCSE 0002 0009, 0012–0013; *'Report of the Joint Working Party',* 1986

deemed be 'essential') and that no more than nine centres were currently justified, although Harefield's application should be reconsidered in two years.[98]

108 Paragraph D of the report's recommendations stated:

> 'The Working Party noted that three Units, namely Bristol, Newcastle and Guy's were doing fewer operations per year than desirable for a supra regional centre. Bristol and Newcastle have legitimate claims for development on geographical grounds and should be encouraged ... The workload of these three centres and Harefield should be reviewed in two years' time.'[99]

109 At the same time that the Working Party was deliberating, the SWRHA received a report on *'District Strategies for NICS for 1986/1994'* from Southmead DHA and Bristol and Weston DHA.[100]

110 The view of the Department at the time was that encouragement of Bristol was to be welcomed. Mr Hurst, Secretary of the SRSAG, put it in his letter of 27 October to Dr Pitman, Specialist in Community Medicine at the SWRHA:

> 'We are anxious to do what we can to encourage referrals from Wales because we would like to see activity levels in Bristol rise …'[101]

111 This approach appeared to be at odds with that reflected in the AIP submission made by the South Glamorgan HA, since the latter plainly had the capacity to reduce, rather than increase, referrals from Wales were it to be endorsed.

112 On 2 September 1986 the Welsh Office and South Glamorgan HA met to discuss the AIP submission. The minute of this meeting is short and was described as 'terse' by Mr Gregory in oral evidence.[102] It said:

> '... it was acknowledged that the Approval in Principle Submission would require revision.'[103]

113 The AIP had the strong support of a leading cardiologist, Professor Andrew Henderson, University of Wales Hospital, Cardiff. He was described by Mr Gregory as:

> '... a man of significant expertise and considerable influence in the development of cardiac services. He was a leading contributor to the Welsh Medical Committee

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[98] Simultaneously, the conclusion of Professor Andrew Henderson reporting to the Welsh Office, was that 'The recommendations for the 9 designated supra regional neonatal cardiac surgical centres in England were based on now outdated estimates of neonatal workload.' WO 0001 0230. Even after consideration of the *'Report of the Joint Working Party'*, the SGHA still criticised its conclusions. WO 0001 0246

[99] RCSE 0002 0013; *'Report of the Joint Working Party',* 1986

[100] WO 0001 0123 – 0142; *'District Strategies for NICS'* 1986/94

[101] UBHT 0062 0213; letter from Mr Hurst to Dr Pitman, dated 27 October 1986

[102] T10 p. 59 Mr Gregory

[103] WO 0001 0224; minute of meeting, 2 September 1986

> report of 1981, and he was ... a leading advocate, perhaps the leading advocate in Wales for the development of a comprehensive Welsh cardiac service.'[104]

114 Professor Henderson described what he saw as the inadequacies of the paediatric cardiology service then available in Wales. Dr Leslie Davies provided a clinic in Cardiff (and in some District hospitals),[105] but was by then ill and he died towards the end of 1986. Additionally, some cardiologists from London provided clinics in Wales. Professor Henderson said:

> 'We have not been able to provide the constantly available, co-ordinated expertise at an acceptably near centre for the South Wales population that is needed for present practice. LGD's [Dr Davies's] present illness has converted an increasingly inadequate service to what is now a potentially dangerous situation.'[106]

115 Professor Henderson prepared a document in support of the AIP submission, dated 2 September 1986. He emphasised that in his view advances in surgery and in non-invasive investigations were responsible for increasing numbers of neonatal and infant cardiac operations being carried out.[107] He thought this was a trend that was likely to continue, and he doubted that the previous assumption of 8.5 open-heart operations on infants under 1 per year per million population was still appropriate in 1986. His views were:

> 'The paediatric cardiac surgical workload actually undertaken in a region of comparable size to the population under consideration for Wales is now of the order of 60 to 65 (40%, i.e. 25, infant) open heart plus 35 to 40 closed heart operations per million per year (Southampton data for Wessex region, population 2.2 million). This implies 130 to 140 (ca. 55 neonatal) open heart plus ca. 80 closed heart operations per year for the Welsh centre. It represents a three-fold increase in infant surgical numbers compared with earlier estimates of 8.5 infant (under one year of age) open heart operations per year per million population (2nd Joint Colleges' Report, 1980).
>
> 'Earlier estimates of need have thus changed very considerably as the specialty has evolved and there has been a major shift towards corrective surgery in the neonatal period. The proportion of neonatal operations is likely to continue rising.'[108]

116 Professor Henderson estimated the occurrence of congenital heart malformations to be between ten and 13 per 1,000 live births.[109]

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[104] T10 p. 59 Mr Gregory

[105] See Chapter 11 for the interrelation of these clinics with referrals to Bristol

[106] WO 0001 0226; report, 2 September 1986

[107] WO 0001 0225; report, 2 September 1986

[108] WO 0001 0225; report, 2 September 1986

[109] WO 0001 0231; report, 2 September 1986

117 Mr Gregory was asked about this figure.

> ‘Q. The advice that you had as a Department was that it was not 12 to 13, it was 8 at most?
>
> ‘A. Yes, that is correct.
>
> ‘Q. If that is right, then this is an overstatement by someone who is arguing the case, is it?
>
> ‘A. Yes, I think that is how you could interpret it, certainly.
>
> ‘Q. It must follow, if one was interpreting this from a Welsh Office point of view, looking at the question of the viability of the service in Cardiff at this stage, that one would see it as being necessary in order to establish a case for paediatric neonatal and infant cardiac surgery, that one would have to, as it were, stretch the elastic around the figures, to justify such a unit on number grounds?
>
> ‘A. I think that is what lies behind it, certainly, but just to make clear, Professor Henderson was in a significantly professionally influential position, and one was not casting doubt on the sincerity with which he held these views, it just seemed to the Department that the evidence it had from other sources pointed to a different conclusion.’[110]

118 A meeting of the SRSAG took place on 2 October 1986, when the Joint Working Party Report of 1 September 1986 was considered and it was recommended that:

> ‘… the workload of Newcastle and Bristol in relation to cost be monitored and efforts to expand workload in those centres be encouraged.’[111]

119 The minutes of this meeting[112] record that the joint Royal Colleges’ Report argued that the incidence of congenital heart defects was likely to remain static, because the development of early inter-uterine detection of problems through the use of foetal echocardiography tended to lead to termination of those pregnancies with problems, which counterbalanced any increase in the birth rate. This argument was contrary to Professor Henderson’s view that there was an increasing need for neonatal and infant cardiac surgery for a given population.

120 The SRSAG meeting was unpersuaded of the case for NICS in Cardiff. The minutes recorded that:

> ‘It would appear from the argument in the report that there is little justification in establishing a centre in Cardiff for the management of a potentially limited number

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[110] T10 p. 66–7 Mr Gregory

[111] WO 0001 0234; minutes of meeting, 2 October 1986

[112] WO 0001 0234; minutes of meeting, 2 October 1986

> of babies with cardiac problems on grounds of doubtful clinical effectiveness and cost efficiency.'[113]

121 The deliberations of the SRSAG and its acceptance of the Joint Working Party Report had a major impact on the attitude of the Welsh Office to the suggestion that it should develop its own NICS in Cardiff. Diana Vass, a nursing officer at the Welsh Office, attended the SRSAG meeting in October 1986.[114] Subsequently, Mrs Vass sent a memo, dated 6 October 1986, to Ms J Roberts, who was a Principal in the Health Policy Division at the Welsh Office, reporting to Mr Gregory. It stated:

> 'I would suggest the most important comment is that we acknowledge a neonatal and infant cardiac service is available for Wales in Bristol – for which resources are protected and that Wales will continue to expect to use the supra regional service and will not be excluded from referring to that service.'[115]

122 The Welsh Office discussed matters at a meeting on 8 October 1986, chaired by Professor Crompton. In his statement Mr Gregory noted that:

> 'a) a supra regional centre had been designated in Bristol for the neonatal and infant service, whereas Cardiff was not so designated;
>
> b) Bristol was at that time under-utilised.'[116]

123 He went on:

> 'The meeting concluded that the cardiac development in Cardiff should be postponed until the results of an organisation and management study were known. The meeting also made it clear that the Supra Regional Advisory Group's ruling that children under 1 year old should be treated at the supra regional centre at Bristol should be supported.'[117]

124 The meeting noted that:

> 'A supra regional centre had been designated in Bristol specifically for the neonatal and infant service, whereas Cardiff was not so designated. Provision at UHW for this service (included in the AIP) would therefore constitute duplication of the service available at Bristol for which the Welsh Office was paying indirectly. Bristol was presently under-utilised, undertaking approximately 50 operations per annum.'[118]

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[113] WO 0001 0235; minutes of meeting, 2 October 1986
[114] WO 0001 0224; minutes of meeting, 2 October 1986
[115] WO 0001 0238; memo dated 6 October 1986
[116] WIT 0058 0006 Mr Gregory
[117] WIT 0058 0010 Mr Gregory
[118] WO 0001 0242; minutes of meeting, 8 October 1986

125 The meeting agreed that the initial development of cardiac services in Wales should consist of three stages, the first of which would be the setting up of a paediatric (i.e. over 1-year-old) unit. The second stage would be theatre provision and the third stage would be the upgrading of facilities for the main cardiac unit.

126 Thus the conclusions of the SRSAG as regards Bristol's continued designation and its desire to 'encourage' work in Bristol, appears to have influenced the Welsh Office's attitude against the proposal that a neonatal and infant cardiac service be developed in Wales.

127 A meeting between medical officers of the Welsh Office and senior clinicians of the South Glamorgan HA took place on 20 October 1986. Mr Gregory's evidence about that meeting was:

> 'The DHA [*sic*] considered it would be unsatisfactory to send all neonatal cases to the supra regional centre at Bristol for treatment, mentioning the danger and distress endured in transporting patients over long distances, and the impracticability of Bristol paediatric consultants providing outlying areas in South Wales with a full service.'[119]

128 The other key influence was finance. The Welsh Office summarised the two key influences on the approach taken:

> 'a. the funds for the project were cash limited, subject to adjustment for inflation, and therefore costs had to be re-examined, neonatal provision being one element of the re-assessment;
>
> 'b. the recommendation of the Royal Colleges was clear and could not be ignored.'[120]

129 The meeting of 20 October 1986 decided that the Welsh Office Medical Group should report to the NHS Director for Wales, making the following points:

> 'a. … that a formal request be made to the Royal Colleges of Physicians and Surgeons by the Welsh Office Medical Group for a sub-committee to provide a re-evaluation of the neonatal cardiac requirements for patients in Wales (Professor Henderson undertook to make preliminary approaches to members of the Royal Colleges committee);
>
> 'b. the project team would examine the costs of the whole scheme with a view to eliminating local additions and arriving at a properly costed scheme;

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[119] WIT 0058 0006 Mr Gregory

[120] WO 0001 0247 – 0248; minutes of meeting, 20 October 1986

> 'c. Welsh Office should consider further the suggestion of the appointment of an independent project director ...'[121]

130 On 28 October 1986, Dr A George, the Deputy Chief Medical Officer (Wales), wrote to Dr Halliday.[122] In the letter Dr George requested the background papers which were considered by the Royal Colleges Joint Working Party in preparing its report of September 1986. He also stated to Dr Halliday:

> 'If Welsh Office is to hold a line on this type of work [this must refer to neonatal and infant work, since the letter is entitled "Neo-natal and Infant Cardiac Surgery"] being undertaken at Supra Regional Centres, Bristol is so designated for South Wales, we must have an assurance from you that it will not be closed and leave us without a readily available service.'[123]

131 Dr Halliday and the Department were willing to assist the Welsh Office. The RCSE, however, took a different view. In a memorandum of 10 December 1986, Dr Jennifer Lloyd, a Senior Medical Officer at the Welsh Office, wrote:

> '... Terence English would not give permission for the Royal Colleges' Working Paper to be circulated. There seems to be a lack of communication between the Royal College of Surgeons and the DHSS on the issue of confidentiality of that paper.'[124]

132 Professor Crompton then wrote on 7 January 1987 to Mr Ian Todd, the new President of the RCSE, seeking the release of the Royal Colleges' Joint Report for consideration by the Welsh Medical Committee on 21 January 1987. Professor Crompton sought to exert considerable pressure on the RCSE, stating:

> 'It would be unfortunate if a unified approach between the Welsh Office and the Department of Health to the provision of neonatal and infant cardiac surgery could not be maintained because full information was only available to the advisory machine to one of the Departments of State.'[125]

133 Professor Crompton's approach appeared to have worked, since the Report was forthcoming in time for the extraordinary meeting of the Welsh Medical Committee of 21 January 1987.

134 In the meantime, whilst attempts were made to obtain the background papers, the Welsh Office Ministers had decided in November 1986 that in the light of the Joint Working Party's apparent endorsement of Bristol as a supra regional centre for neonatal and infant cardiac services, the proposed Welsh Unit should not include

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[121] WO 0001 0249; minutes of meeting, 20 October 1986

[122] References to the Department of Health include references to the DHSS, prior to its separation into the Departments of Health and Social Security

[123] WO 0001 0250; letter from Dr George to Dr Halliday dated 28 October 1986

[124] WO 0001 0262; memo dated 10 December 1986

[125] RCSE 0002 0022; letter from Professor Crompton to Mr Todd dated 7 January 1987

such services. This decision was reflected in a note from Mr Ivor Lightman, Deputy Secretary to the Welsh Office with responsibility for Health and Social Care, to Professor Crompton of 26 November 1986, which stated:

> ‘Ministers made it perfectly clear at yesterday’s Health Policy Board meeting that they accepted the advice from the Royal Colleges that neonatal cardiac surgery should be centred on Bristol with the Cardiff surgeons forming part of the “team” in the way you described. They also made it clear that having had the advice and having received decisions from Ministers we should now get on with it, which means making the position clear to the “opposition” and proceeding with planning on the basis agreed while recognising that we may well take some flak. Naturally, the Press Office and others will have to be warned about that.’[126]

135 In Bristol itself at this time, there was optimism that the number of referrals[127] from South Wales would increase.[128]

136 For the first two years of the SRS (1984 and 1985) there had been a meeting of representatives from the NICS SRCs hosted by the Department in London. Despite an initial suggestion that these meetings become an annual event, the Department now decided to discontinue them. As Mr Hurst put it in a circular letter of 30 October 1986:

> ‘Our view is now that the service is sufficiently well established for these meetings to be no longer necessary; the Department is also under pressure to reduce meetings in order to effect financial savings, and I am sure that your time is valuable too.’[129]

137 Dr Eric Silove, consultant paediatric cardiologist in Birmingham, who had attended the previous meetings, wrote to the Department on 17 November, regretting the decision:

> ‘I feel it is a pity that you are proposing not to continue with the annual meeting … It proved to be a most helpful forum not only for helping establish the service but also for looking well into the future.’[130]

138 The ‘Decision Paper for 1987/88’[131] extended the funding arrangements by also introducing capital funding, with effect from that year. It was also recorded that the

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[126] WO 0001 0253; note from Mr Lightman to Professor Crompton dated 26 November 1986

[127] The issue of referral patterns from Wales to Bristol and other parts of the country is dealt with fully in Chapter 11. The section on Wales within that chapter also deals with how resources were allocated for the funding of those referrals from Wales to Bristol

[128] UBHT 0062 0216; memo from Dr Ian Baker, Assistant General Manager (Planning)/District Medical Officer, to Mr Graham Nix, Senior Assistant Treasurer (Financial Management) at the B&WDHA

[129] ES 0002 0026; circular letter dated 30 October 1986

[130] ES 0002 0025; letter from Dr Silove to DoH dated 17 November 1986

[131] UBHT 0278 0377; SRS 1987–88 Secretary of State’s Announcement

advice of the Joint Working Party to continue NICS as an SRS was accepted, 'so that the necessary expertise can be concentrated in a limited number of centres.'[132]

139 Harefield and Brompton Hospitals had been added to the designated centres, but it was envisaged 'that there would be little need for expansion in the total service.'[133]

140 In the interim, there had been a visit to Bristol by Professor Crompton and colleagues from the Health Professional Group of the Welsh Office, in the autumn of 1986. This arose because Professor Henderson had made critical comments about the performance of the Bristol Unit as part of his paper in support of the AIP submission, and Professor Crompton and his colleagues '… were motivated to explore for ourselves whether there was any substantiation of Professor Henderson's critical comments about the Unit'.[134] (These critical comments are explored later, in reviewing concerns expressed about paediatric cardiac surgery at Bristol.)[135] The visit followed an earlier one made by Professor Crompton and his colleagues in about 1984, very shortly after designation.

141 Professor Crompton told the Inquiry that on both visits he met Dr Jordan and Dr Joffe and also Mr Wisheart. On the second occasion Professor Crompton and his colleagues briefly met Mr Dhasmana in addition.[136]

142 Following the visit, Dr Jennifer Lloyd, Senior Medical Officer at the Welsh Office, prepared a written report, dated 27 November 1986, summarising the results of the visit. Her report indicated that contact had been made by Professor Crompton and senior medical colleagues at the Welsh Office with the Department, with clinical and community medicine colleagues at the SWRHA, and at the BRI and BRHSC.

143 As to the visit to Bristol, Dr Lloyd's report said:

> 'The visit to Bristol disclosed that currently (April 1 1985 – March 31 1986) 40 cases from 3 health authorities in Wales had been treated at the Bristol Children's Hospital and 4 at the Bristol Royal Infirmary. Thus the Bristol Service is already providing a substantial part of the service need for this category of case. There is evidence in the past 6 months that 2 more health authorities are also sending cases to Bristol. It is interesting to note that the number of cases from South Wales referred is roughly equal to the number referred within South Western excluding Bristol and Gloucester.'[137]

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[132] UBHT 0278 0377; SRS 1987–88 Secretary of State's Announcement

[133] UBHT 0278 0378; SRS 1987–88 Secretary of State's Announcement

[134] WIT 0070 0004 Professor Crompton

[135] See Chapter 21

[136] WIT 0070 0004 Professor Crompton

[137] WO 0001 0257; Dr Lloyd's report, 27 November 1986

144 Dr Lloyd went on:

> 'In frank discussions with the clinicians [i.e. in Bristol] there was a positive wish to increase throughput and continue the trend of improving outcome with the ensuing maintenance and developing of skills.'[138]

145 Dr Lloyd's report continued:

> 'On discussion with the staff it was made clear that the consultants providing the Bristol service accept and indeed welcome a commitment to provide the infant and neonatal cardiac surgery service for South Wales. They acknowledge the natural aspirations of clinical staff in Cardiff to provide the total paediatric service on one site but they point to (and can demonstrate by the Bristol service) the advantages in lower mortality and morbidity due to increasing expertise and adequacy of equipment that result from the greater throughput of cases.'[139]

146 It is not clear to which Bristol clinicians in particular Dr Lloyd is intending to refer. Nor does she explain what evidence, if any, was cited in support of the suggestion that there was a 'trend of improving outcome' to 'continue', nor whether this trend of improvement was said to be an absolute one and/or a relative improvement compared with other centres. Further, it is not clear by what evidence 'the Bristol Service' can 'demonstrate' the 'advantages' referred to as resulting from 'the greater throughput of cases'.

147 Dr Lloyd also stated:

> 'We were unable to obtain from DHSS, who do not hold figures broken down by units, any figures on outcome by centre. We did however raise the question of outcome with Bristol staff. They put to us the accepted point that outcome is influenced greatly by case mix. They were quite open in quoting outcomes for some of the commoner procedures they undertake. They see a gradual improvement in these as expertise grows and specialist equipment becomes available. For most of the more commonly occurring conditions their figures compare well with other centres. They acknowledge however that surgeons in different centres develop special expertise in rarer conditions and that outcomes may therefore vary greatly for these between centres.'[140]

148 It is not clear what, if any, further inquiry was made of Bristol by the representatives of the Welsh Office to seek justification for the argument based on case mix. It is not clear on what basis the implicit suggestion was made that the Bristol case mix was more difficult than elsewhere. The Welsh Office does not appear to have pressed for further information or explanation. Nor does it appear that further information was tendered to it.

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[138] WO 0001 0259; Dr Lloyd's report, 27 November 1986

[139] WO 0001 0259; Dr Lloyd's report, 27 November 1986

[140] WO 0001 0260; Dr Lloyd's report, 27 November 1986

149 The last passage quoted from Dr Lloyd's report includes an implied admission by the Bristol clinicians that their results, for less 'commonly occurring conditions' did not compare well with other centres. The Welsh Office does not appear to have established what these rarer conditions were, and no steps were ever taken to suggest that patients with those conditions should be referred to units other than Bristol. Whilst it seems that the Bristol clinicians volunteered data on the commoner procedures, it appears that they were neither asked for, nor did they provide, data on the rarer conditions.

150 Professor Crompton told the Inquiry:

> 'I believe that the answers we got were honest and seemed to be full. The clear recollection I have is that we were told that indeed they knew that they could do better; that it was their intention to improve year on year; and that the local health authority, whether it was Bristol and Weston or the RHA, I would not know, had by 1986 greatly improved the fabric of the accommodation that was in the Bristol unit.'[141]

151 Dr Lloyd's report is consistent with the recollection of Dr (later Dame) Deirdre Hine, then Deputy Chief Medical Officer (Wales), of the 1986 visit. She stated in her written statement to the Inquiry:

> 'The discussions we had with both the clinical staff of the service and of the Regional Health Authority gave us no cause for anxiety. They indicated that the outcomes for the simpler operations were good and that those for the more complex procedures were improving as the throughput of cases increased. We were, however, unable to obtain any detailed statistical evidence for these claims.'[142]

152 In her December report Dr Lloyd reiterated what she had already stated in her previous report of 27 November 1986. Dr Lloyd expressed a clear preference for a policy of using Bristol for Welsh neonatal and infant cardiac work. Her December report said:

> 'The decision which has to be taken lies between 2 clear options –
>
> '1. to provide self standing comprehensive paediatric cardiology and cardiac surgery based in Cardiff or
>
> '2. to provide paediatric cardiology and cardiac surgery from Cardiff with the element of infant and neonatal surgery based in Bristol. This would be consistent with the views of the Supra Regional Advisory Group.

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[141] T21 p. 47 Professor Crompton

[142] WIT 0297 0002 Dame Deirdre Hine

> ‘The paediatric and cardiology and cardiac surgery services could most appropriately and effectively be provided for Wales on the basis of the second option. However, this would require careful implementation and planning …
>
> ‘We would wish to recommend that neonatal and infant cardiac surgery should be provided from Bristol on the basis of a joint service.’[143]

153 Following this report, an extraordinary meeting of the Welsh Medical Committee took place on 21 January 1987. The Welsh Office representatives at the meeting summarised the situation in this manner:

> ‘i. Bristol currently offered the certainty of a service for infants and neonates.
>
> ‘ii. Problems were apparent with the provision of adult services in Cardiff.
>
> ‘iii. Difficulties were occurring in recruiting junior medical and nursing staff to work in South Wales, and were unlikely to be easily solved.
>
> ‘iv. The Joint Working Party Report addressed itself to questions of quality, a difficult concept for small caseloads.
>
> ‘v. Paediatricians in Gwent had explained that they were very satisfied with the service provided by Bristol.
>
> ‘vi. Because it had been shown that quality of service was closely related to numbers dealt with in any one unit, there would be a danger of there being 2 “second rate” units at Cardiff and Bristol if the proposals being put to the Committee were accepted.
>
> ‘vii. Infant cardiac surgery at Bristol might be less certain to continue after the 1989 DHSS Review if doubts were expressed over its service to South Wales patients.’[144]

154 At the January meeting, the Welsh Medical Committee heard representations from Professor Crompton, Dr George and Dr Lloyd on behalf of the Welsh Office and from Professor Henderson, Mr R C Williams, Mr Butchart and Dr Verrier Jones from South Glamorgan HA. Mr R C Williams argued that the Joint Working Party’s conclusions in respect of supra regional services were of little or no application to Wales. Mr Butchart argued that Bristol appeared to have been designated as an SRS for geographical considerations, not because it was an existing centre of excellence, as had been the basis for designating the other supra regional units.[145]

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[143] WO 0001 0266; Dr Lloyd’s report, December 1986

[144] WO 0001 0275; Dr Lloyd’s report, December 1986

[145] WO 0001 0278; minutes of meeting, January 1987

155 The conclusions of the Welsh Medical Committee were:

> '… the ideal solution would be for a comprehensive Paediatric Cardiology Service to be developed in Cardiff. However, it recognised that such a service would not be attainable for the foreseeable future, because of the absence of the necessary infrastructure, difficulties in recruiting appropriate junior medical staff and nurses, and reservations about the likely number of patients requiring this form of treatment. Consequently Neo-Natal and Infant Cardiac Surgery should continue to be provided from Bristol. It is further agreed that Paediatric Cardiology should be developed in Cardiff as a matter of urgency, with an immediate need for one Paediatric Cardiologist and a second to be in post as soon as possible.
>
> 'It is also advocated that close liaison should be established between the Paediatric Cardiology Service in Cardiff and the Supra-Regional Paediatric Cardiac Surgery Service in Bristol. In future, a review of the facilities in Cardiff would be necessary if demands increase with advances in diagnosis and surgical techniques.'[146]

156 The Welsh Office accepted this advice. Thus it was decided that cardiac surgery for children aged one year and above should be provided in Cardiff.[147] The Minister's private office (Welsh Office) said that the Parliamentary Under Secretary of State:

> '... has noted the advice contained in Mr McGlinn's [Welsh Office] submission of 3 February. He agrees that the paediatric cardiac unit to be provided at Cardiff should not *at present* be developed to include facilities for neo-natal and infant cardiac surgery and that the Bristol unit should combine to provide the service for South Wales patients. The Minister has commented that in announcing this decision it would probably be wise to say that the matter will be kept under review in the light of future circumstances.'[148]

157 Thus NICS were excluded from the initial stages of the Cardiff development. Professor Henderson remained unhappy. The Inquiry received evidence that the Chairman of the South Glamorgan HA was under pressure from Professor Henderson:

> '... not to restrict the freedom of clinicians to refer patients to those hospitals in which they have confidence.'[149]

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[146] WIT 0058 0007 Mr Gregory; and WO 0001 0286 – 0287 Welsh Medical Committee

[147] WIT 0058 0008 Mr Gregory

[148] WO 0001 0291; note dated 10 February 1987 (emphasis in original)

[149] WO 0001 0294; note dated 5 March 1987

158 In a note of 5 March 1987, Mr Gregory referred to Professor Henderson's continued concerns, and stated:

> '… the DHA is looking to us to accept that although Bristol is the supra regional centre for South Wales, clinicians in Wales still retain the usual discretion to refer patients from Cardiff to hospitals of their choice.
>
> 'I am not sure what this means in practical terms. On the assumption that this is merely a face-saving exercise for Professor Henderson then I think we may be able to go along with it. If that is the case, all we need is a very brief letter of reply which does not open up the whole issue but does not resile from the decision we have already obtained from Ministers.'[150]

159 In December 1987 the Welsh Office asked the RCP to set up a task force to review cardiac surgery and cardiology in Wales, with a particular emphasis on NICS. It specifically requested that evidence be taken from Dr Halliday.[151] Clinicians in Bristol were aware that cardiologists in Wales had requested the view of the RCP earlier in the year and, on 3 August 1987, wrote to the RCP with their views.[152]

160 The Report of the Cardiology Committee of the RCP said that:

> 'The Advisory Group[153] is unanimous in reaffirming the importance of the development of the paediatric cardiac unit, already approved by the Welsh Office, to include paediatric cardiology and paediatric cardiac surgery, and this to be developed in association with the existing general paediatric department, neonatal unit, and regional cardiac and cardiac surgical centre. The Advisory Group considers that this unit should ultimately provide management for the whole of congenital heart disease. Presuming this concept is accepted, there is a need now to appoint a paediatric cardiologist, who should be expert in cardiac catheterisation, interventional techniques, and echocardiography. He should establish links with local paediatricians in South Wales who are anxious for this service, which should slowly be established. In addition a cardiac surgeon should be appointed as soon as possible. He should be capable of carrying out both paediatric and adult cardiac surgery. There is not the caseload at the present time to justify the appointment of a "pure" paediatric cardiac surgeon. These two new appointees will be the focus for the developments of the new service working to set up new lines of referrals and patterns of care.'[154]

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[150] WO 0001 0294; note dated 5 March 1987

[151] WO 0001 0317 – 0318; letter dated 15 December 1987

[152] UBHT 0133 0029; letter dated 3 August 1987

[153] WO 0001 0339; The Royal College of Physicians Advisory Group on Cardiac Services in South Wales. The Advisory Group's terms of reference were: 'To provide medical advice to the Welsh Office on the provision of cardiology and cardiac surgery services to the population of South Wales (2 million)'

[154] WO 0001 0344 – 0345; Report of the Royal College of Physicians

161 The Committee further concluded that there was a need for:

> '... about 100 paediatric cardiac operations per year. The Royal College considered that, in due course, the Cardiff unit should provide cardiac surgery for children under 1 year old.'[155]

162 On 22 January 1988 Paper SRS(88)2 was prepared for the SRSAG.[156] It discussed the current situation for NICS and, for the first time, one of the options was de-designation of the whole service.[157] The paper noted that:

> '… returns from the designated units are concerned with quantity not quality, i.e. type of operation performed and mortality rates are unknown factors.'[158]

The Report identified that, based on a two surgeon unit, '… the minimum open-heart workload is likely to be at least 80 cases per year', and that, referring to Bristol in particular,[159] 'Three of the designated units fall far short, i.e. Guy's, the Bristol Royal for Sick Children and the Freeman, Newcastle' and that 'probably [those] three have a very small workload.'[160]

163 The Paper was discussed at the SRSAG meeting on 4 February 1988 and its recommendation was that the Society of Cardiothoracic Surgeons (SCS) be asked to comment and carry out a fact-finding survey, which it agreed to do. It was to advise on whether SRSs for NICS should continue at all. Sir Keith Ross, the then President of the SCS, was approached.

164 Additionally, Dr Halliday and Mr Alan Angilley, SRSAG Administrative Secretary 1987–1992, arranged to visit Wales to discuss current and future service needs for South Wales. On 24 February 1988 Dr Hine wrote to Dr Marie Freeman, Acting Regional Medical Officer for SWRHA. Dr Hine stated in her letter:

> 'I have drawn up the attached Agenda in which, as agreed with you, the two distinct elements, i.e. cardiac surgery under one year and cardiology at all ages together with cardiac surgery over one year, are distinguished from one another. We would be grateful to have any up-to-date figures available to you which illustrate the current demand from Wales on Bristol for either form of service. The latest figures I have relate to the period up to June 1986 and are for infant and neonatal cases only.'[161]

It was plainly the belief of the Welsh Office that the SWRHA was monitoring such numbers.

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[155] WIT 0058 0008 Mr Gregory

[156] DOH 0002 0240 – 0247; Paper SRS(88)2

[157] DOH 0002 0242; Paper SRS(88)2

[158] DOH 0002 0242; Paper SRS(88)2

[159] DOH 0002 0240 – 0247; Paper SRS(88)2

[160] DOH 0002 0242; Paper SRS(88)2

[161] UBHT 0062 0398; letter from Dr Deirdre Hine to Mr Angilley dated 24 February 1988

165 The visit to Wales took place on 7 March 1988. In a paper presented to a meeting held during the visit, by the DHSS, it was noted that there were 'highly significant' differences in outcome between centres with high and low output. Bristol was described as 'one of the smallest centres in terms of throughput.' It was 'however seen as having a legitimate claim for development on geographical grounds and the consideration of this has included its proximity to the South Wales population.'[162]

Continued designation of NICS

166 On 19 May 1988 the Executive Committee of the SCS met and, amongst other things, it was reported by the then President, Sir Keith Ross, that the DHSS had requested the SCS to 'consider whether it was in the best interests of all concerned' for NICS to remain in the SRS.

167 The SCS concluded that the SRCs should remain but that the situation should be kept under review. A questionnaire that the DHSS wished to circulate to the SRCs was also tabled:

> 'This was agreed, but it was noted that the questionnaire was extremely superficial.'[163]

168 In September 1988 the SCS set up a small sub-committee chaired by Professor David Hamilton, Department of Clinical Surgery, Edinburgh University, to liaise with the RCP and the British Cardiac Society (BCS), both of which were already looking into the future of paediatric cardiac surgery.[164]

169 On 22 February 1989 there was a visit on behalf of the Specialist Advisory Committee (SAC) in Cardiothoracic Surgery to the BRI and to Frenchay Hospital.[165] The Report concluded that:

> 'The visitors were impressed by the quantity and quality of work performed at both hospitals and particularly by the training offered.'[166]

170 On 12 May 1989 the Executive Committee of the SCS met and received a report from the sub-committee whose Chairman, Professor Hamilton, explained that it had been 'extremely difficult' to obtain the necessary data and that staffing levels and facilities had not yet been assessed. The sub-committee found that, of the ten centres surveyed, '3 of them were considered good; 4 of them fair; one inadequate and one irrelevant and one had not submitted a return (Leeds)'. Professor Hamilton was concerned that confidentiality would be breached if a report were submitted to the Department.

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[162] UBHT 0062 0401; *'Supra Regional Centres for Infant and Neonatal Cardiac Surgery'*, March 1988

[163] SCS 0004 0004. The Bristol questionnaire, completed by Mr Wisheart, is at UBHT 0193 0016. It contains mortality figures for 1985–1987 inclusive, for both open and closed operations on under-1s (UBHT 0193 0017)

[164] SCS 0004 0007; minute dated 21 September 1988

[165] RCSE 0002 0213 – 0220; SAC Report, 22 February 1988

[166] RCSE 0002 0219; SAC Report, 22 February 1988

However, the meeting concluded, 'after discussion', that 'the DHSS would have the figures anyway and thus the confidentiality was not a concern in their case.'[167]

171 It was noted that Departmental funding was 'based upon population and there was general approval for the continuance of supra regional designation of such centres.'[168]

172 On 28 July 1989 the SCS delivered its interim report on NICS units in England and Wales to Dr Halliday.[169] The report contained this passage: 'Annual audit of work performed (including hospital survival), in this age range should continue to be carried out by the Department of Health.'[170]

173 Sir Terence English commented on the assumption that the Department was undertaking such an audit:

> 'A. Certainly, it was our belief that the Department had access to the UK Cardiac Surgical Register [UKCSR] data which each unit would have filled in, and could have provided to the Department if asked. I believe they were asked about it.
>
> 'Q. So your understanding was that, if you like, if you put yourself in Dr Halliday's shoes, you would have had the Cardiac Surgical Registry returns for each individual unit?
>
> 'A. Yes.
>
> 'Q. So putting yourself in, as you thought, leaving aside whether it is right or wrong, but as you thought Dr Halliday's position was, you would have been able to see how one unit compared against another?
>
> 'A. Yes, and also, if one unit seemed to be doing rather badly ...'[171]

174 In fact, the SRSAG did not obtain each unit's return to the UKCSR until the internal market was introduced in 1991.

175 The 1989 SCS report contained data showing mortality for under-1s after open-heart surgery.[172] Two units (one of which was Bristol) were shown as having statistically significantly higher mortality than the others. Sir Terence agreed that this was the sort of data he would expect questions to be asked about and that it was disquieting.[173] He also agreed that had he looked at this data in any detail, he would have concluded

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[167] SCS 0004 0015; SCS meeting, 12 May 1989

[168] SCS 0004 0015 – 0016; SCS meeting, 12 May 1989

[169] DOH 0002 0223 – 0237; SCS Interim Report

[170] RCSE 0002 0028; SCS Interim Report

[171] T17 p. 117 Sir Terence English

[172] DOH 0002 0233; *'The Interim Report of the Working Party on NICS Units in England and Wales'*

[173] T17 p. 121–2 Sir Terence English

that it required some serious explanation. He acknowledged that, as a member of the SRSAG at the time, he should probably 'have taken more account' of this data.[174]

176 The report was discussed at the SRSAG meeting on 28 September 1989. It was noted that:

> 'Bristol, Newcastle and Guy's Hospital were operating at sub-optimal levels; this had previously been identified in the 1986 report.'[175]

177 The de-designation of those units that were 'non-viable' and operating at 'sub-optimal' levels was discussed. Dr Halliday was asked about this in evidence to the Inquiry:

> 'Q ... the non-viable units which are referred to in the second paragraph, is that a reference back to Bristol, Newcastle and Guy's, because they were operating at sub-optimal levels?
>
> 'A. Yes.
>
> 'Q. So "sub-optimal" might refer to numbers; it might refer to success rates, and the report itself makes the point that the two tend to go together and the point you have just been emphasising?
>
> 'A. Yes.
>
> 'Q. So the idea was, was it, in the Group, "We really ought to de-designate those units"?
>
> 'A. That we ought to consider de-designating those units.'[176]

178 Dr Halliday explained that he was reassured by the conclusions of the 1989 *'Interim Report of the Working Party'*, which recommended that Bristol, 'should be encouraged to increase their numbers annually'.[177] Dr Halliday told the Inquiry that this was 'very reassuring' to him, 'that the problem remained one of non-referral, rather than outcome.'[178]

179 In a subsequent written statement to the Inquiry, Dr Halliday said that the:

> 'relatively high mortality figures naturally raised questions but I personally was reassured by the conclusion of the experts in this field namely that "Two centres

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[174] T17 p. 123 Sir Terence English
[175] DOH 0002 0214; SCS Interim Report
[176] T13 p. 59–60 Dr Halliday
[177] DOH 0002 0230; Interim Report, T13 p. 57 Dr Halliday
[178] T13 p. 56 Dr Halliday

> (Newcastle and Bristol) have a less than average turnover of work and should be encouraged to increase their numbers annually".'[179]

180 Dr Halliday visited Bristol, and the two other units in the report 'singled out … as requiring review', in early 1990.[180] The report of the visit, recorded in SRS (90)6, concluded that:

> '... although officials found the Bristol centre to be soundly based and giving every sign that the centre would be a viable designated unit, and despite the fact that geographical spread of the designated centres is desirable, there remains a question mark over the centre's long-term viability in supra regional terms.'[181]

It also stated, in more general terms, that the profession's advice was 'that about seven centres are required to cover the caseload of England and Wales'.[182]

181 At the SRSAG meeting on 26 July 1990 the report of Dr Halliday's visit was considered:

> 'The Chairman invited Mr English [Sir Terence English] to give members the views of the [RCSE] on this service. Mr English considered that this service should remain designated, but with no more than 9 units. It would be helpful to have surgical data from each unit'.[183]

182 As to Bristol in particular, Sir Terence is recorded in the minutes as saying:

> '… this unit should retain designation but [the RCSE] recommended [it] should be pressed to increase the workload.'[184]

Mr McGlinn attended the meeting as an observer from the Welsh Office and he assured the meeting that:

> '... the Welsh Office had no plans to support a neonatal and infant cardiac surgery unit and would continue to look to Bristol to provide a service for Wales.'[185]

183 By September 1990 it was reported that, although outside the SRS system, Cardiff, Oxford and Leicester were all performing NICS.[186] In October 1990 Dr Halliday reported to the SRSAG that Professor Tynan at Guy's Hospital was arguing that the whole NICS service should be de-designated.[187]

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[179] WIT 0049 0024 – 0025 Dr Halliday, quoting from UBHT 0061 0204
[180] DOH 0002 0200; Paper SRS (90)6
[181] DOH 0002 0200; Paper SRS (90)6
[182] DOH 0002 0202; Paper SRS (90)6
[183] DOH 0002 0196; Paper SRS (90)6
[184] DOH 0002 0196; Paper SRS (90)6
[185] DOH 0002 0196; Paper SRS (90)6
[186] SCS 0004 0026; minute dated 21 September 1988
[187] DOH 0002 0168; Professor Tynan would again write a report to this effect in June 1992 – see DOH 0002 0126

184 At the meeting on 3 October 1990, the SRSAG agreed that the NICS should 'ideally be concentrated in no more than six or seven centres and that proliferation occurred to the detriment of patients'.[188] This meeting considered SRSAG Paper (90)15, a discussion document on the units at Bristol, Newcastle, Guy's and Harefield.[189] At the meeting the view in favour of a reduced number of centres was generally accepted, but no clinician was willing for his or her unit to be de-designated. As Dr Halliday put it:

> 'The only difficulty is, I met with all the clinicians involved in this, and every single clinician I met in the designated units and the non-designated units would endorse what is in the minute, that we only need 6 or 7 units. It is the usual thing: "As long as it is not my unit that is closed". So everyone I spoke to endorsed our policy whole-heartedly: "As long as it is not my unit". They did not say that, but that was the connotation'. [190]

185 As regards Bristol, the Inquiry heard evidence that by 1991 Bristol was pleased to be a university teaching hospital designated as an SRS centre for NICS and hoped that it would become a heart transplant centre within two years (it had applied for such designation in May 1991).[191]

186 Mr Wisheart's evidence included this exchange with Professor Jarman:

> 'Q. I wondered if it would give you a bit of kudos, being identified as a supra regional service, a feather in your cap, as it were?
>
> 'A. I suppose there was an element of that but there was also kudos in doing the adult work well. I think cardiac surgery brings its own satisfactions and rewards as well as its disappointments at times.
>
> 'Q. I wonder also whether there had been any thought at that time of becoming a heart transplant centre?
>
> 'A. We had done in approximately 1990. It was either 1990 or 1991 when we appointed a new consultant, Mr Hutter in fact, who had as part of his training a time with Sir Terence English at Papworth and he himself therefore was trained and skilled and competent in this area.'[192]

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[188] DOH 0002 0168; minutes of SRSAG meeting, 3 October 1990

[189] DOH 0002 0053; Paper SRS (90)15

[190] T13 p. 83 Dr Halliday

[191] T94 p. 121 Mr Wisheart

[192] T94 p. 121 Mr Wisheart

187 A Report and Statement of Need dated 27 July 1990, *'Paediatric Cardiology and Paediatric Cardiac Surgery in Bristol – The Case for a New, Integrated Unit'*, was written by Dr Jordan. It stated:

> 'Bristol is now recognised as a supra regional centre which takes patients, not only from the South West Region, but also from parts of Wessex and South Wales … Bristol will almost certainly become a centre for heart and heart-lung transplants within the next year or two. Initially we expect to start with adult patients, but with the developments in this field which are now occurring, such transplantation in children will follow.'[193]

188 On 24 July 1991 Dame Deirdre Hine, then Chief Medical Officer (Wales), wrote to Dr Halliday on behalf of the Welsh Office. Amongst other things, she said:

> 'Within perhaps the next 3–5 years, I expect to see the University Hospital of Wales in a position to offer fully comprehensive paediatric cardiology and cardiac surgery for children of all ages. Within this period a step by step build up of neonatal and infant cardiac surgery will occur. All of this has very clear implications for the current Supra Regional Services Advisory Group strategy governing the pattern of services in the field of neonatal and infant cardiac surgery. It may be that de-designation of the supra regional status of existing units is very much closer than any of us would have anticipated just a year or two ago.' [194]

189 The SRSAG met again on 30 July 1991. On 31 July Dr Halliday wrote to Sir Terence English, who had been absent from the meeting:

> 'The Advisory Group at its meeting yesterday considered ways in which the cardiac surgical service for neonates and infants might be rationalised in order to ensure the continued designation of this service. It was suggested that it would be possible to define within the existing designated service those complex cardiac surgical procedures which should continue to be designated and to identify the units where this service could be effectively provided. If this were possible it would mean that some units presently designated under the existing arrangements could then be de-designated thus bringing about a rationalisation of the service.'[195]

190 Sir Terence replied on 19 September 1991, stating that in his view it would be very difficult to try to relate designation to specific categories of operative procedures.[196] His letter also referred to the possibility:

> '… of some of the smaller or less effective units ... being de-designated in order that the good and responsible units could continue to provide a valuable service.'

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[193] WIT 0097 0024 – 0025 Dr Joffe

[194] RCSE 0002 0063 – 0064; letter from Dame Deirdre Hine to Dr Halliday dated 24 July 1991

[195] RCSE 0002 0066; letter from Dr Halliday to Sir Terence English dated 31 July 1991

[196] DOH 0003 0003; letter from Sir Terence to Dr Halliday dated 19 September 1991

Sir Terence identified Bristol, Newcastle, Harefield and Guy's as the units that there were 'questions marks over in my mind'.[197]

191 Dr Halliday wrote to Mr Wisheart on 17 October 1991, indicating that the Department, in conjunction with the SRSAG, had commissioned a management consultancy study of the costs of the SRS.[198]

192 Dr Halliday wrote to Sir Terence on 20 December 1991,[199] enclosing the draft paper SRS (91).[200] In the letter Dr Halliday commented:

> '… it is difficult to refute the logic of the conclusions, given the problems of remaining within the supra regional criteria and continuing the designation of the service.'

193 In draft paper SRS (91) it was stated that:

> 'Members had previously considered a paper, SRS (90)15[201] which had provided more information on the units at risk. Bristol and Newcastle were considered to be essential on geographical grounds ...'[202]

194 It was also noted that 'officials were asked to discuss with both units ways in which the activity might be increased'.[203] This comment seems to confirm Sir Terence's view that supporting the units was a matter for the SRSAG and the local units themselves, rather than for the Royal Colleges.[204]

195 Sir Michael Carlisle in his oral evidence agreed that the reason for Bristol's continued designation was its location. His evidence included this:

> 'Q ... It appears to be suggested ... that the only claim that Bristol had for continued designation was what is called "geography". Broadly, does that correspond with your recollection?
>
> 'A. It does. I seem to recollect that Newcastle and Bristol were two places that were regarded, certainly for a considerable time that I recall, as necessary for geographic reasons.'[205]

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[197] T17 p. 148 Sir Terence English

[198] UBHT 0277 0141; letter from Dr Halliday to Mr Wisheart dated 17 October 1991

[199] DOH 0003 0004; letter from Dr Halliday to Sir Terence English dated 20 December 1991

[200] DOH 0003 0005; SRS (91) *'Report on Supra Regional Designation'*

[201] DOH 0002 0173; SRS (90) 15 *'Report on Supra Regional Designation'*

[202] DOH 0003 0005; SRS (91) *'Report on Supra Regional Designation'*

[203] DOH 0002 0173; SRS (91) *'Report on Supra Regional Designation'*

[204] T18 p. 200–1

[205] T15 p. 48 Sir Michael Carlisle

196 Sir Terence had no input into the drafting of SRSAG Paper SRS (91). He did not agree with its conclusion:

> '... I think it was exceptional because I suspect, and I put it no stronger than that, that Dr Halliday may have seen the Royal College of Surgeons in particular, had consistently advocated that the service continue to be designated and I believe that, round about 1990–1991, the Department began to feel uncomfortable with designation of the service and probably wanted to see it de-designated, and I think that in that circumstance there may have been an exceptional lack of communication which might not have taken place in another setting.'[206]

197 On 8 January 1992 Sir Terence replied to Dr Halliday, stating, among other points: 'I do not believe that Bristol and Newcastle should be considered essential on geographical grounds',[207] although he acknowledged that geography 'was an important factor to be considered ...'.[208]

198 In questioning, it was suggested to Sir Terence that, if geography were discounted, the continuation of Bristol's designation on the basis of 'potential' was misplaced:

> 'Q. That may seem to have the danger in it that it amounts to continued designation, as it were, on a "wing and a prayer"; that although there is no geographical reason strong enough on its own, although there never has been a sufficient track record of numbers, one can hope that the service will develop even though there has been no sufficient development up until now. Would you care to comment on that way of looking at the issue?
>
> 'A. Yes. I think one could look at it in that way.'[209]

199 On 24 January 1992 Professor Hamilton wrote to Sir Terence indicating that Dr Halliday was sending him 'the figures for the last five years from the designated units' carrying out NICS. Dr Halliday had also agreed to attend a meeting with a small working party from the RCSE.[210]

200 Paper SRS 92(2), *'Designation Issues. Neonatal and Infant Cardiac Surgery',*[211] was considered by the SRSAG at its meeting on 4 February 1992. The paper stated that the number of units in England undertaking NICS was thirteen, whereas the epidemiological evidence suggested that the number of units required to provide the

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[206] T18 p. 105 Sir Terence English; Dr Halliday called this suggestion 'quite absurd' WIT 0049 0026

[207] RCSE 0002 0081; letter from Sir Terence to Dr Halliday dated 8 January 1992

[208] T17 p. 137 Sir Terence English

[209] T17 p. 140 Sir Terence English

[210] RCSE 0002 0085; letter from Professor Hamilton to Dr Halliday dated 24 January 1992

[211] DOH 0002 0044; SRS(92)2 *'Report on Designation of NICS'*

service was no more than seven and probably nearer five.[212] The paper also stated, amongst other things, that:

> 'Members accepted the conclusions set out in the paper SRS (90)15 that in general terms, all other factors being equal, there is a strong case for Bristol and Newcastle in terms of geographical spread. [213] They agreed that it would be difficult if not invidious to de-designate the centres in question on the basis of surgical expertise, and doubted whether it was possible to do so on the basis of referral pattern.'[214]

201 Dr Halliday emphasised that the SRSAG alone was not in a position to recommend to Ministers that a unit be de-designated on grounds of surgical expertise. He was asked about the paragraph from the paper SRS 92(2), *'Designation Issues. Neonatal and Infant Cardiac Surgery',* set out above:

> 'Q. Again, help me with the wording of it. It may or may not be yours, but what was meant in that paragraph: actually surgical expertise in the general sense, or was it the outcomes of particular procedures?
>
> 'A. Well, I think the two go together. I think we were talking about outcomes of particular procedures. I think the difficulty we are in here is all the documents that we considered this morning highlight that almost from day 1 we were facing a situation where we might have to de-designate this service, or units within the service.
>
> 'The problem was that however much we tried, and however much advice we got from the various medical organisations, no-one recommended de-designating particular units, so we were faced with the situation where the only option was to de-designate the service. That is why we talk about the importance of geography, the problems about de-designating on expertise, or referral problems. Unless someone could provide us with the evidence which would allow us to take that decision, we had no alternative but to de-designate the service.'[215]

202 At a meeting of the SRSAG on 4 February 1992, Sir Terence offered to set up a working party to look at the question of designation of NICS. He told the meeting that:

> '... the most recent reports concluded that keeping 90–95 per cent of neonatal and infant cardiac surgery work concentrated in 6 or 8 centres was most beneficial to patient care.'[216]

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[212] DOH 0002 0047; SRS(92)2 *'Report on Designation of NICS'*

[213] A change from the wording of SRS (91) at DOH 0003 0005 of 'essential on geographical grounds'

[214] DOH 0002 0044; Paper SRS (92)2

[215] T13 p. 106–7 Dr Halliday

[216] DOH 0002 0033 – 0036; minutes of SRSAG meeting, 4 February 1992

203 Dr Halliday, on behalf of the SRSAG, formally accepted the offer on 6 February.[217] It was agreed that the Working Party would report by 1 July to be in time for the SRSAG meeting later that month.

204 Mr Steven Owen, then Administrative Secretary of the SRSAG, visited Bristol on 6 February 1992. He recalled receiving some mortality data during his visit, which he said he passed to Dr Halliday. A note of the meeting sets out this data.[218] Dr Halliday was asked about this in evidence:

> ‘Q. ... Yesterday we were told by Mr Owen that he visited Bristol in February 1992. When he visited Bristol then, he was passed mortality figures which did not mean a lot to him, so he passed them on to you. First of all, do you recollect that?
>
> ‘A. Yes. I mean, I was getting data fairly regularly, yes.
>
> ‘Q. The second question: do you recollect what, if anything, you did with those figures?
>
> ‘A. The difficulty is, as I have said, having figures in isolation, without the machinery to analyse it, is of no particular value. It would have been strange for me to be given – I mean, I was not given any figures with the suggestion that there was a problem here. I was given figures as I was on many visits. Sometimes my administrative colleagues would visit the units with the object of dealing with financial matters, and would be handed data. They would come back to me, or Dr Prophet,[219] and would hand us that data.
>
> ‘If, however, we were given the data and told that there was a problem with that data, that would be a different matter.
>
> ‘I have no recollection of any data being presented to me from Bristol with the caveat that there was a problem.
>
> ‘If there had been a problem, I would have clearly gone to the College for advice, but to be given data without the suggestion that there was a problem, would not have given me the opportunity to raise this with the College. I mean, it would be pointless me giving them the data from one year and saying, “What do you think of this?”.’[220]

205 On 12 February 1992 Sir Terence wrote to Professor Hamilton asking him to be the Chairman of the Working Party[221] and he accepted. Professor Hamilton wrote to Mr Wisheart on 10 March, asking him for relevant data.[222]

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[217] DOH 0003 0012; letter dated 6 February 1992

[218] DOH 0004 0045; note of meeting, 6 February 1992

[219] Senior Medical Officer in Dr Halliday’s division who had the policy resonsibility for paediatric cardiac surgery

[220] T13 p. 113–14 Dr Halliday

[221] RCSE 0002 0146; letter from Sir Terence English to Professor Hamilton dated 12 February 1992

[222] UBHT 0061 0241; letter from Professor Hamilton to Mr Wisheart dated 10 March 1992

206 Professor Hamilton delivered the *'Working Party Report'* to Sir Terence, with his covering letter, on 19 June 1992.[223] In relation to the number of centres it was recommended that:

> '… 9 centres now be recognised for supra regional designation and funding … [They] are: Great Ormond Street, Birmingham, Liverpool, Leeds, Wessex, the Royal National and Brompton Hospital, Bristol, Newcastle and Leicester.'[224]

207 The effect of the advice was that Harefield and Guy's should be de-designated, and that Leicester should be designated. Thus, there would be a net reduction of one in the number of SRCs, from ten to nine.

208 Sir Terence was asked by Counsel to the Inquiry for his initial reaction to the recommendation that Bristol continue to be designated:

> 'Q. What argument would you derive from the data and from what you have already told us as to your knowledge of Bristol, which would justify its continued designation as a centre for the neonates and infants?
>
> 'A. That it was functioning at a lowish level, certainly not the lowest; and that it was still regarded as being an important centre.
>
> 'Q. In terms of your own reasons for supporting it earlier, geography was not essential, and potential appears to be belied by the trend downwards?
>
> 'A. Potential still has not been realised, I agree.
>
> 'Q. Is it not the case that if you were to apply your own approach to it, you would have said: "Well, this trend really argues against there ever being a realisable potential here, now."
>
> 'A. I certainly did not think that at the time that I received this report.
>
> 'Q. If you had the benefit of hindsight, do you think you might have taken that view?
>
> 'A. I think that I should have initially given a more critical analysis, or given more critical analysis to Table 1 of the report, but I had asked a group of very responsible clinicians to look at this. They had accepted the terms of reference; they had collected a lot of data, come up with a report that I could understand their reasoning for wishing to continue to advise that the service be designated and how this could be achieved. And the recommendations to ask Guy's to either amalgamate with another London unit or fail to continue to get funding, and similarly, to ask Harefield to amalgamate with the Brompton or face withdrawal of

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[223] RCSE 0002 0162; letter from Professor Hamilton to Sir Terence English dated 19 June 1992

[224] RCSE 0002 0167; *'Working Party Report'*

> funding, and to recognise that Leicester was doing good work, these all struck me as being perfectly reasonable at the time.'[225]

209 On 2 July 1992 Sir Terence (as President of the RCSE) wrote a letter to Dr Halliday, enclosing the *'Working Party Report'*, of which at this stage he was fully supportive. His letter concluded:

> 'The working party collected a lot of data on which to base their recommendations and should ... be congratulated on a report which has the full support of the Royal College of Surgeons.'[226]

210 Sir Terence also wrote to Professor Hamilton on 2 July 1992, thanking him for a 'balanced and authoritative report' that had the full support of the RCSE.[227]

211 In a letter to the Inquiry received after the conclusion of the hearing of oral evidence, however, Professor Hamilton related that, although mortality was quoted in one of the Tables, '... it is possible that insufficient attention was given to these figures by the working party'.[228]

212 On 15 July 1992 Dr John Zorab, Medical Director of Frenchay Hospital, Bristol and a consultant anaesthetist, wrote to Sir Terence.[229] He enclosed an article from the 'MD' column in *'Private Eye'*.[230] His letter stated, *inter alia*:

> 'Sometime last autumn, I made one or two efforts to get to see you in order to discuss the delicate and serious problem of mortality and morbidity following paediatric cardiac surgery in Bristol. I have no vested interest in this and the problem is outside my immediate sphere of influence but great anxieties were being expressed by some of my colleagues at the Royal Infirmary. In the event, I never made contact with you and the matter passed from the forefront of my mind.
>
> 'Matters have come to a head once again and the enclosed piece from *'Private Eye'*, whilst possibly having some inaccuracies, quotes some statistics which have been confirmed elsewhere. One of the newer consultant cardiac anaesthetists feels that the mortality rate is too distressing to be tolerated and is job-hunting elsewhere.'[231]

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[225] T18 p. 126–7 Sir Terence English

[226] DOH 0003 0013; letter from Sir Terence to Dr Halliday dated 2 July 1992

[227] RCSE 0002 0179; letter from Sir Terence to Professor Hamilton dated 2 July 1992

[228] WIT 0044 0004 Professor Hamilton

[229] RCSE 0002 0188; letter from Dr Zorab to Sir Terence English dated 15 July 1992

[230] SLD 0002 0005; *'Private Eye'*

[231] A full description of the events resulting from this letter is set out in Chapter 27

213 At its meeting on 28 July 1992, from which Sir Terence was absent, the SRSAG:

> '... noted the Royal College of Surgeons Working Group Report which recommended that the service should continue to be designated and the number of designated units should be reduced from the current 10 to 9.'[232]

214 Sir Michael Carlisle told the Inquiry that by 1992, NICS was consuming 'nearly 25 per cent' of the SRSAG budget.[233] He said there was evidence that NICS was beginning to have completed its early developmental stage. It 'was a mature service that was taking rather more of the supra regional services finances than it should.' He continued: 'I mean, it [de-designation of NICS] was not a financial decision.'[234]

215 The minutes of the July meeting continued:

> 'Dr Halliday reported that since receiving the Royal College of Surgeons' report, he had been approached by Sir Terence English, who indicated that since submitting the report he now had reservations about the continued designation of the Bristol unit.
>
> 'The Advisory Group discussed the issue at length but concluded that it was unrealistic to expect to restrict the delivery of the service to those units for which the Royal College of Surgeons' report recommended continued designation …'[235]

De-designation of NICS

216 In the event, the SRSAG decided to de-designate the whole NICS, stating that this was 'a fairer decision in terms of medical and surgical rights of patients than to restrict designation to a few surgical units.'[236]

217 On this point Sir Michael was asked:

> 'Q. One of the difficulties that we have in making sense of what is said there is that the thesis, up until now, and the advice, has been that it is in a patient's best interests that there should be a designated service. It is contrary to a patient's interests that there should be proliferation of services, and it would be desirable to use whatever efforts one could, within obviously the limits of time, to restrict proliferation of services?
>
> 'A. Correct.
>
> 'Q. One appreciates that there may have to be a bowing to the inevitable, but is there any particular reason that you can help us, why is it described as a "fairer

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[232] DOH 0002 0099; minutes of meeting of SRSAG, 28 July 1992

[233] T15 p. 41 Sir Michael Carlisle

[234] T15 p. 41 Sir Michael Carlisle

[235] DOH 0002 0099; minutes of meeting, July 1992

[236] DOH 0002 0099; minutes of meeting, July 1992

> decision in terms of the medical and surgical rights of patients" than the continuation of a system with sufficiently few designated units to achieve the objects of the system?
>
> 'A. I have a little difficulty with that, in retrospect, I have to confess. I think it goes back to the proximity of service, the geographical element. I am sorry, I cannot help you more than that. I find it a slightly ambiguous paragraph myself, in retrospect.'[237]

218 Sir Terence said that he was unable to understand the logic of the reference to 'fairer in terms of medical and surgical rights'.[238]

219 This same point, about fairness, was put to Mr Steven Owen:

> 'I find it difficult to answer that question after this period of time, frankly, but I think it is simply a recognition that the nature of the service had changed, proliferation was widespread, and it was simply accepting reality. I think the de-designation decision itself was an acceptance of reality.'[239]

220 Sir Michael was asked whether matters would have taken a different course had the Working Group recommended a greater reduction in the number of centres being funded by the SRSAG for NICS:

> 'Q. Suppose that Professor Sir Terence English's Working Party had come up with the suggestion that there are six names, six centres, which the Royal College recommended for continuing designation. Do you think that probably the Advisory Group would have said, "Okay, we will retain designation for those six"?
>
> 'A. I think it is highly likely.
>
> 'Q. So it follows, does it, that the real problem or the real cause of de-designation of the service was not the fact that it was a mature service and was not the input from Guy's, it was simply a function of numbers?
>
> 'A. It was proliferation.'[240]

221 In his supplementary statement of 18 December 1999, Dr Halliday said that:

> '... my assessment of the likely outcome of the Supra Regional Services Advisory Group meeting [on 28 July 1992] was that the NICS service would be de-designated. The [SRSAG] had no alternative. In such circumstances Sir Terence's

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[237] T15 p. 78–9 Sir Michael Carlisle

[238] T18 p. 168 Sir Terence English

[239] T12 p. 89–90 Mr Owen

[240] T15 p. 42–3 Sir Michael Carlisle

> reservations were not important. Of course I had no way of knowing how serious these reservations were.'[241]

222 Dr Halliday continued:

> 'Had the NICS service continued to be designated but Bristol was to have been de-designated then Sir Terence's reservations would have been extremely important and the [SRSAG] would have wished to know in detail what these reservations were. I would therefore have been pressing Sir Terence for details. In the context of the [SRSAG] meeting however the details of Sir Terence's reservations were irrelevant.'[242]

223 Dr Halliday saw July 1992 as the end date of SRSAG's involvement with NICS:

> 'A. ... It was de-designated in 1992. It was funded for two years after that, but that was not a matter for the Advisory Group.
>
> 'Q. It remained, did it not, the responsibility of the Advisory Group?
>
> 'A. No, it did not, no.' [243]

224 Professor Hamilton wrote to Sir Terence on 3 August 1992. It appears from the letter that Professor Hamilton and Sir Terence had spoken twice, in July 1992, some days prior to the SRSAG meeting, and that Professor Hamilton had also spoken to Sir Keith Ross (a fellow member of the Working Party) on the morning of Monday 27 July 1992. Professor Hamilton said in the letter:

> 'I hope that you had a highly successful trip to and safe journey back from Pakistan, and are refreshed after a demanding but successful term as President.
>
> 'Following our telephone conversations of Thursday evening, July 23rd, and Friday afternoon, 24th, I was not entirely happy about our agreement to take Presidential and Chairman's action over the Working Party's report. On reflection, I realised a possible specific source of "breach of confidentiality" which could arise, and a further feeling that the de-designation of one of the units would probably "leak out" in the course of time. Also, the members of the Working Party were unanimous in their findings and gave considerable thought to their recommendations. Like you, I was unable to contact Keith Ross but did so early on Monday morning, the 27th, after he had returned home from holiday. He was equally concerned that we had changed the report and suggested, on reflection, that we should both speak with Norman Halliday to reverse the decision and the instructions that you had given him.

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[241] WIT 0049 0034 Dr Halliday

[242] WIT 0049 0034 Dr Halliday

[243] T89 p. 170; Dr Halliday explained that Chris Spry, a member of the SRSAG, brokered a funding arrangement with Regional General Managers which lasted until the spring of 1994

> '... the Working Party could be requested by the Advisory Committee on supra regional funding to *reconsider* the mortality figures of specific units (or unit), and possibly to amend its findings.' [244]

225 Sir Keith gave written evidence to the Inquiry. He said:

> 'It is safe to say that when David Hamilton telephoned me at home on 27th July 1992, when I had just returned from Scotland, I had no idea of the events leading up to the telephone call. I am sure David Hamilton did his best to explain the sequence of events, but under the circumstances (and I have no clear memory of the conversation), I must have agreed with his concern regarding the working group's conclusions being altered. Whether he or I suggested telephoning Dr Halliday is immaterial, but he had to be given our views. There was no way that I could have talked with Terence English who was either in, or on his way to, Pakistan, nor was there time to reconvene the working party before the SRSAG meeting, which was due the next day or the day after …
>
> 'Finally, I have no recollection of suggesting to Dr Halliday that the Working Party could be requested to reconsider the mortality figures of specific units with a view to possibly amending its findings. I would like to think that I would have recommended this, but as explained above, this never happened.'[245]

226 When he was shown Professor Hamilton's letter of 3 August 1992, in the course of his first appearance at the Inquiry, Dr Halliday said:

> 'This letter changes the whole context. My discussion with Sir Terence, or at least his discussion with me about his concerns about Bristol simply meant that he had reservations about Bristol and therefore he was not entirely happy with the report from the College.
>
> 'This letter would suggest that there appears to be more to it than that, and I cannot comment on that.'[246]

227 Dr Halliday accepted that the letter suggests that the discussions between Professor Hamilton and Sir Terence had involved the issue of mortality findings.[247]

228 Sir Michael Carlisle was emphatic that he had no knowledge of the contact between Professor Hamilton, Sir Keith Ross, Sir Terence English and Dr Halliday and knew nothing of the discussions suggesting alterations to the Working Party's report.[248]

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[244] RCSE 0002 0197; letter from Professor Hamilton to Sir Terence English dated 3 August 1992 (emphasis in original)

[245] WIT 0031 0006 – 0008 Sir Keith Ross

[246] T13 p. 90 Dr Halliday

[247] T89 p. 164 Dr Halliday

[248] T15 p. 77 Sir Michael Carlisle

229 After returning from Pakistan and learning what had occurred at the meeting on 28 July 1992, Sir Terence had indicated that he wished to speak to the issue of de-designation of NICS at the next meeting of the SRSAG, in September 1992.[249]

230 Sir Terence spoke at the meeting, but he does not claim to have mentioned concerns specifically about Bristol. Sir Terence accepted in evidence that he should probably, at least, have set out his concerns about Bristol in writing to Sir Michael. Sir Terence said:

> ‘A. I think that my last meeting of the Group [*sic*], I certainly spoke to my concerns about the de-designation of the service. I do not think I did mention Bristol specifically at that time. That is where the matter rested. I then left the Group. I know that Professor Browse [President, RCSE, from July 1992] knew of my concerns, but I think he did not feel any need to take them any further forward, and indeed, should not have, unless I had specifically asked him to, and I did not.
>
> ‘Q. Because he left them with you?
>
> ‘A. Yes.
>
> ‘Q. So it was, as it were, your responsibility?
>
> ‘A. Correct.
>
> ‘Q. And you had expressed them orally to Dr Halliday, but not otherwise?
>
> ‘A. Right.
>
> ‘Q. And never, it seems, from what you have said, thereafter expressed those concerns?
>
> ‘A. That is right.
>
> ‘Q. Do you think, perhaps, that you ought to have done so?
>
> ‘A. I think it is a difficult question. I think that I probably should have written at least to the Chairman of the Group, Sir Michael, formally about it, if I had not brought it up to the open meeting, the last one I attended. I suspect that probably is what I should have done.

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[249] RCSE 0002 0200; letters (from Sir Terence to Mr Owen), RCSE 0002 0202 (Mr Owen’s reply) and RCSE 0002 0205 (from Sir Terence to Sir Michael); none of these letters made reference to any problems at Bristol

> 'Q. Although it may be difficult now in retrospect to say why you did not, can you help as to why you might not have done?
>
> 'A. I think I was very cross that the Group had failed to accept the very considered advice of the professional Working Party that they had commissioned. That may have had something to do with it.
>
> 'Q. So you felt outwith the Group?
>
> 'A. I did, rather.
>
> 'Q. You simply did not think about raising the issue anywhere else?
>
> 'A. No. No. And would not. As I say, I think the right thing probably would have been to have written formally to Sir Michael.'[250]

231 Sir Terence said that after the 29 September meeting (his last as a member of the SRSAG), he felt that the matter was closed and beyond his further intervention.[251]

232 At the end of his evidence, in response to a question from the Chairman, Sir Terence acknowledged that, in retrospect, he should have done more to bring his concerns about Bristol to the attention of others. He said:

> '... I do accept the implied criticism, and indeed, the criticism that I should have done more to bring my concerns to the Supra Regional Services Advisory Group specifically about the mortality and the concerns expressed by Dr Zorab, than I did, and in retrospect I think I should have.'[252]

233 The decision of the SRSAG, to designate NICS, stood, coming into effect (taking into account financial implications) in April 1994.[253]

Monitoring of quality

234 Dr Ian Baker, Consultant in Public Health Medicine, B&DHA since October 1991, took the view that although he had a responsibility to ensure that the service for the over-1s was producing an acceptable outcome, the supra regional service for the under-1s was 'supervised through their [i.e. the SRSAG's] own arrangements'.[254]

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[250] T18 p. 174–5 Sir Terence English

[251] T18 p. 187 Sir Terence English

[252] T18 p. 202 Sir Terence English

[253] DOH 0002 0156; minutes, 29 September 1992

[254] T36 p. 73–4 Dr Baker

235 Those involved in the SRSAG itself did not share this view. Mr Angilley, Administrative Secretary of the SRSAG, said:

> 'The statutory responsibility for the provision of health care and therefore for standards is firmly in the hands of the local health bodies that provide that service.'[255]

236 Dr Peter Doyle[256] inclined to the view that 'the clinicians' had the responsibility for monitoring the outcomes of care,[257] as opposed to the SRSAG, but also said subsequently that he had 'no idea' who had the responsibility for monitoring the quality of outcome.[258]

237 The question as to what, if any, responsibility was accepted by the DoH for the designation and performance of an SRC, and to what extent it took the view that it had, as direct paymaster, control over such units was dealt with by a number of witnesses.

238 Sir Alan Langlands, Chief Executive of the NHS Executive,[259] placed responsibility on the local hospital, subsequently the Trust:

> 'In the case of NHS Trusts, Supra-Regional funds were allocated directly from the Department of Health to the NHS Trust responsible for the Supra-Regional Unit with effect from 1 April 1991. The NHS Trust took on managerial and clinical responsibilities for the proper use of those funds.'[260]

239 As to Districts, Sir Alan saw them as having had no real responsibility for SRSs:

> 'There is, or was at that time, a clear responsibility on district health authorities to ensure that the health and health service needs of their population were being adequately met and that means the whole range of services from primary to tertiary services. But beyond that, I can see that there is no real responsibility here and that the responsibility is much easier to define in relation to individual clinicians, the Trust where that service was located and the NHS Executive who, through these advisory groups, were running the national commissioning arrangements and allocating money.' [261]

240 Nonetheless, the evidence was that responsibility for the quality (in the sense of clinical outcome) of SRSs was confused. This confusion was considered by Sir Alan to be a failure for which the NHSME was to some extent responsible. In response to a question from Professor Jarman, he stated:

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[255] T11 p. 18 Mr Angilley

[256] The Medical Secretary of the National Specialist Commissioning Advisory Group (successor to the SRSAG) since 1994

[257] T67 p. 11 Dr Doyle

[258] T67 p. 13 Dr Doyle

[259] Sir Alan Langlands was Deputy Chief Executive of the NHS Executive 1993–1994, and thereafter became Chief Executive

[260] WIT 0335 0044 Sir Alan Langlands

[261] T65 p. 64–5 Sir Alan Langlands

'… there was confusion and … the distinctive roles and responsibilities of each of the players was not adequately clarified. I think that the Department of Health, the NHS Executive in particular, must take some responsibility for that. It falls into my category of systemic failure. You cannot expect people to behave sensibly in this position unless they are absolutely clear where they fit in. So I think the position is as described, I think there was a failure there, a confusion.

'Q. Just to take that further, that may be related to the fact, as Sir Graham Hart said to us, that the NHS had no proper measurement of the quality of care it was providing. I just wonder whether you feel that the reason for confusion you mention and the lack of proper measurement that he mentioned could have been related to the fact that, as he said, ministers were unwilling to get involved in dealing with the profession, the medical profession particularly, with regard to matters of clinical performance?

'A. I think I would separate the points. I hold up my hand to the fact that there was confusion here. There is no denying it. The fact that I have not been able to adequately explain it today or cover it effectively in my statement suggests that there was confusion. I think that is wrong. I think that I and the NHS Executive should take responsibility for that. I could mount all sorts of things in mitigation about how busy everybody was at the time and what a terribly complex change it was, but I do not. I think it is wrong that these roles and responsibilities were not clarified. On the subject of proper measurement, I am conscious of the fact that this is an area you know more about than I do, but I think there is a separate point there, which is that services like this all around the globe are trying to find effective forms of measurement. I think we are towards it in the data sets, the audit processes that I described earlier in relation to cardiac surgery. So I would want to separate the two points.

'Q. There was a third point.

'A. On the third point about the attitude of Ministers, well, again, I think it depends on timing. I can never remember a situation where Ministers said "We are reluctant to get involved in the clinical processes". But I do remember a culture where it would have been unusual for Ministers to get involved in the detail of clinical activity, but equally, in this period of the early 1990s, there were some very dramatic cases, for example in relation to mentally ill people where Ministers did intervene and did want to see very fast improvements in service and did require the NHS Management Executive, as it then was, to behave in a managerial way. I would think that position is now more pronounced and that current Ministers have no hesitation about intervening in areas where they feel, rightly in my view, responsible and where they feel they have to act, so that the actions they have taken in reinstating the very important quality assurance arrangements in relation to the breast and cervical screening services I think was an absolutely justifiable intervention, which no clinician in their right mind could have suggested was inappropriate. So I think attitudes have been changing over time, and I think that

> really the point I want to get across here is a sort of evolutionary point: that through all of this, the relationship between the government medical profession and the public has been changing and I think Sir Donald Irvine brought this out very well in some of his evidence, which suggests that issues of public accountability and self-regulation have to be in keeping with the current public mood. They cannot somehow be rooted in the past or in sort of romantic notions of clinical freedom in a bygone age. We are living in a different world.'[262]

241 That there was confusion and uncertainty as to responsibility for the monitoring of clinical outcomes in the SRSs, with a view to ensuring appropriate quality of care, was endorsed by a number of other witnesses. Professor Crompton expected the SRSAG to do it:

> 'I would have expected from the beginning, when they established the supra regional centres, that there would have been a system of data capture and analysis and publication from each of the centres, distributed freely to the Department of Health and to Regional Health Authorities who were sending patients there from Wales or wherever and that the Supra Regional Services Advisory Group would have been in full knowledge of all the facts relating to this important initiative. If that was not the case, then I am surprised.'[263]

242 The SRSAG supervisory mechanisms were described by Mr Angilley in his statement:

> 'As Secretary to the Advisory Group, my work included the monitoring of activity levels and costs at the designated centres against the Group's expectation when it agreed levels of funding. In the early years we carried out no detailed monitoring of cost and activity through the year and relied on annual figures submitted by the designated centres. These figures showed actual and forecast levels of activity and cost. The Advisory Group used this information to produce recommendations on funding of each centre in the following financial year. My background as an economist led me during my period in post to seek improvements in the costing and activity statistics provided by the centres. The introduction of contracts in 1991 was accompanied by quarterly activity figures as well as an annual report from the unit. The contract set out the format of the annual and quarterly reports.'[264]

243 As to performance in SRCs, the SRSAG looked to the Medical Secretary to raise any issues and the Medical Secretary, in turn, looked to the College members on the SRSAG to comment on performance.

244 The Colleges could visit or, if requested, report but they did not initiate reviews. It was not until 1991 that there was a suggestion that the Colleges should 'police' the system.[265]

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[262] T65 p. 103–6 Sir Alan Langlands

[263] T21 p. 72 Professor Crompton

[264] WIT 0034 0002 – 0003 Mr Angilley

[265] SCS 0004 0032; minutes of meeting, 21 February 1992

245 However, Sir Terence English told the Inquiry:

> 'I do not believe that the Royal College of Surgeons or Physicians, or any other Medical Royal College, can be held responsible for performance in individual units. I think the value of the Colleges resides in their capacity to provide professional advice when invited, and to do so in as objective and fair a way as possible. I think if there are difficulties that crop up in a unit, a College or two Colleges can combine to provide a visitation that can be quite extensive, and then very helpful to management. I think the Supra Regional Services Advisory Group had a responsibility – a difficult responsibility, but a responsibility nonetheless – for performance in the units that they designated, because they were funding them.'[266]

246 Dr Halliday made clear in his evidence that the SRS was a funding arrangement, and that the SRSAG did not have responsibility for monitoring the quality of the care provided by supra regional units:

> 'I was the architect of the Supra Regional Service arrangements. It was I who drafted all the papers, made all the proposals and negotiated with the profession. At no time did we consider that the Advisory Group which would eventually be set up would have monitoring responsibilities for any of the services. Their role was to advise the Secretary of State on which services would be centrally funded. It was a funding arrangement.'[267]

Moreover, he stated:

> '... the statutory duty for provision of health services rests with the Health Authorities… The Supra Regional Services Advisory Group did not alter the statutory arrangements.'[268]

247 Dr Halliday saw the local hospital management as having the role of monitoring quality, prior to the 1991 reforms. During the first occasion on which he gave oral evidence, he said:

> 'None of the supra regional services functioned in isolation. They were almost invariably part of a general hospital. So the management of the general hospital would have to manage the unit which was designated supra regional. I would have expected them to look after the provision of facilities and all outcome measures that they would want to use in any sphere, as they would with any other service.'[269]

248 The evidence of Professor Sir Kenneth Calman, Chief Medical Officer for England (CMO) from 1991–1998, was that:

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[266] T18 p. 200–1 Sir Terence English

[267] T89 p. 134–5 Dr Halliday

[268] T13 p. 112 Dr Halliday

[269] T13 p. 113 Dr Halliday

‘A. I considered that it would be the responsibility of the Supra Regional Services Advisory Group to ensure that there was a process for monitoring; and that that process and the outcome was reported to the Supra Regional Services Advisory Group.

‘Q. It is not quite exactly what you said before.

‘A. I am trying to clarify it for you.

‘Q. Before you said they would be responsible for monitoring it, they could go upwards to the Department of Health or go to specialists.

‘A. They were responsible for ensuring the system was in place for monitoring the outcome. They could not do the monitoring themselves. They would get the data once it had been monitored and if there was a problem, presumably they would talk to an appropriate person within the Department of Health.

‘Q. So they were responsible for getting a system and looking at the results?

‘A. I think in general, that is the Department of Health’s responsibility: ensuring that there are systems in place which monitor the data. They do not necessarily monitor it themselves. So I am sorry if I have confused you. I do not think I have confused myself on this, because I think they did have a responsibility to ensure that it was being monitored, and that the results would be fed into them.

‘Q. So when you say “they” it is the Department of Health and the SRSAG, working together, [which] had the responsibility for making sure there was a system and looking at the results to see if there was a problem?

‘A. Yes.’[270]

249 Sir Kenneth was asked about the same topic by the Inquiry Chairman:

‘Q. ... was it your evidence that there ought to be a system for monitoring as well as a system for seeking advice, or was it your evidence that the SRSAG itself should do the monitoring?

‘A. I do not think the SRSAG itself could do the monitoring, because it would not be set up to do that, but it should be ensuring that there was a system in place to do the monitoring.

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[270] T66 p. 98–9 Professor Sir Kenneth Calman

> ‘Q. And looking at the results?
>
> ‘A. I think looking at the results too.
>
> ‘Q. And examining the results?
>
> ‘A. Yes.’[271]

250 When this evidence was put to Dr Halliday (when he gave oral evidence for the second time, in December 1999), he agreed that the SRSAG had a responsibility for ensuring a system was in place for monitoring outcomes, but only in the latter part of the period, after the introduction of contracting in 1991:

> ‘Audit was not a major interest of the Department of Health at the time. Myself, I kept it as a policy issue within my division all the time that I headed the division, which was for 15 years.
>
> ‘Each year I was constantly told that medical audit was not part of the Department’s responsibility and that I should drop it, and I argued that I should retain it as long as I met all my other targets in terms of work. As long as pursuing that activity did not affect my other work I should be allowed to retain it, and I did.
>
> ‘So we were very active in encouraging medical audit in the field, despite the fact that it was not Departmental policy at the time.’[272]

251 Dr Halliday emphasised that the SRSAG was dependent on the ‘medical profession for any data which it had as to surgical outcomes and surgical performance …’[273]

252 Sir Michael Carlisle stated that the SRSAG was not ‘a rubber stamp committee’. However, he too emphasised the degree of reliance that the SRSAG placed on senior members of the medical profession for interpretation of data and ‘early warnings’ about problems with the service. Sir Michael’s evidence included this exchange:

> ‘Q. What you are perhaps telling us, and again, correct me if I am wrong, is that if it occurred to you that there might be serious grounds for concern with any particular unit, leave aside one doing neonatal cardiac infant surgery, that your first port of call would have been to the medical men to say, “Well, look, give me a view on this. What is this all about?”
>
> ‘A. Absolutely right. One relied upon them, I suppose in a manner of exception reporting, to come forward if there were known perceived problems in any unit where they had knowledge and expertise. We had a substantial network formally and informally for medical people. I have referred to the President of the Royal

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[271] T66 p. 100–1 Professor Sir Kenneth Calman

[272] T89 p.138 Dr Halliday

[273] T13 p. 3 Dr Halliday

> College of Surgeons; there were other eminent medical people on that group, and I think there was a sufficiently powerful group of people and network of people to be able to pick up evidence, albeit verbally, of problems.
>
> 'In those cases, those had been brought or raised at the committee, at the [SRSAG], I would have seen action was taken to do something about enquiring more about it.
>
> 'Q. So you, in wishing to take things forward in the best interests of patients, as you did, you were really reliant upon the input that the medical men had to give you?
>
> 'A. Absolutely so. It is not my area of expertise to interpret medical data.'[274]

253 With effect from 1991 service level agreements, described as 'contracts', were entered into for the delivery of SRSs. Sir Michael accepted that, 'as a contractor, the Department of Health obviously had an accountability [for the way in which SRSs were managed].'[275]

254 On a final matter concerning performance and monitoring, Dr Halliday was asked how often it was that a supra regional unit was de-designated on the grounds of poor clinical performance. He was unable to recollect an example of this:

> 'We have de-designated services, but I cannot recollect us ever de-designating a particular unit. It is very difficult to de-designate units, because although you might find that the profession supported the decision, there might be a reluctance, you know, a decision to de-designate the service, there might be a reluctance to de-designate a particular unit. There are often very good reasons for that. For example, Guy's was a unit that was constantly being referred to as one that should be de-designated, but it is very difficult, when you go along to see the unit and you find in fact they are leading the world in prenatal diagnosis, they are one of the leading international units in interventional catheterisation, and say, "De-designate this unit". It is very difficult'.[276]

The information collected by and available to the SRSAG

255 When Sir Michael Carlisle became Chairman of the SRSAG, in April 1989, he perceived a need to improve the system of assessing bids for supra regional funds. The minutes for the SRSAG meeting of 28 September 1989 stated that:

> 'The Chairman noted that the White Paper reforms raised large issues for the supra regional services. He felt that the current method of assessing bids for additional funding left a good deal to be desired; the broad brush approach would need to

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[274] T15 p. 29–30 Sir Michael Carlisle

[275] T15 p. 3 Sir Michael Carlisle

[276] T13 p. 102–3 Dr Halliday

> give way to a system of contracts. The Group needed to know much more about the costs of providing supra regional services …'
>
> 'When the principles were resolved, there would be a need for reliable accounting data as well as information on outcomes of treatment.'[277]

256 Sir Michael emphasised that his desire to see a system of collection of information about the quality of SRS was not part of the de-designation debate, but was something he saw as an important management tool:

> 'Q. So the position is, is it, that in 1992 the units in the various different services were not giving very detailed information about outcomes to the Group?
>
> 'A. I, of course, did not see much evidence of that. It may be that Dr Halliday and others – not others, Dr Halliday in particular – who had strong liaison with units, may have seen more information than I did, but I do not think it is wrong to say there was more emphasis on the volumetric than the qualitative data …
>
> 'You can see from the 1989 paper that I was very keen that some outcome information should be brought forward to complete the total picture, so that our judgement as a group in the corporate sense could be better informed. So we have an interest in it. What we did not have was the information …
>
> 'This was nothing to do with designation or de-designation; it is about running good services. I should like to have seen, this was the very first step, the annual report and the annual report of the units, leading up to a situation where I hoped that there would be periodic performance reviews of the units and services within the Supra Regional Services Advisory Group. We could not do every service and every unit every year, but we could start to commence that process … I was hoping through reports and performance reviews to establish some process whereby the total picture of what is going on could be more evident, not just for management purposes but also so we could advise the Secretary of State that continued investment in these services was appropriate or not.'[278]

257 Sir Michael explained that the SRSAG lacked what he called 'hard management information'. He said that, despite this, 'I think we got a reasonable feel for most things except outcome'.[279]

258 Dr Halliday said that the SRSAG received anonymised data from the SCS each year and this allowed the SRSAG 'to identify the trends in terms of mortality in all the units, but we could not identify the units'.[280] However, Dr Halliday did not know how the SCS collected its data, nor the form in which it was made available by it to cardiac

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[277] DOH 0002 0214; minutes of meeting, September 1989
[278] T15 p. 11–14 Sir Michael Carlisle
[279] T15 p. 16 Sir Michael Carlisle
[280] T13 p. 46 Dr Halliday

units across the country.[281] He described the Society as 'very secretive' and referred to 'difficulties' which the SRSAG had 'in getting any progress from the Society'.[282]

259 Dr Halliday said that it was only when contracting began, in 1991, that the SRSAG 'insisted'[283] that the returns to the UKCSR were included in the monitoring returns sent annually by units to the SRSAG.

260 Sir Terence took the view that 'it would have been perfectly proper to have analysed quality of output in terms of mortality, and de-designate it if necessary.'[284] Having said that, he recognised that nothing other than crude measures of mortality were available:

> 'I think that the output of crude mortality is there as a sort of warning, if you like, that if it raises an issue, that then you need to go in and do a much more detailed and difficult analysis.'[285]

261 Dr Halliday explained that if the SRSAG had information about an apparently under-performing unit, it would produce a paper and recommend to the Chairman of the SRSAG that the President of the appropriate Royal College set up a working group to review the situation.[286]

262 Dr Halliday was asked:

> 'Q. Suppose the Working Group reports and says, "Well, it is not doing very well; on the other hand, it is not doing desperately badly". What would the likely outcome be? Would the service likely remain designated, or not?'
>
> 'A ... I think people would sweat over midnight oil about what we should do, but the difficulty would be, if that is the professional advice that it should continue, how do you stop it?
>
> 'Q. It all comes down to – this started the question I was asking you – it depends on the professional input you get in the Supra Regional Services Advisory Group from the Royal Colleges?
>
> 'A. I do not know who is better to judge the practice of medicine than the doctors …'[287]

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[281] T89 p. 143–4 Dr Halliday
[282] T89 p. 144 Dr Halliday
[283] Sir Michael Carlisle's word – T15 p. 15
[284] T18 p. 109 Sir Terence English
[285] T18 p. 110 Sir Terence English
[286] T13 p. 108 Dr Halliday
[287] T13 p. 108–9 Dr Halliday

The number of neonatal and infant open-heart operations at Bristol

263 Departmental Paper SRS (83)17[288] was prepared in 1983 for consideration by the SRSAG as part of the process of considering NICS for SRS status. It includes tables showing regional rates of operation for under 18 years of age, together with estimated needs for NICS (based on the 1979 British Paediatric Association Report[289] and the Second Joint Cardiology Committee Report of 1981).[290]

264 Bristol figures for 1983–1984 are to be found in a document prepared by the Bristol clinicians, as part of the creation of the SRS in Bristol.[291] The figures for 1984–1985 show that Bristol carried out 13 open-heart and 39 closed-heart operations.[292]

265 At the meeting of consultants from NICS units held on 4 October 1985 figures were presented to indicate the number of open-heart operations at each of the nine centres for 1984–1985. Bristol figures appear as set out in the paragraph above.[293]

266 It was clear to the Birmingham representative, Dr Silove:

> '… that several of the figures were spurious and in particular the representatives from Leeds and Newcastle suggested that the actual figures were very much less.'[294]

267 There followed an exchange of correspondence between Dr Silove and Mr Hurst, Administrative Secretary of the SRSAG 1983–1987.[295] In his letter of 2 January 1986 to Dr Silove, Mr Hurst wrote:

> 'I hope you will appreciate that Regions are responsible for the data they submit to the Department and that the Department is obliged to accept their submission.'[296]

268 On 6 January 1986 Dr Silove replied:

> 'I do appreciate that the Regions are responsible for the data that they submit to the DHSS. However, at the 4 October meeting several of the clinicians present indicated that the data from those Regions was a fiction.'[297]

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[288] WIT 0482 0349 Dr Moore

[289] BPCA 0001 0014; 1979 BPA Report

[290] RCSE 0003 0017; 1981 JCC Report

[291] UBHT 0278 0577 – 0579; there are also calendar year figures (see DOH 0004 0028 and Mr Wisheart's evidence, T41 p. 128–33)

[292] UBHT 0278 0507 and UBHT 0278 0487; form entitled NICS and a table in Secretary of State's announcement on SRS for 1986–1987

[293] ES 0002 0019; table entitled Neonatal and Infant Cardiac Surgery

[294] ES 0002 0021; letter dated 9 December 1985

[295] ES 0002 0020 – 0024; correspondence between Dr Silove and Mr Hurst

[296] ES 0002 0024; letter from Mr Hurst to Dr Silove dated 2 January 1986

[297] ES 0002 0023; letter from Dr Silove to Mr Hurst dated 6 January 1986

269 The Bristol figures, in summary, for the period from 1983–1984 until 1992 are in the table below:

Table 4: Table of open and closed figures

	1983–1984	1984–1985	1985–1986	1986–1987	1987–1988	1988–1989	1989–1990	1990–1991	April 1991–January 1992
Open	3	13	16	26	28	33	39	45	32
Closed	36	39	52	55	57	56	60	82	42

270 Dr Halliday was shown the figures for the number of NICS operations at Bristol. His evidence included this:

> ‘Q. ... whatever the assurances that had been made to you by the Royal College of Surgeons on this rather nebulous basis, nothing in fact was happening very much to improve the throughput at Bristol?
>
> ‘A. Well, it is increasing, but it is not significant.
>
> ‘Q. That must have been a matter of concern, then, to the [SRSAG]?
>
> ‘A. It was, yes.
>
> ‘Q. It would imply, because of the low numbers, that the outcomes were unlikely to be as good as they would be in one of the larger centres?
>
> ‘A. Well, as we have agreed, all the evidence suggests that the more operations you do, the better you are. But of course there are always exceptions to that and I can give you many examples of people who have done only a few operations, but their results are quite outstanding: the cardiac surgeon in St Bartholomew’s Hospital, for example, who only did three heart transplants but his success rate was 100 per cent. So there are many factors that influence this.
>
> ‘The other thing I think you need to take into account is at the time Bristol were only doing 11, 14, 24. There were other units in the country doing 11, 13, 24, and were getting outstanding accounts.’ [298]

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[298] T13 p. 36–7 Dr Halliday

271 In relation to the Bristol figures Dr Halliday said:

> 'Q. So the Advisory Group were in a position in the 1980s to identify an under-performing unit?
>
> 'A. Yes.
>
> 'Q. Did they do so in respect of Bristol?
>
> 'A. Bristol was always a worry. It was a particular worry to me, but it was a worry in a sense that I could not understand why referrals were not increasing, and I made many visits to Bristol, to the Welsh Office, and met many people in the South West, clinicians I mean mainly, but also managers, to try and identify what the problem was. It never became clear. …[299]
>
> 'Q. What I am asking, did it appear to you that there were questions to be asked in respect of Bristol?
>
> 'A. Questions to be asked in respect of Bristol?
>
> 'Q. Because you were able to compare its performance with the national, and the question is in two parts: did it seem to you that the performance was less good than the average, the first question; and the second question: if so, what if any steps did you take about it?
>
> 'A. The evidence did suggest that Bristol was not performing as well as the other units.'[300]

272 Sir Michael Carlisle told the Inquiry that he knew that 'it has always been a struggle' for Bristol to increase its referral numbers.[301] However, as Chairman, he had no role in attempts to increase the number of referrals to Bristol.[302]

The encouragement/strengthening of the Bristol Unit

273 Dr Halliday placed some emphasis on the fact that the Royal Colleges inspected the supra regional units regularly.[303] He was not able to be specific as to the content of the strengthening steps which might have been expected from the Colleges.

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[299] Dr Halliday told the Inquiry that he did not perceive the split site as a barrier to Bristol's development

[300] T13 p. 46–8 Dr Halliday

[301] T15 p. 53 Sir Michael Carlisle

[302] T15 p. 53 Sir Michael Carlisle

[303] T13 p. 102 Dr Halliday

274 Dr Halliday was questioned by Mrs Maclean of the Inquiry Panel on the nature of support for Bristol from the Colleges:

> ‘Q. ... You suggested that you were looking to the Royal Colleges for support in the development of Bristol. I wonder if you could give me some examples of the kinds of things you meant by that support?
>
> ‘A. Actually, I did not say I was looking to the Royal College for support, I said that the Royal College had offered their support. You see, the Colleges are responsible — one point perhaps I should have made earlier is that we are very fortunate in the way that our Royal Colleges assist us, because they are not formally part of the National Health Service. They have no responsibility for the provision of services. Their role is educational and the training of doctors. Yet despite that, they are only too happy to contribute their time, and sometimes money, to look at the things we want them to address. So I think we are very lucky in that sense.
>
> ‘In the case of Bristol, we were in a situation where the Advisory Group had decided, based on all the evidence we had, that we should designate the neonatal and infant cardiac surgery. If we did not have a centre in the South West, a significant part of the population would not be served. We had to take into account Wales as well, although Wales was not part of the supra regional service arrangements.
>
> ‘When it was suggested that Bristol be designated, even then we had concerns, because it did not seem to be, you know, as good as the other units in terms of facilities, staffing and so on. When the College offered, through Sir Terence, to say that they would assist us in strengthening that unit, my interpretation of that would be that the College had “powers”, in inverted commas, through their visits to say whether the facilities were effective, and if they were not effective, they could withdraw their recognition of it being a training post. That is a very powerful weapon for managers.
>
> ‘The second thing is that they can influence their young consultants coming along, or Senior Registrars, and suggest to them that if they would like to apply to Bristol, it would be in their long-term interests. So I expected them, both in terms of their visitations and encouraging staff, good staff, to take posts in Bristol, that they would strengthen the unit.
>
> ‘But it is not something I could actually interfere with. The College has its own way of ensuring its standards are met.’[304]

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[304] T13 p. 120–2 Dr Halliday

275 Sir Terence rejected the view that the SAC or the Hospital Recognition Committee (HRC) was better placed than the SRSAG to gather intelligence on NICS. He told the Inquiry:

> 'As far as neonatal and infant cardiac surgery is concerned, the College would become informed and involved at whatever time they were asked to look at a particular problem or to do a particular piece of work for the Group, but otherwise the detailed information that we would gather from the five-yearly visit of the SAC and the five-yearly visit of the HRC to a particular designated unit, that information, although strong on training, in terms of the total service, would be less than I would have expected the Supra Regional Services Advisory Group to have held themselves, because they designated these units and they had the purse strings and they were monitoring them.'[305]

Sir Terence was asked about the extent to which the SAC for cardiothoracic surgery had regard to the 'quality' of surgery performed by the consultants providing the higher training in the specialty:

> 'A. I think this was approached variably by different members of the SAC, different visitors. Some would enquire informally into it, others would like to see the results from the previous few years. We had ours available at visits with mortality statistics against them; others did not. It was not a requirement as such. It was perhaps something — well, it certainly did not receive as much attention as the quality of the training which the individual was receiving.
>
> 'Q. Quality of training was the whole purpose of the visit?
>
> 'A. Correct.
>
> 'Q. So inevitably, quality of outcome would not, could not, receive as much consideration as that, but I think what you are telling me – I want to be sure I am right about it – is that whether formally or informally, it was the expectation of all concerned that those visiting the unit would ask about quality of outcome, or quality of surgery?
>
> 'A. I think the reality of it was that generally, throughout surgery, it was not regarded — it was not common to enquire specifically about mortality at SAC visits. I am not sure about that, but as a generalisation, I think that is true.'[306]

276 Sir Terence explained that to the extent that the SAC visits looked at 'quality' they did so by reference to factors other than the surgical results of the consultants:

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[305] T17 p. 37 Sir Terence English

[306] T17 p. 26–7 Sir Terence English

> ‘They would be primarily interested in what the facilities were in that hospital: the number of operating sessions that were staffed and available for training; the number of times that the Registrar could attend an outpatient clinic, ward rounds with consultants, how many times he or she was operating on their own or with consultant help, or assisting consultants. They had a logbook which was introduced in the late 1980s, I think, which all trainees, when they were registered with the SAC, had from then on to keep, and it was an account of every operation that they were involved with, either as the first operator or as the assistant, and they were required to keep information on mortality in that.
>
> ‘That would always be discussed at the time of the visit. But that was looking at the trainee’s operative outcome in terms of mortality rather than his boss’s, or the unit’s.’[307]

277 Visits by the HRC and the SAC to the same hospital at about the same time could produce different pictures of the institution inspected, as was the case at Bristol in 1994.[308]

278 Sir Terence told the Inquiry that, by 1986, when he chaired an RCSE and RCP Working Party[309] looking at NICS:

> ‘… it was apparent that Bristol had not developed to the extent that we may have expected; that there was a problem with respect to the development at that time. It had certainly not increased its numbers hugely. But it was felt that there was still the potential there and that it would be worth reviewing it and seeing how it went in the next few years.’[310]

279 The 1986 Working Party concluded that on the basis of current and future likely demands for NICS, it was not possible to justify more than nine centres for England and Wales. Indeed, on the grounds of cost-benefit considerations alone, the view was that it might be advantageous to concentrate the work in as few as six larger centres. Sir Terence agreed that this conclusion would have meant that smaller centres such as Bristol, Newcastle and Guy’s would have been vulnerable to de-designation.[311]

280 Sir Terence told the Inquiry that the Working Party intended the SRSAG and the local hospital management in Bristol to do the ‘encouraging’ of Bristol:

> ‘Q. Were you there suggesting that the Supra Regional Services Advisory Group itself should do the encouraging?

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[307] T17 p. 28–9 Sir Terence English

[308] Compare the SAC visit of 8 July 1994 (RCSE 0002 0222) with the HRC visit of 13 July 1994 (RCSE 0002 0234). See, generally, T17 p. 39–56. Within the Royal College of Surgeons, Sir Terence told the Inquiry that, in essence, any cross-referencing between two such Reports would be more a matter of accident than design; see also T17 p. 57–8

[309] RCSE 0002 0009; RCP *‘Working Party Report’*; note that Professor Hamilton was also a member of this Working Party

[310] T17 p. 87 Sir Terence English

[311] T17 p. 90 Sir Terence English

> ‘A. Yes, and more generally than that: that one would hope that it would have filtered down from there to the hospital itself, to the management of the hospital and to the staff involved in that hospital; that a report like that, which would inevitably go to the supra regional units themselves, one would hope, that they would take account of it.
>
> ‘Q. The encouragement that was to be given: what form did you think that would take?
>
> ‘A. I think all sorts of ways: the provision of the facilities, if this was the block, appointment of an additional surgeon or anaesthetist skilled in paediatric anaesthesia – wherever the block lay, it ought to be corrected.’ [312]

281 Sir Terence said that he did not think that there was anything that the Royal Colleges could do other than to draw attention to the need to ‘encourage’ Bristol:

> ‘I do not think that there was any specific encouragement which either the Royal College of Physicians or the Royal College of Surgeons could have given to the BRI at that time to increase their throughput in paediatric neonatal and infant cardiac surgery.’[313]

282 He added:

> ‘... this was a service which had been designated by the Advisory Group [SRSAG]. They had asked an opinion in the Colleges as to what the present situation was; they were given that opinion, but controlling the purse strings, as I have already said, really gave the Department a huge potential for some control over development. I can only suspect that that was not exercised in this particular case where it perhaps should have been.’[314]

283 Sir Terence explained that he saw the role of the Royal Colleges as being essentially reactive, setting up committees and producing reports when requested to do so by the SRSAG. He said:

> ‘... I would put it to you that the Colleges have the responsibility of providing a professional report on a particular service or a particular issue when asked by the Supra Regional Services Advisory Group, who, on the basis of that report, ought to then require the local hospital to improve that service, because they are funding it.’[315]

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[312] T17 p. 95 Sir Terence English

[313] T17 p. 99 Sir Terence English

[314] T17 p. 100 Sir Terence English

[315] T17 p. 104–5 Sir Terence English

The inability to control 'proliferation'

284 Sir Michael Carlisle emphasised that the powers of the SRSAG were limited:

> 'But to get back to your question, we have no directional powers. Much is made of "designation" or "de-designation", but I do not feel we were doing anything else but trying to get the profession to control the proliferation of this service, and others, voluntarily.' [316]

285 The question was put to Sir Graham Hart, Permanent Secretary at the DoH from 1992 to 1997, whether the Secretary of State for Health could take steps to limit proliferation. Sir Graham said:

> 'My understanding is that ... some of the units that were doing these procedures outside the supra regional services arrangements had a good record. So why should he [the Secretary of State], in a sense, intervene? I think he created the right kind of environment in which the tendency would be towards limitation and specialisation, but he was not, as it were, putting down an absolutely rigid framework within which there was no room for movement at all.' [317]

286 In supplementary written evidence to the Inquiry dated 9 February 2000, Sir Terence said:

> '… the "profession" never had the power to rationalise the service. All we could do was to provide authoritative reports on what we felt was best for the service, in the belief that if we recommended de-designation of units in order to preserve the continued designation of the whole service, this would be acted upon by the SRSAG and the Department of Health. Being centrally funded services gave the SRSAG the power to cut off funding for units, which may not have made them stop immediately but which would have been a big disincentive to carry on the work.' [318]

287 In a supplementary written statement to the Inquiry dated 18 December 1999,[319] Dr Halliday made the point that control of proliferation was all the more difficult in the NHS after the reforms of 1991, since trusts had more freedom to decide which services they would provide and, at least in the early post-reform years, competition was encouraged.

288 Dr Halliday accepted that:

> 'In the interest of patients and the service generally all the evidence points to the need to concentrate the services in as few units as possible.'[320]

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[316] T15 p. 57 Sir Michael Carlisle

[317] T52 p. 25 Sir Graham Hart

[318] WIT 0071 0067 Sir Terence English

[319] WIT 0049 0034 Dr Halliday

[320] WIT 0049 0019 Dr Halliday

He commented that:

> 'Managers in non-designated units who allow such services to be provided, must be held responsible. If funding was not provided, the clinicians could not undertake the work.'[321]

289 In his supplementary statement, Dr Halliday also accepted that the DoH, the Welsh Office and the Royal Colleges were not able to influence the referral pattern to the Bristol Unit.[322]

290 Dr Halliday accepted that the supra regional arrangements themselves were not sufficient to bring about the degree of control over the development of the service which would be needed to keep down the number of centres undertaking NICS.[323] He was asked:

> 'Q. ... If we go back to your statement, 49/3, the second sentence of your paragraph 3, you dealt with one reason for setting up Supra Regional Services Advisory Group arrangements and you say: "Another equally important reason was to control the development of such specialised services." Have I misunderstood what you meant by that?
>
> 'A. You have not misunderstood, but the arrangements themselves were not sufficient. I mean, clinical medicine is not something that is easy to control, as we see from every country in the world, so that a system like this required additional powers from other sources before they could actually impose control.'[324]

291 At the end of the first session of Dr Halliday's evidence, the Chairman questioned him about the difficulties of the supra regional provision of NICS:

> 'Q. ... The impression I have is that as a service – let alone we are talking about any particular unit – this particular service concerned with neonatal and infant cardiac surgery, etc., was doomed from the start, in that the very criterion of one year had an element of arbitrariness in it. The criteria for supra regional services could not appear to ever be met, at least in some of the units. There were either going to be too many units or there was not enough throughput; there was already an existing and established service; there was therefore an inability to make dirigisme from the centre actually work. There were no financial sticks, only carrots. And there was always the issue of clinical freedom, whatever that may mean, operating against

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[321] WIT 0049 0019 Dr Halliday

[322] WIT 0049 0016 Dr Halliday

[323] T13 p. 13 Dr Halliday

[324] T13 p. 16 Dr Halliday

the interests. Would that be a fair set of observations, or have I got it completely wrong?

'A. No, that is entirely fair, but the other element of that is the situation where the Department was aware that there were allegations by reputable, experienced clinicians that there were children who were not being diagnosed and treated in this speciality. You cannot ignore that.

'We were aware that there were parts of the country in which we were very poorly covered, and other parts of the country which were over-generously provided, so there had to be something done about the service. The supra regional service advisory arrangements appeared to offer that mechanism, and it has worked in other services very effectively.

'We then consulted with appropriate Colleges and their view was that it should be a designated service. In fact, their view is to this day that it should be a designated service, but I agree with you, it has not worked. But we did try.

'I think that is all one would expect a Department to do: to try to make the system work. If it is not possible for a variety of reasons, and there are no powers to ensure that it happens, then there is nothing we can do.'[325]

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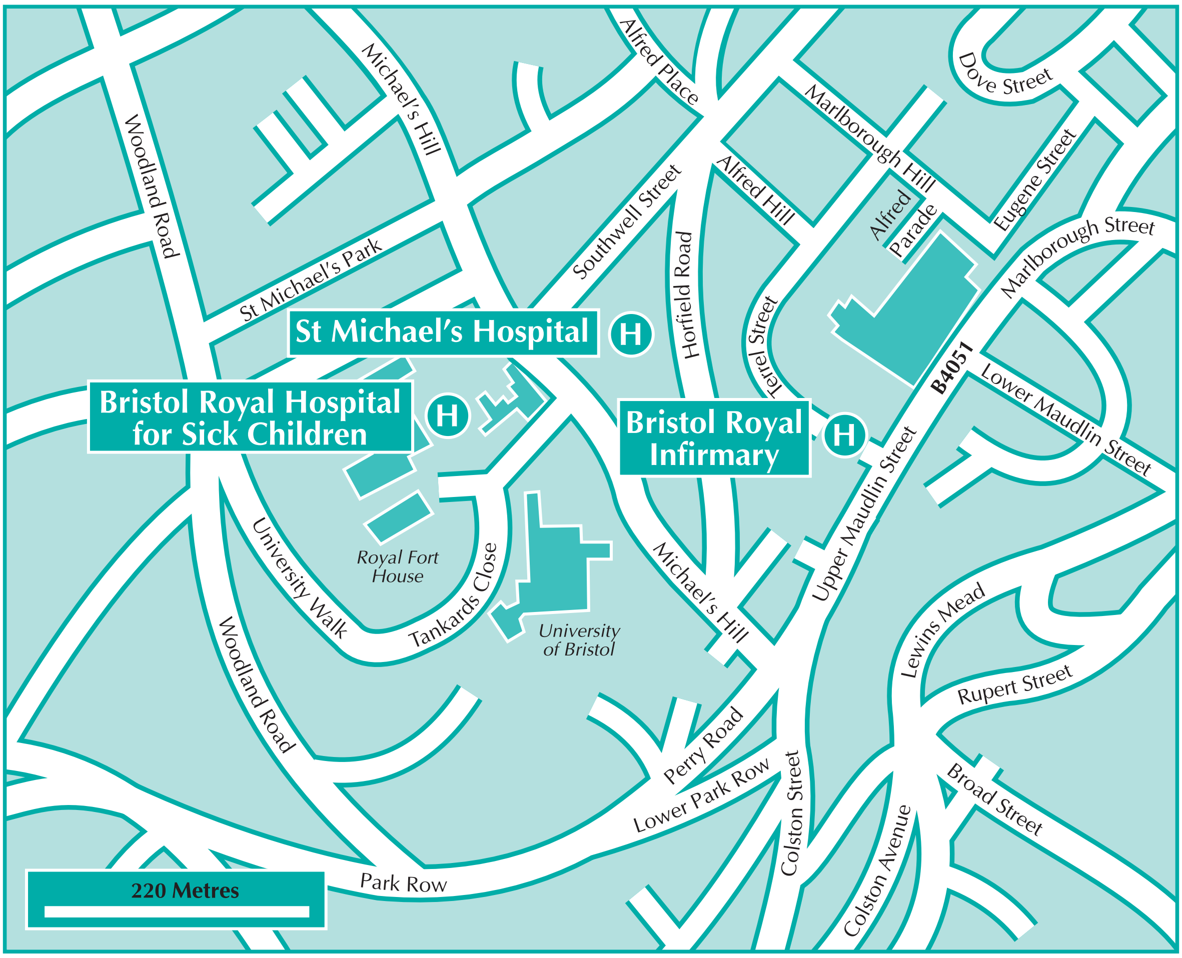
[325] T13 p. 127–9 Dr Halliday

Chapter 9 – The Split Service

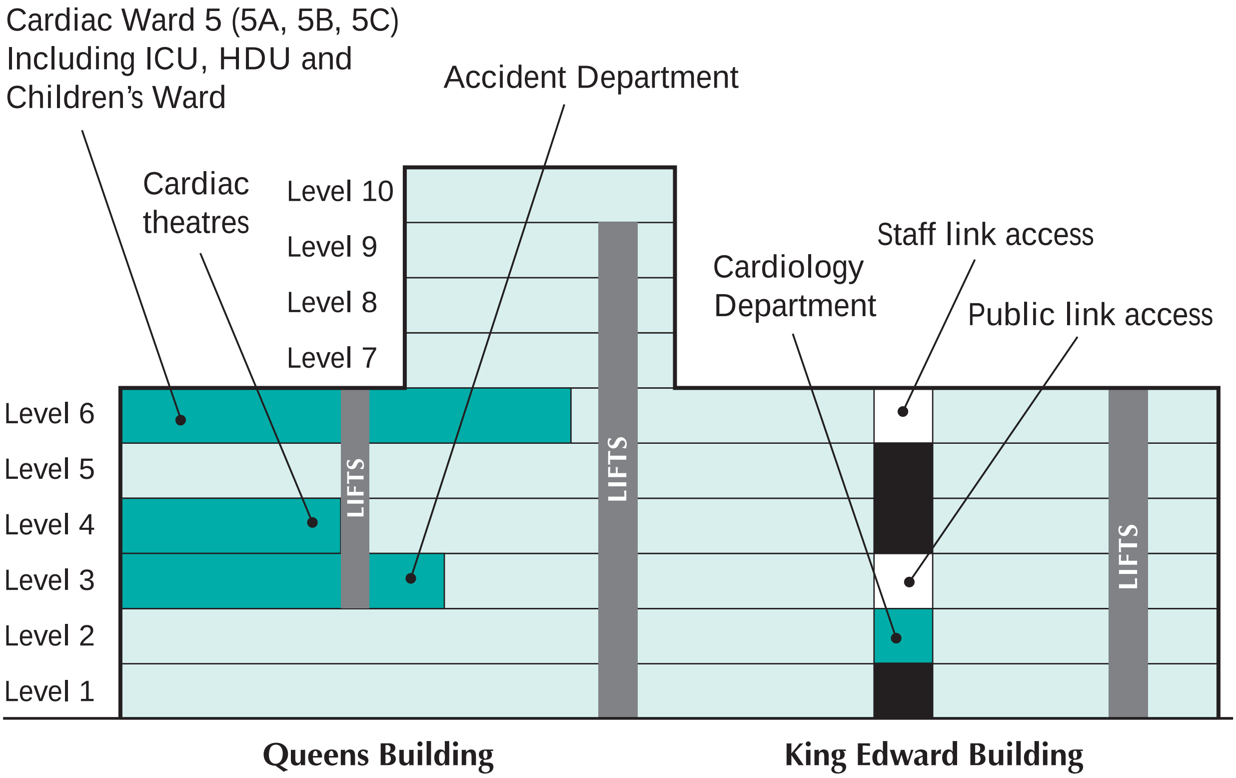
Introduction

1 The services involved in paediatric cardiac surgery were split between two sites: the Bristol Royal Infirmary (BRI) and the Bristol Royal Hospital for Sick Children (BRHSC) (sometimes referred to in evidence as the Bristol Children's Hospital (BCH). The purpose of this chapter is to describe the evidence commenting on the effects of the split service and efforts to address its effects.

Location of relevant Bristol Hospitals during the period of the Inquiry's Terms of Reference



Bristol Royal Infirmary departmental relationships during the period of the Inquiry's Terms of Reference



View from Upper Maudlin Street (not to scale) **ICU:** Intensive Care Unit **HDU:** High Dependency Unit

2 Before, during, and since the period 1984–1995, Bristol has been served by a group of hospitals, including the BRI and the BRHSC. Prior to 1 April 1991 this group was the United Bristol Hospitals (UBH)[1] and, following Trust status, the United Bristol Healthcare (NHS) Trust (UBHT).[2]

3 For the purposes of the Inquiry, the term 'split service' refers to the fact that, throughout the period of the Terms of Reference, until October 1995, the paediatric cardiac surgery service was split between the BRHSC and the BRI. The cardiologists were based at the BRHSC, as was the performance of closed-heart surgery. Open-heart surgery was performed at the BRI.[3] The service was united in one building on 16 October 1995 when open-heart surgery was moved to the BRHSC. Until then, different facilities existed for children at the BRI and the BRHSC respectively. The Intensive Care Unit (ICU) at the BRI served both child and adult patients.

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[1] The Bristol Royal Infirmary, Bristol Royal Hospital for Sick Children, formerly the Bristol Royal Children's Hospital a.k.a. Bristol Children's Hospital, Bristol Eye Hospital, Bristol Maternity Hospital, Bristol General Hospital, University of Bristol Dental Hospital; between 1960 and 1974 they were joined by: Bristol Homeopathic Hospital and Farleigh Hospital (Mental Handicap)

[2] The Bristol Royal Infirmary, Bristol Royal Hospital for Sick Children, Bristol Eye Hospital, Bristol General Hospital, Dental Hospital, Barrow Hospital, Keynsham Hospital, St Michael's Hospital, Bristol Oncology Centre

[3] The Inquiry heard that as a result of the split service, children who received treatment on both sites would have two sets of medical records

4 This chapter sets out the evidence relating to the effects of the split site and the consequent split service, and efforts made to address them.

5 Differences in the nursing care at the two sites are described in Chapter 13 and Chapter 15 as are the effects of the split site and consequent split site service on the cardiologists.

6 The organisation of counselling and bereavement services over the two sites is described in Chapter 16.

Comments by those outside the Bristol service

7 Professor Peter Fleming, Head of the Division of Child Health, Department of Clinical Medicine, University of Bristol, was Chairman of the multidisciplinary working party on paediatric intensive care convened by the British Paediatric Association (BPA) which produced a report in 1993, *'Care of Critically Ill Children'*. The report, based on data for 1991 and a smaller data set for 1993, included information from the South West and specifically from the ICU at the BRI and the BRHSC. Returns were received from 80% of the hospitals in the UK. The report showed that 20.5% of children received intensive care in adult intensive care units and, of these children, 23% were under 1 year of age.

8 Professor Fleming in his written evidence to the Inquiry stated:

> 'Overall, the quality of care offered in the Paediatric Intensive Care Unit at the Bristol Children's Hospital was, and remains, of a very high standard.'[4]

9 Children were also cared for in the ICU at the BRI together with adults. Professor Fleming went on:

> 'It is, however, important to say that one of the major conclusions of the working party was that, in general, throughout the country, the quality of care in terms of availability of appropriately qualified staff, awareness of the special needs of children and physical organisation of the units to deal with children's special needs in adult intensive care units was deemed quite unsatisfactory. The working party concluded that it was inappropriate that children should be admitted to adult intensive care units and that, in general, intensive care for children should be provided and properly staffed and equipped with paediatric intensive care units.'[5]

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[4] WIT 0505 0002 Professor Fleming

[5] WIT 0505 0002 Professor Fleming

10 Dr Jane Ratcliffe, Honorary Secretary of the Paediatric Intensive Care Society (PICS), was asked by Counsel to the Inquiry how common it was in the 1980s and early 1990s for the cardiologists to be on one site and the surgeons on another:

> 'I cannot think of another unit where the cardiologist and cardiothoracic work were in a different site. I can think of several units, that there were separate cardiothoracic sites, but they were together, in effect, so I am not able to think of one.
>
> 'I find it very worrying, because you need somebody to consult very rapidly. I know that the geography of the Royal Infirmary and the Bristol Children's Hospital is not across town, but even so, I think I would find it very difficult in working practice to try and work and do justice to both sites.'[6]

11 Dr Susan Jones, President of the Association of Paediatric Anaesthetists of Great Britain and Northern Ireland (APA), discussed the Confidential Enquiry into Peri-Operative Deaths (CEPOD) report in the following exchange:

> 'Q. When it [the CEPOD report] concluded paediatric anaesthesia should not be undertaken by those who had only occasional experience in the field, what was the reaction of the APA, or, indeed professional anaesthetists, to that conclusion?
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> 'A. I think the APA certainly supported that conclusion. I think the majority of sensible anaesthetists supported that conclusion, and indeed, since that time, I think for a lot of anaesthetists, it has acted as a catalyst, the CEPOD report, and an awful lot of anaesthetists have flatly refused to anaesthetise small children and infants if they felt it was outside their competence. They have insisted the children are moved to a more appropriate centre.
>
> 'Q. CEPOD had recommended that you should not undertake paediatric anaesthesia if you only had occasional experience in the field. Are you able to help us, then, on the implementation of that recommendation, because it was not, I understand, an immediate event after CEPOD had reported?
>
> 'A. No, I think that they were recommendations; they were not totally enforceable. I think it just gave people, any sensible thinking people, a document to which they could refer and say, "I think we should move these children. I think we should plan to move these children. I do not think we should be doing these in our hospital any more".'[7]

12 Dr Jones continued in the following exchange:

> 'Certainly we would not recommend admitting children to an adult ward … I think surgeons, generally, and those treating children and adults do not want the children

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[6] T7 p. 162–3 Dr Ratcliffe

[7] T8 p. 13–14 Dr Jones

> moved to another site. That is a generalisation. Things are often historical. One starts with a unit that is basically an adult one, and then children have been taken on board, as it were, the whole thing is blown up, and it becomes very difficult to dismantle the mixed unit. You actually have to put the children into another hospital, or into another children's hospital. It is actually very expensive to move — setting up, the capital needs are high, the infrastructure, the actual staff costs of moving a unit and everybody looks twice at the costs these days.
>
> 'Q. When you say that a surgeon might get in the way of such a move, is that a comment on the organisation of hospitals to reflect surgical specialties, or is that a comment on personalities?
>
> 'A. A bit of both really. I think that when people do children and adults, the children often come out second best, I think. They are often smaller in number anyway.'[8]

13 Dr Jones told the Inquiry that it was fairly common in 1993 for children to be admitted to a part of an adult ICU ward. She went on:

> 'I think that it has been changing gradually, anyway, as big paediatric tertiary referral centres, mainly at children's hospitals, have actually expanded their intensive care unit and, indeed, provided retrieval teams so that they can actually go to a DGH [District General Hospital], or wherever, to actually pick up these children and transfer them back.'[9]

14 Sir Terence English, President of the Royal College of Surgeons of England (RCSE) from 1989 to 1992, commented in the following exchange:

> 'Q. … the split site that existed at Bristol was … an additional black mark … against Bristol continuing to be a designated centre … ?
>
> 'A. I think it may have been an inhibition to the proper development of the service, yes, and in that respect, may have been seen as an undesirable feature, but not necessarily a black mark.'[10]

15 Professor Gareth Crompton, Chief Medical Officer for Wales 1978–1989, told the Inquiry:

> 'I remember that this was a matter of considerable anxiety. It was clearly an arrangement, the split site; it was not conducive to best standards of patient care.'[11]

16 Professor David Baum, then President of the Royal College of Paediatrics and Child Health (RCPCH) and Professor of Child Health, University of Bristol, was asked about

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[8] T8 p. 25–6 Dr Jones

[9] T8 p. 28 Dr Jones

[10] T17 p. 109 Sir Terence English

[11] T21 p. 53 Professor Crompton

the approach of healthcare professionals in 1984 to nursing children on mixed adult and paediatric wards:

> ‘At that time, if one were looking at or were preparing a policy document, I have no doubt that the conclusion would have been very firmly, these should be separate entities. That would apply if one was talking about the mix from adolescence and adult, let alone younger children and babies, let alone if they were profoundly ill.
>
> ‘In the ten to 15 years since the time that you are addressing, we have progressed somewhat, but it has only been in the last two or three years that under the heading of paediatric intensive care services, as you know, the Government has come down on the side of not only having a policy, but actually implementing a policy, so that in all parts of the land we are still at the implementation phase, there should be a separate fully equipped, fully staffed paediatric intensive care unit. That has still not been totally achieved for the nation in May 1999.’[12]

17 Professor Baum went on:

> ‘I spent many of my formative years running to another hospital across a car park and through a tennis court with a sick baby in my arms to go from the delivery ward to the neonatal intensive care unit. It was becoming apparent that this was a bad arrangement. It took several years to have the budget and the will to rearrange that so that they were cheek by jowl. It was very difficult to get it right in the historical context.’[13]

18 Miss Sue Burr, Paediatric Nurse Advisor to the Royal College of Nurses (RCN), commented:

> ‘I do not have access to the staffing levels of paediatric intensive care. I would not have thought that that was uncommon, and in fact we do have situations, and you have the evidence, I am sure, in relation to the number of children who are nursed even now in adult intensive care units that I think one of the quite recent reports showed that there was a large number of these units which did not employ any registered children’s nurses at all. So I do not think that the situation at the BRI was that uncommon.’[14]

19 Asked by Counsel to the Inquiry about the process of transferring a patient from one site to another, Dr Duncan Macrae, Director of Paediatric Intensive Care at the Royal Brompton Hospital, London, told the Inquiry:

> ‘I think the process is the same, there needs to be just as much preparation to undertake a ten-minute transfer as there needs to be to transfer a child hundreds of miles. The preparation, the stabilisation, packaging, loading safely into the vehicle,

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[12] T18 p. 40–1 Professor Baum

[13] T18 p. 45 Professor Baum

[14] T34 p. 40 Miss Burr

> is exactly the same whether or not the distance is one hundred yards or one hundred miles.'[15]

20 Dr Macrae went on:

> 'The risks of long transfers are mainly down to inadequate preparation … These [inadequate oxygen supply or battery life] are avoidable factors, as is a child cooling down because it is not adequately protected from cold, by being wrapped up. As are things like secretions building up in the tracheal tube because there has been inadequate humidification. These are all things that in the present age transport teams are trained to address, but I think it is fair to say that across the country ten or more years ago, many of these issues received scant attention and I am certainly aware of transport over relatively short distances that was conducted very poorly because of those failures. But, as I say, there were very limited facilities for the specialist types of transfer that we can undertake today.'[16]

21 Mr Leslie Hamilton, consultant cardiac surgeon, also told the Inquiry about the transfer of patients in the following exchange:

> 'Q. This chimes with views given to us yesterday by Professor de Leval and Mr Stark, the children coming from Bergen in Norway to Great Ormond Street might often arrive in a much better condition than children coming up the road from Luton, simply because of the quality of care they had had during the transfer process.
>
> 'A. I think the experience in Perth in Australia at the moment, where they do not currently have a paediatric cardiac surgeon, they transfer patients 4,000 miles, something in that order, to Melbourne and they have no problems. I do not think distance is an issue.'[17]

22 Mr Hamilton commented on the effect of the split site and the split service on the communication within a care team such as the one at Bristol, where the cardiologists were on a different site from the surgeons:

> 'I think it is more philosophical than physical. I think communication is an attitude within a group, rather than being physically there to talk in person. I think if you have the environment that people get on and have the same long-term view and the same aims, then communication should not be a problem.'[18]

23 Mr Martin Elliott, consultant cardiothoracic surgeon, was invited to apply for the Chair of Cardiac Surgery at the University of Bristol in late 1991. He was approached initially by Mr Wisheart and then by Professor John Farndon. Mr Elliott stated in his

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[15] T51 p. 117–18 Dr Macrae

[16] T51 p. 118–19 Dr Macrae

[17] T51 p. 117 Mr Hamilton

[18] T51 p. 144 Mr Hamilton

written evidence to the Inquiry that he 'was interested in the opportunity and visited Bristol on a number of occasions to discuss the position and to review facilities, organisation and potential for change.'[19]

24 After 'much thought' Mr Elliott stated that he decided not to apply.[20] He wrote to Mr Wisheart on 3 January 1992 to inform him of his decision.[21] In response to Mr Wisheart's request Mr Elliott prepared a more detailed report of the reasons not to apply.[22]

25 Mr Elliott stated in his written evidence to the Inquiry:

> '… the arrangements then in place in Bristol for surgery for children with congenital heart defects were unsatisfactory, indeed I was of the opinion that it was inefficient and potentially dangerous.'[23]

26 Mr Elliott referred to the split service and went on:

> 'Perhaps the simplest way to explain why this arrangement was unsatisfactory is to consider an imaginary case managed under the two regimes, Bristol and the Ideal Unit. The imaginary patient I propose is a new-born baby admitted *in extremis* to the Bristol Children's Hospital with a provisional diagnosis of coarctation of the aorta. The child would need to be admitted to either a high dependency unit or a neonatal ICU and need urgent resuscitation by paediatrically trained staff. Ventilation might be required and an immediate examination by a paediatric cardiologist would be undertaken. An echocardiogram would be done and a treatment plan defined. If the diagnosis was indeed coarctation of the aorta then surgery could be undertaken in the Children's hospital on the next available list, (hopefully the next day although the logistics of this in Bristol might have made this difficult). If, however, the echocardiogram was to reveal a VSD and an interrupted aortic arch, then repair would require open-heart surgery. In Bristol the patient would have had to be transferred to the BRI, to the adult ICU in preparation for open-heart surgical repair. Contact with paediatricians would have been lost and the level of the support would have fallen. An urgent space would have had to be found on the operating list, almost certainly at the expense of adult patients, and the surgery undertaken.

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[19] WIT 0467 0003 Mr Elliott

[20] WIT 0467 0003 Mr Elliott

[21] JDW 0003 0102; letter from Mr Elliott to Mr Wisheart dated 3 January 1992

[22] WIT 0467 0011 – 0027; Mr Elliott's paper *'The Chair of Cardiac Surgery in Bristol'*

[23] WIT 0467 0003 Mr Elliott

> 'Post-operatively, our imaginary patient is likely to have been sick. Skilled treatment would be required. If we further imagine an acute deterioration a day or two later, the surgeons may have been operating at the BRI or the Children's, there was no paediatric intensivist, and ECHO would have to be done by the radiologists, and the cardiologists would be at the Children's or outlying clinics. The risks were obvious.
>
> 'In the Ideal Unit the change in diagnosis would have only limited impact. There would be no need for patient transfer, there would always be a list available to children and there would be no need to displace an adult patient (or more than one since these patients need prolonged ICU care). The consequences for the adult programme would also be considerable. …
>
> 'Thus, to me, the split site issue was one of the major reasons not to apply for the post. I thought it inefficient, archaic, inhibitory to progress and potentially dangerous.'[24]

27 Mr Elliott continued:

> 'Clearly all senior people at the BRI and Children's Hospital carry some responsibility for this issue. There was a conventional, if complex, matrix of responsibility in place at Bristol which should have been able to make appropriate changes. However, the very existence of the split site, the complexity of the management structure and the politics surrounding the, then, new Trust arrangements, inhibited change and obfuscated forward thinking.'[25]

28 He stated:

> '… it was clear to me that one of the people most wanting to make change was James Wisheart … Almost all the clinicians I met were in favour of transferring all paediatric heart surgery services to the Children's.'[26]

29 Mr Elliott had a meeting with Mr Peter Durie, Chairman of the UBHT, to discuss, amongst other things, his concerns about the split site. Mr Elliott stated that he found Mr Durie's suggestions as to how to deal with this issue 'totally unacceptable'.[27]

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[24] WIT 0467 0004 – 0005 Mr Elliott

[25] WIT 0467 0006 Mr Elliott

[26] WIT 0467 0006 Mr Elliott

[27] WIT 0467 0007 Mr Elliott

30 Mr Elliott stated:

> ‘Mr Durie outlined the structure of the new Trust organisation, and the financial arrangements. He stated that there was no way that resources could be made available to correct the split site issue in the short or medium term … I had said that there might be a possibility of getting new business (more patients) from neighbouring regions (Wales, the South West) if we were able to develop a high quality service, but that it would be impossible without the children’s services being centralised away from the BRI. I also pointed out that this would free up resources to increase throughput of, and potentially income derived from, adult practice.’[28]

31 Mr Elliott went on:

> ‘Mr Durie made it quite clear that in his view it would be up to me, as the new incumbent, to generate the income to pay for the changes required. I thought that this was not going to be possible. Making the changes was the only rational way to improve both service and income, and the only way to generate the basis for safe, modern neonatal cardiac surgery. I thought it was wrong to place the burden of income generation from clinical practice on the new Chairholder. The changes had to be made BEFORE any income could be generated.’[29]

32 Mr Durie was asked by Counsel to the Inquiry about the split site in the following exchange:

> ‘Q. One of the three reasons given … by Mr Elliott for not taking the job is the split site. How big an issue was the split site for you in 1991/92?
>
> ‘A. It was not a big issue for me because it was not unique. In Bristol quite a lot of the specialties for paediatrics were not happening in the Children’s Hospital. Just to name a few, within the UBHT there was ENT happening in a general hospital; ophthalmology happened in the Eye Hospital. Trauma in fact still happens in the BRI. So from our point of view, not everything being in one site was not surprising, and just in Bristol alone, you then had Southmead dealing with all the paediatric nephrology and Frenchay dealing with all paediatric neurosurgery and medicine, so it did not come to me as a very high worry or high priority.
>
> ‘Q. You say in your statement it has never been suggested that the split site was having an adverse effect on surgical outcomes, so far as you were aware.
>
> ‘A. That is correct.’[30]

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[28] WIT 0467 0007 Mr Elliott

[29] WIT 0467 0007 Mr Elliott (emphasis in original)

[30] T30 p. 69–70 Mr Durie

Comments by referring paediatricians

33 A number of referring paediatricians commented on the split service. Dr Perham, a consultant paediatrician at Derriford Hospital, Plymouth, wrote:

‘… my impression … is of a somewhat disjointed service which particularly seemed to be the result of problems related to a split site delivery.’[31]

34 Professor Obsorne, a consultant paediatrician at the Royal United Hospital, Bath, wrote:

> ‘I knew they were operating under difficult circumstances on a split site.’[32]

35 Dr Vulliamy, a consultant paediatrician at the Breconshire War Memorial Hospital, Powys, commented:

> ‘I had held the Paediatric Cardiac Surgical Services in Bristol in high regard though I was aware there had been limitations on the type of procedure that would be undertaken. The separation between the BCH and BRI seemed to present some practical difficulties.’[33]

36 The split site was a matter about which Dr Jordan had spoken to referring paediatricians. He expressed his concerns to them that:

> ‘… we still had not, right up to the time that I retired, got the cardiac surgery moved up the road. That is of particular importance to paediatricians because paediatricians are really very keen on the idea that children should be looked after in a paediatric environment.’[34]

Comments by nursing staff in the UBH/T

37 Fiona Thomas, Clinical Nurse Manager, stated in her written evidence to the Inquiry:

> ‘The set up [at the BRI] was that children and adults were nursed together in the same ward. The segregation of children was attempted to the best of the staff’s ability by using beds 1 and 2 to care for the children. This was not always possible due to the pressure on beds. … The staff level to manage the ITU was about 70 full-

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[31] REF 0001 0147 Dr Perham

[32] REF 0001 0021 Professor Osborne

[33] REF 0001 0095 Dr Vulliamy

[34] T79 p. 143 Dr Jordan

> time nurses, but with holidays, nights and days off, to a lay person it may seem that there was always new staff coming and going, but this was due to the very large number of staff employed on ward 5. The nursing staff do not work in a trial and error way, they do what is appropriate for the child at that time. A child's condition can change very quickly and care needs to be adapted accordingly.'[35]

38 Ms Pauline Chinnick, who has held various nursing posts at the BRHSC since 1983, stated in her written evidence to the Inquiry that as regards the mixed adult and child environment:

> '… it was recognised that the situation was difficult as it could upset adult patients and the parents of children on cardiac ICU. It also, in my opinion, diluted knowledge and skills and made nursing staff less able to build up expertise.'[36]

39 Ms Chinnick went on:

> 'Parents also became frustrated with the split site in that the cardiac surgeons were not so readily available on the ward at BRHSC. Parents could make comparisons with surgeons of other specialties on the ward, who appeared more available.'

However, she also noted:

> 'The cardiac surgeons would visit BRHSC even if it was very late. For example, on occasions, they came after midnight.'[37]

40 Mr Graham Brant was a staff nurse on Ward 5B from March 1991 until he was promoted to senior staff nurse later that year and then to charge nurse in May 1993. He stated in his written evidence to the Inquiry that children on Ward 5 in the BRI, 'missed out on some of the facilities of the Children's Hospital, e.g. child sized tables and chairs, paintings on the wall …'.[38]

41 Mr Brant stated that:

> 'Most of the nurses at the BRI were not RSCNs [Registered Sick Children's Nurses], but they had paediatric nursing experience.'[39]

42 He described the wards at the BRHSC as 'very cramped'.[40] He stated that there was more space in the ICU at the BRI, such that children were separated from the adults as much as possible. Mr Brant expressed the view that the nursing care of the paediatric patients at the BRI was of the highest order and 'at times the care may have been better for paediatrics than the adults as the senior nurses had looked after the children while

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[35] WIT 0172 0006 Fiona Thomas
[36] WIT 0532 0041 Ms Chinnick
[37] WIT 0532 0041 Ms Chinnick
[38] WIT 0513 0013 Mr Brant
[39] WIT 0513 0013 Mr Brant
[40] WIT 0513 0013 Mr Brant

the adults tended to be looked after by the junior staff'.[41] He stated that from a nursing point of view, communication and collaboration between the two centres (the BRI and the BRHSC) was very good. He stated that he did not think that there was a problem between doctors on either site. He concluded:

> '… with hindsight it is easier to say that it is better for the patient for all cardiac surgery to have been performed at the BRHSC, but as it was not we did the best we could and I did not think that the care was at all compromised.'[42]

43 Ms Joyce Woodcraft, an RSCN and RGN who worked at the BRHSC from 1977 to April 1994, told the Inquiry that, although there were difficulties in the surgeons integrating their ward rounds at the BRHSC with their work at the BRI, it was something they were able to achieve.[43] She was asked by Counsel to the Inquiry about the transfer of patients from the BRI to the BRHSC in the following exchange:

> 'Q. And how well did communication between the two sites work, to manage a transfer, in your experience?
>
> 'A. The staff at the BRI would phone us and inform us, as I say, of drips and drains and particular drugs that the child was on before they were transferred up.
>
> 'Occasionally we would get — they would forget to phone us to say that the child was actually on the way, and that could cause a problem if we were in the middle of an acute situation. If they phoned we might have said "can you hang on for half an hour or an hour" or something. That was not a frequent occurrence.
>
> 'It did happen occasionally, but not — I would not have said it was a routine, that they all came up without being announced, not in my experience.
>
> 'Q. Again, "occasionally" can mean once a year, twice a year, once a month?
>
> 'A. I would not like to say.
>
> 'Q. Something that you can remember occurring, but not with great frequency?
>
> 'A. Yes, but not as a big deal, really.'[44]

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[41] WIT 0513 0013 Mr Brant
[42] WIT 0513 0014 Mr Brant
[43] T57 p. 34–5 Ms Woodcraft
[44] T57 p. 37–8 Ms Woodcraft

Comments by those providing support and counselling

44 The Reverend Leonard Burn, a retired Hospital Chaplain to the Central Bristol Hospitals from 1981 to 1983, stated in his written evidence to the Inquiry that the split site ‘was inconvenient, but not a problem’.[45]

45 Father Bernard Charles, a part-time Hospital Chaplain at the BRI and the BRHSC from 1991 to 1996, stated in his written evidence to the Inquiry:

> ‘It seemed to me that the needs of children receiving cardiac care were different from those of adults and that it was unfortunate that both were cared for, post operatively, on the same ward [at the BRI]. I obtained the impression that conditions were a little cramped, making it difficult for parents to be at the bedside of sick children for long periods, and that facilities for parents to rest and relax, and be accommodated, were lacking.’[46]

46 Canon Charmion Mann (Assistant Chaplain and then Chaplain at the BRHSC from 1988 to 1994) stated in her written evidence to the Inquiry:

> ‘I felt it was probably disconcerting for parents to have two groups of carers [at the BRHSC and the BRI] looking after their child. There was necessarily a break in the continuity of care. We (the staff) within the BCH were aware that the BRI was not staffed as a children’s hospital and felt that it was a shame that the site was split.’[47]

47 The Reverend Robert Yeomans (Spiritual Adviser to the UBHT from 1993) stated:

> ‘I felt having children and adults together was particularly beneficial. It created a family environment and for many people it seemed to accelerate the healing process … For many adults it put their illness into context, and they loved watching the children play…’[48]

48 The Reverend Helena Cermakova (Chaplain at the BRHSC and St Michael’s from 1995) stated that she ‘did not sense during this time (early 1995, when I joined the BRHSC) that the split site caused any difficulties’.[49]

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[45] WIT 0284 0010 The Reverend Burn

[46] WIT 0277 0009 Father Charles

[47] WIT 0273 0006 Canon Mann

[48] WIT 0274 0013 The Reverend Yeomans

[49] WIT 0272 0006 The Reverend Cermakova

49 Mr Rhett Dunford, a social worker at the BRHSC from 1990 to 1994 before moving to the BRI, contrasted facilities at the two sites:

> 'At the Children's Hospital parents had accommodation and support of other families. It was a child centred environment. This was not available for them at the Bristol Royal Infirmary. It was difficult for parents if children were admitted straight to the Bristol Royal Infirmary as they appeared to miss out on some of the pre-operative preparation.'[50]

50 Miss Helen Stratton, Cardiac Liaison Nurse at the BRI from 1990 to 1994, told the Inquiry:

> 'Helen Vegoda felt quite strongly that it was her role to look after the parents at the Children's Hospital and my role was at the Bristol Royal Infirmary.'[51]

51 Miss Stratton said that she wished her role to be more integrated between the two sites:

> 'I was also aware that there was this cavern between the nurses at the BRI and the nurses at the Children's Hospital and I wanted in some small way to see how that could be improved, whether that was through communication, whether that was through going to the Children's Hospital and speaking with people informally and setting up the Paediatric Cardiac Nurses' Association which I did whilst I was there as well.'[52]

52 Miss Stratton told the Inquiry that this 'cavern' related essentially to the two groups of patients:

> 'I know a lot of the nurses at the Children's Hospital felt quite strongly because they were trained paediatric nurses that the children should not be having surgery on an adult unit. Their views were obviously shared amongst a number of people.'[53]

53 She went on:

> 'I think the split site meant that there was a communication problem. I mean, not between Helen Vegoda and I, in as much as we met on a regular basis, but I think with the nursing staff just because they were not both in the same hospital there were inevitably communication problems. I am not aware of any particular instance where I thought, "Gosh, you know if people had communicated that or the children had been nursed in the Children's Hospital all the time that would not

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[50] WIT 0384 0006 Mr Dunford

[51] T46 p. 46 Miss Stratton

[52] T46 p. 96–7 Miss Stratton

[53] T46 p. 97–8 Miss Stratton

> have happened". I cannot specify instances, although I am sure people will be able to do that, but I cannot.'[54]

54 Mrs Jean Pratten, founder of the Bristol and South West Children's Heart Circle, told the Inquiry:

> '… there were two separate managements, as I mentioned earlier, of each hospital so the whole of the cardiac services for children were not integrated in one unit; there were two completely different sections.'[55]

55 Mrs Vegoda told the Inquiry that before Miss Stratton took up her post:

> '… one of the difficulties of the split site and the fact that I was going down to ward 5 was that I did not really get to know the nurses well. We did not sit together and have time to discuss the role. I went down there to see families and sort of came out again. That was not my base. So I do not think I necessarily developed a close rapport with the nursing staff, but that was the main reason, and also the fact that there was a lot of nursing staff and … they were continually changing.'[56]

56 Mrs Vegoda went on:

> '… it would have been very helpful right at the beginning had there been somebody covering Ward 5. I think the split site was very difficult.'[57]

57 As regards the effect of the split site on parents, Mrs Vegoda told the Inquiry:

> 'I think the split site was really quite difficult for parents to cope with, for a number of reasons. Primarily that they had got used to the Children's Hospital and they then went to a strange building, a strange hospital and one that was not dedicated to children. So it was not ideal …
>
> '… I do remember parents commenting on the fact and being, I think, aware that this was not a paediatric environment. For example, I think some parents commented on the fact that the nursing staff were not particularly aware of feeding difficulties of, say, young children post-operatively. I cannot remember anything specific at the moment, but just a general awareness that this is not a paediatric setting.
>
> 'What particularly was commented on, and for some parents it was very stressful, was the first time they were shown around Intensive Care in Ward 5. They found that extremely difficult because it was a mixed unit with adults in it.'[58]

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[54] T46 p. 164–5 Miss Stratton
[55] T47 p. 26 Mrs Pratten
[56] T47 p. 138 Mrs Vegoda
[57] T47 p. 139 Mrs Vegoda
[58] T47 p. 164–5 Mrs Vegoda

58 Mrs Pratten in her written evidence to the Inquiry stated:

> 'The split site proved extremely hard for parents to cope with. For many years the catheter lab was in the BRI and parents of children in the BRHSC were left anxiously waiting for their child's return at the whim of the ambulance service. It was always very hard for parents to have to face their child's open heart surgery in an unfamiliar hospital, with an age range of patients from 0–80.'[59]

Comments by parents/patients

59 Many parents commented on their experience of the split site and service.

60 Penelope Plackett, mother of Sophie who underwent surgery in 1988, stated in her written evidence to the Inquiry:

> **'Transfer to the BCH:**
>
> 'When I returned to the BRI, I was told Sophie was being moved to Bristol Children's Hospital. I was very unhappy about this. At the cardiac catheterisation and biopsy at the Children's Hospital, the staff on the baby unit were uncaring. They seemed to spend their days drinking tea and chatting to one another, emerging every four hours to feed the babies. The transfer to the Children's Hospital went ahead. I only saw the nurses when they came with Sophie's drugs, and her care was left entirely to me. She was being bottle fed but I could not get her to suck or swallow. I asked for help with her feeding over and over again, but nobody came to my assistance.[60]
>
> **'Problems at the BCH:**
>
> 'Mr Dhasmana persuaded me, much against my will, that I needed a break and should go home to Exeter for the weekend. I did so, although I did not feel that I could trust the staff to give Sophie proper care and attention. When I returned to Bristol, she had an appalling case of nappy rash with noticeable burns on her skin. She had obviously been left in a soiled nappy for a long time. I hated every second of the time Sophie and I spent at the Children's Hospital. I hated the nurses and whole place. It was a nightmarish blur.'[61]

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[59] WIT 0269 0010 – 0011 Mrs Pratten

[60] WIT 0012 0010 Penelope Plackett

[61] WIT 0012 0011 Penelope Plackett

61 Janet Baker, mother of James who also underwent surgery at Bristol in 1988:

> '… thought the BRI was brilliant. It was bright and jolly and there were nice toys around and the staff seemed very nice. The contrast with my experience of the Bristol Children's Hospital could not have been more extreme.'[62]

62 Another parent, in their written evidence to the Inquiry, described Ward 5 in 1991 as:

> '… an adult ward, but the children who were there were together at one end, although that meant they were some way away from the nurses' station. It seemed a gloomier place than the Children's Hospital …'[63]

63 Christine Ellis, mother of Richard, expressed concern that in 1991:

> 'There did not seem to be the same pastoral care in the BRI as there was in the Children's Hospital …'[64]

64 John McLorinan, father of Joseph, told the Inquiry of his view of the general environment as between the BRHSC and the BRI in 1991:

> 'I suppose in the children's ward one feels very much supported and cushioned and cradled, and in the BRI, where they have the heart cases, one was more aware that people might die more often and things like that. It was not really geared for children and families. It was a bit frightening and worrying like that, and obviously the practical care of Joe was more difficult for the staff, but I think the staff made every effort to overcome that.'[65]

65 Alison Thomas, mother of Dafydd, in her written evidence to the Inquiry, stated that in 1992:

> 'I found the experience of having to travel with Dafydd from the Children's Hospital to the BRI on the morning of surgery highly traumatic. Dafydd and I were being transferred from everything we knew and felt secure within the Children's Hospital to an unknown destination in terms of experience. All I knew was that I had seen the IT Unit the day before and didn't like it. The nurses at the Children's Hospital had been friendly and caring … we did not know the nursing team that would receive Dafydd. It gave rise to a great sense of insecurity. I could have done without that at that very stressful and important time in my life and that of Hugh my husband and of Dafydd. We were also saying goodbye to Helen Vegoda who had

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[62] WIT 0018 0003 Janet Baker

[63] WIT 0135 0006; this parent was one of a number of parents who gave a witness statement to the Inquiry and gave only partial consent to publication of the statement, as they did not wish to be publicly identified

[64] WIT 0023 0011 Christine Ellis

[65] T2 p. 173 John McLorinan

> been a great support during the period leading up to the operation and also all the other parents who had been friendly with us.
>
> 'I remember being very pleased when Dafydd was able to be released from the IT Unit back to the Children's Hospital. On return to the Children's Hospital, although it seemed antiquated compared to the high-tech of the IT ward, nonetheless one was back in the caring child orientated environment. That is not to say that Dafydd did not receive care and attention in the IT unit or that the nursing team could have been any more caring than they were with myself, Hugh and Dafydd.'[66]

66 Alison Thomas told the Inquiry:

> 'Being up at the Children's Hospital, surely it would make more sense for children to be treated at the hospital that they were admitted to, rather than being shipped, having had a pre-med even, by ambulance on the morning of an operation down to another hospital. In fact, Dafydd took rota virus down there with him and it could have closed the whole unit down, I believe. Certainly, in my opinion, it was an awful lot less than perfect.' [67]

67 Another parent described his concern about the facilities at the BRI in 1993 in his written evidence to the Inquiry:

> 'As part of the pre-operation procedure we were shown round ward 5 at the BRI, including the part of the ward where the patients would be kept in intensive care following the operation. Our general impression was that it was somewhat less satisfactory than in comparison to the Children's Hospital where we had been very happy with the atmosphere and the facilities.'[68]

68 Alison Lyne, mother of Charlotte, stated that in 1993 when she was at the BRI after the BRHSC: 'I felt like I had been abandoned'.[69]

69 In 1994, when Helen Sadler's son, Edward, was moved from the BRI to the BRHSC she stated that: 'We were told that he might benefit from the change to more congenial surroundings'.[70]

70 Helen Johnson, mother of Jessica, told the Inquiry that the ICU at the BRI in 1995 was 'limbo land, because there were adults in there as well as children and the adults were totally, you know, unconscious …'.[71]

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[66] WIT 0029 0010 Alison Thomas

[67] T5 p. 103 Alison Thomas

[68] WIT 0134 0005 – 0006; this parent was one of a number of parents who gave a witness statement to the Inquiry and gave only partial consent to publication of the statement, as they did not wish to be publicly identified

[69] WIT 0408 0004 Alison Lyne

[70] WIT 0287 0013 Helen Sadler

[71] T44 p. 144 Helen Johnson

71 Commenting on the mixed adult–child environment, in her written evidence to the Inquiry, Brenda Rex, mother of Steven, described Ward 5 as it was in 1986:

> ‘We walked over to the BRI and were shown round the ward by a sister. We were horrified to find both children and adults were placed on the same ward. I was told that work was underway to establish a nursery ward for babies and younger children.’[72]

72 Sandra Suckling, mother of Jason, stated that in 1988:

> ‘Ward 5 had adults in it with the adults being at one end and children at the other. I felt that this was in some ways quite nice and I remember there was an old man in his seventies on the cardiac unit. He used to watch the children playing. He told me that he was very worried about having his own surgery and he said watching the children gave him the strength to go ahead with his pending heart surgery.’[73]

73 Another parent stated that in 1992:

> ‘The nurses at the BCH were better at treating children than those at the BRI. There was more of a sense of personal responsibility there. At the BRI the nurses were dealing with adult patients and children at the same time. There seemed to be a higher ratio of nurses to patients at the BCH. At the BRI it often felt as though the children were being left unattended. Also the doctors at the BCH were better at dealing with children.’[74]

74 Philip Wagstaff, father of Amy, told the Inquiry that in 1993:

> ‘… the impression of the ITU was that I was surprised that it was a mixed adult and children’s unit as such. When we saw it the night before, I believe there was only one or two children in there, and the rest of the beds were adults who had undergone heart surgery. And obviously the adults were very poorly, and we found it distressing seeing all the other patients in there. It just struck us as unusual that they were all mixed in at that stage.’[75]

75 Alison Lyne stated that in April 1993:

> ‘One of the nurses showed me around the Intensive Care Unit, it was full of adults and I found it very sterile and depressing. It would have been nice to have seen some concession made towards the babies and children such as pictures and mobiles. I felt that I was invading the adults’ privacy.’[76]

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[72] WIT 0219 0010 Brenda Rex

[73] WIT 0536 0008 Sandra Suckling

[74] WIT 0423 0008; this parent was one of a number of parents who gave a witness statement to the Inquiry and gave only limited consent to the publication of the statement, as they did not wish to be publicly identified

[75] T2 p. 29 Philip Wagstaff

[76] WIT 0408 0005 Alison Lyne

76 In her written evidence to the Inquiry Debra Hill, mother of Thomas, stated that in April 1995:

> ‘Thomas was surrounded by croaky old men and ladies on their last legs, even in Intensive Care’.[77]

Staffing levels

77 Christine Ellis, mother of Richard, commented on staffing levels in 1991 in her written evidence to the Inquiry:

> ‘After his period in the ITU Richard was transferred back to the ward in the BRI that he had first been admitted to for a period of time. The staff in that ward suggested that he was better to be transferred back to the Children’s Hospital because they did not have the ability to give the one to one attention and the particular attention to an infant that was required and accordingly Richard was transferred by ambulance back to the Children’s Hospital …’[78]

78 Deborah Gillard, mother of Christy, stated of her experience in 1989:

> ‘The standard of care on the general ward had struck [us] as lower than it might be; babies were often left to cry for long periods of time, and the staff included many bank nurses, who did not seem as attentive as the regular staff.’[79]

79 Andrew Hall, father of Laurence, referring to 1994, stated:

> ‘It did not appear that set teams were allocated to each individual patient and there was always a lot of new faces around; in particular, a lot of temporary agency staff working on the ITU.’[80]

80 Michelle Cummings, mother of Charlotte, told the Inquiry of her experience in 1987 in the following exchange:

> ‘Q. And you say in your statement that there were no specially trained nurses around?
>
> ‘A. I meant ITU nurses. There were no intensive care nurses.
>
> ‘Q. Obviously there were no children’s nurses?
>
> ‘A. Yes, but I meant she was not having intensive care nurses looking after her, which, you know, I mean, the attention that these children get when they are in ITU. There was also the other issue over the risk of infection on a general surgical

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[77] WIT 0381 0006 Debra Hill

[78] WIT 0023 0011 – 0012 Christine Ellis

[79] WIT 0161 0004 Deborah Gillard

[80] WIT 0172 0003 Andrew Hall

> ward, so close, which again, could not be addressed because of the circumstances.'[81]

81 Belinda House, mother of Ryan, told the Inquiry of her experience in 1990: '… most of the nurses were more relaxed nursing the adults'.[82]

82 In oral evidence Linda Burton, mother of David, told the Inquiry of her experience of the ICU at the BRI in 1991:

> 'Staff never sat down, they were constantly on the move, testing and reading and administering drugs, very caring, very attentive.'[83]

83 Nursing and staffing levels in the ICU are dealt with later in Chapter 15.

Transfer back from the BRI to the BRHSC

84 Susan Jenkins, mother of Nathan, stated that, in 1984, she:

> '… was approached by the nursing staff, and they asked did I mind Nathan being transferred back to the Children's Hospital because he was taking up a bed that someone else could have'.[84]

85 Robert Briggs referred in his written evidence to the Inquiry to the rapid rise in heart rate and temperature of his daughter, Laura, following transfer back to the BRHSC in 1988:

> 'We were told at the time that this incident may have arisen because of the transfer from one site to the other, and particularly in retrospect we feel that it was somewhat undesirable that she should have been moved so soon after her operation. At the time we did not question it because we were firstly worried for Laura and then relieved that it had all been sorted. We do not understand why it should have been necessary to move her quite so soon and it seems to us that it created a risk that preferably should have been avoided.'[85]

86 Bernadette Powell described how, in 1991, her daughter, Jessica, was moved back to the BRHSC by ambulance:

> 'Between the time I left the hospital and the time of my mother's arrival (about 11am), Jessica was moved to the Bristol Children's Hospital by ambulance. I could not believe that this had been done without either our knowledge or our presence.

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[81] T3 p. 155 Michelle Cummings

[82] T6 p. 93–4 Belinda House

[83] T5 p. 30 Linda Burton

[84] WIT 0252 0014 – 0015 Susan Jenkins

[85] WIT 0136 0006 Robert Briggs

> I had been in the hospital minutes before, and someone could have told me she would be moved. I was very upset, and was back in Bristol by lunchtime.'[86]

87 Michelle Cummings told the Inquiry of the transfer of her daughter, Charlotte, from the BRI to the BRHSC in 1987:

> 'She was moved by ambulance to the Children's Hospital, straight through casualty, and up to the Intensive Care and they did not even know we were coming. There was no intensive bed for her, no life support machine, and they were still hand ventilating her, so we went through to the baby unit and they were full up. There was no cot for her in there, because they were hoping they could have set up a mini intensive care in one of the rooms for her.'[87]

Comments by the UBHT

88 The UBHT in its written evidence to the Inquiry commented on the split site and service:

> 'Since the publication of the report on the Welfare of Children in Hospitals in the late 1960s/early 1970s it has been the policy within the National Health Service that children should be nursed separately from adults, wherever possible, in dedicated children's units and nursed by Registered Sick Children's Nurses. The policy of UBHT in the 1980s to move children's cardiac surgery to the Bristol Royal Hospital for Sick Children was in accordance with this policy, but in practice it was thwarted by lack of capital funding.
>
> 'It should be noted that it is often not possible in District General Hospitals to provide separate intensive care facilities for children, although in major specialist paediatric centres such as the Bristol Royal Hospital for Sick Children, there are separate specialist paediatric intensive care units.
>
> 'As the statements of the witnesses confirm, patients and parents were shown the intensive care unit and the extensive monitoring equipment which would be attached to the patient post operatively. Assurances were given that staff were sensitive to modesty. Curtain tracks were around patients to enable procedures to be undertaken with as much privacy as possible. Patients were only accommodated in the mixed sex, adult/children's intensive care unit for the minimum period possible, following which children were transferred to a separate children's side ward.'[88]

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[86] WIT 0240 0007 Bernadette Powell

[87] T3 p. 149–50 Michelle Cummings

[88] WIT 0030 0013 UBHT

89 Fiona Thomas, Clinical Nurse Manager, stated:

> 'The Bristol Royal Infirmary is adult focused compared to the Bristol Royal Hospital for Sick Children. … The nursery on Ward 5 cared for both pre and post operative children. This would have been no different to the equivalent ward in the Bristol Royal Hospital for Sick Children.'[89]

Comments by clinicians in Bristol

90 Mr Wisheart told the Inquiry that the problem of the split site was known in 1984, but that it took until October 1995 to resolve.[90]

91 He explained in his written evidence to the Inquiry:

> 'Although the need for this development had been recognised as a theoretical proposition for a very long time there were at least two reasons why it did not become a practical one until after the late 80s. The first was that before 1987 there were no catheter facilities within the Children's Hospital, so the children had to be transferred to the BRI for diagnosis, and back again to the BRHSC. The second was that at the time the whole cardiac surgical enterprise was so small that to divide it into two would have weakened it seriously, even if it had been actually possible from the financial and personnel standpoint.'[91]

92 Mr Wisheart went on:

> '… it is wrong to describe the operating theatre and intensive care unit as *adult* facilities into which children were placed. It is correct to say that they were facilities which were created *both for children and adults.*'[92]

93 Mr Wisheart was asked by Counsel to the Inquiry about the concerns expressed by parents about transport between the BRI and the BRHSC:

> 'I think the shape of the problem is little different for catheterisation of children and open heart surgery, and I think that they are really talking of the problems associated with the transport of very sick children backwards and forwards on the same day before and after the investigation.
>
> 'The issue of transport occurred or persisted, if you like, with a relatively small number of children who needed to be transferred for urgent surgery to the

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[89] WIT 0151 0012 Fiona Thomas

[90] T40 p. 130 Mr Wisheart

[91] WIT 0120 0051 Mr Wisheart

[92] WIT 0120 0094 Mr Wisheart (Mr Wisheart's emphasis)

> Infirmary, but of course the other problems were that the children were being cared for at a site which was some distance from the Children's Hospital.'[93]

94 Mr Wisheart indicated that there were organisational problems arising from the split site: the difficulty in recruiting and retaining paediatric nurses; the failure to attract Mr Martin Elliott to the Chair of Surgery; and the rejection by the Joint Committee on Higher Medical Training Visitor, Dr Elliott Shinebourne, in 1992, of the proposal to create a Senior Registrar post in paediatric cardiology at the BRHSC.

95 Asked by Counsel to the Inquiry whether the decision to move the paediatric surgical workload to the BRHSC was eventually taken so as to increase further the number of adult patients who could be treated at the BRI, Mr Wisheart replied: 'I would not put it that way'.[94]

96 The issue was explored in the following exchange:

> 'A. It is absolutely right to say the increase in adult work was the occasion or opportunity which permitted the children's work to be moved, but there was a clear and independent motivation and desire to do that.
>
> 'Q. Would you go this far: that it was the proposed expansion in adult surgery which was the impetus for the move to the Children's Hospital?
>
> 'A. I think I would still stick to "occasion".'[95]

97 Mr Wisheart was asked about the funding application made by Dr Joffe in June 1992 to help resolve the split site issue. He was asked if he played a part in the formulation of the application:

> 'I think I asked him to do that — or we agreed that he should do it, would be better, I am sorry.'[96]

98 He went on, in the following exchange:

> 'A. I think it would be fair to say that the technical details of funding are something that clinicians have a vague awareness of but it is not their prime interest. So that for funding opportunities or potential, I mean, we would be looking for advice to the financial experts within the Trust or at Region, or whoever.
>
> 'The question that I have asked myself, on seeing this, is, when we prepared our proposals in 1990, why did we not knock on this door then? In a sense, all I can say is that the proposals were prepared and they went to all the appropriate authorities

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[93] T40 p. 128–9 Mr Wisheart
[94] T40 p. 120 Mr Wisheart
[95] T40 p. 125 Mr Wisheart
[96] T41 p. 147 Mr Wisheart

> at District as it then was and Region, and nobody prompted us to think that this was an avenue to go down.
>
> 'Q. So the plain truth is that, notwithstanding experience of having made an application for capital funding earlier, and having had to live daily with the effect of lack of resources generally, no-one actually thought of it?
>
> 'A. I think Mr Nix [the then Assistant Treasurer/Financial Manager (Acute) of B&WDHA] has said somewhere that he and his colleagues at Region nearly privately created the application in 1987, and I think our awareness of it was really very limited. It was merely a financial device operated by the financial people, and it did not work, but there we are.'[97]

99 Dr Joffe told the Inquiry that he did not attempt to obtain funding under the Supra Regional Service (SRS) system to deal with the split service[98] before 1992, as he was not aware 'of the opportunity to request capital sums from the Supra Regional Services Group until 1992/93'.[99]

100 Mr Wisheart told the Inquiry that the appointment of a specialist paediatric cardiac surgeon and the resolution of the split site issue were both proposed and decided upon before the allegations in respect of paediatric cardiac surgery became public. He went on:

> 'This was the unit making what it thought was best plans for the future, at that time, with the assistance of the Trust, of course, as a whole.'[100]

101 Mr Dhasmana stated in his written evidence to the Inquiry that he was involved in 1988 in discussions with Dr Pitman, consultant in public health medicine at SWRHA, regarding a cardiac services strategy for the Region. He stated that he indicated his agreement to the transfer of the children's services to the BRHSC:

> 'I believe that it would be a step in the right direction if we did aim to achieve this goal as children would then be looked after in one place for all their cardiac problems. … I personally would support the move to split children's services from here and hope that the staffing level would be raised in a few years' time.'[101]

102 He told the Inquiry:

> 'The problem with the BRI, because it is a place in the hospital where it is mainly an adult service, so whenever we wanted to recruit a paediatric trained nurse in the cardiac surgery, we were not very successful because nurses who were trained in

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[97] T41 p. 148–9 Mr Wisheart

[98] JDW 0003 0142 – 0144 Dr Joffe

[99] T90 p. 34 Dr Joffe

[100] T92 p. 2 Mr Wisheart

[101] UBHT 0163 0003; letter from Mr Dhasmana to Dr Pitman dated 12 September 1988

> children's care, they are in high demand everywhere and there is a shortage in almost all hospitals so obviously they get absorbed there quickly.'[102]

103 Dr Jordan, referring to the visit in 1991 by Dr Elliott Shinebourne which resulted in a decision not to approve the appointment of a Senior Registrar, told the Inquiry:

> 'My recollection is that they had no problems with the investigational side but they did not like the fact that there was no open-heart surgery on the same site.'[103]

104 Dr Jordan's views are indirectly referred to by a draft report[104] of March 1984, which urged that the transportation of critically ill infants should be avoided.

105 Dr Martin told the Inquiry that transfer from the BRHSC to the BRI 'might be a factor that could potentially increase the risk of surgery in some of these patients and that was of concern'.[105]

106 Dr Martin's evidence included this exchange:

> 'Q. You have already said that in the course of transfer a couple of children were less stable than you would have wished. No doubt that is a reflection of the fact that there is a split site?
>
> 'A. … This is also obviously talking about parents' experience and patients' experience rather than necessarily talking about clinical care. So as I understand it that is referring to the overall environment and change of environment.'[106]

107 Dr Martin went on:

> 'With regard to patients having open-heart surgery, with our busy commitments at the Children's Hospital it was often very difficult for me to get to the Royal Infirmary on an absolutely regular and fixed basis. Not everyone may know the geography of the area, they are separated by about a five minute walk downhill but it is a very steep hill coming back so it does involve some effort, if you like, going up and down, it does involve some time going up and down … but your commitments at the Children's Hospital often made it very difficult to get down there at set times … That made it very difficult to be actively involved in the day-to-day management of these patients, or minute-to-minute management of those patients.'[107]

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[102] T86 p. 18–19 Mr Dhasmana

[103] T79 p. 159 Dr Jordan

[104] UBHT 0295 0240; draft report dated March 1984

[105] T77 p. 13 Dr Martin

[106] T77 p. 27 Dr Martin

[107] T77 p. 33–4 Dr Martin

108 Dr Martin then explained the interaction with the surgical team in the following exchange:

> 'A. … I personally found it difficult to get actively involved in the care of the patients down there [at the BRI]. Patients were under the care of surgeons, the surgical team were looking after the patients in conjunction with the anaesthetic team. It was very difficult to arrange a time when you could be there when other people were there to discuss the individual case, so usually when I went down I would find there was no one else actually physically there that I could talk to about the case and —
>
> 'Q. The communication between yourself and the surgeon would necessarily have particular difficulties because of that?
>
> 'A. It would be difficult, yes. There would be occasions when surgeons or anaesthetists might specifically ask for an opinion about this or that and of course we would give that opinion and there would be some discussion. But just in the day-to-day management it was very difficult to get very actively involved.
>
> 'That was not due to not wanting to, it was very difficult. You felt a little bit of an outsider when you went down there to visit patients; that was not my primary base; you felt as though people did not know you quite as well. You were not primarily directing their care so any advice you might give, whilst I am sure people would say it would be listened to, it may not have been acted upon.'[108]

109 Dr Martin stated:

> '… we thought that by perhaps incorporating a unified site it was more likely we would be able to improve the care of the younger children, particularly neonates and infants, because on the site based at the Children's Hospital we would have had a full range of paediatrics specialists, a greater input from paediatric nurses and we felt that might impact particularly in the younger age group. We did not know for sure but that was an impression we had.'[109]

110 Dr Burton, a consultant anaesthetist, who had worked at the UBH/T from 1959 to 1991, stated in his written evidence to the Inquiry:

> 'There were several disadvantages of working in a split site. Probably the most significant disadvantage was the problems caused by the simultaneous arising of difficult situations in both places. It was, of course, impossible to solve these problems personally and one had to rely on telephone contact with the other hospital. When dealing with the children, the disadvantages of not working in a paediatric teaching hospital were very obvious.'

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[108] T77 p. 35–6 Dr Martin

[109] T77 p. 17 Dr Martin

He also notes in his statement the problems of lack of medical cover.[110]

111 Dr Joffe told the Inquiry:

> ‘One of the factors that we struggled with throughout this period was the split site and the question of whether that was a factor in producing worse results than there should have been and while it was very difficult to identify specific issues, I think there was an overall feeling that if the unit was centralised and under one roof … and if the staffing was at its optimum levels, that we might be able to get or we should get better results. But that was the situation that there was at the time and although the request or the recommendation was made for unification of paediatric cardiac surgery from as far back as 1981, certainly when I arrived after 1980, there was no progress at that stage for a variety of reasons. Probably the major one being the fact that the unit at the BRI was needing to increase its adult throughput …’[111]

112 Dr Joffe also told the Inquiry:

> ‘I forgot to mention in terms of the question about the availability of paediatric cardiologists at the BRI that Dr Jordan specifically made a point of going to the BRI every day and often twice a day, so it was not as if there was no presence whatsoever at the BRI. He found it slightly easier than I could because earlier on he was still involved in adult cardiology, had an office at the BRI, and needed to be there anyway, and indeed, he and later Dr Martin were running an outpatient clinic for adolescents and adults who had grown from the childhood period, usually post surgery, at the BRI. Therefore, they had some time when they had to go. So, apart from the weekends, I would say that on a daily basis there was at least one call by a paediatric cardiologist who would look at all the patients, not only his or her own, but all paediatric cardiac cases, and make recommendations about management, if necessary.’[112]

113 Dr Joffe added, in the following exchange:

> ‘Q. To what extent was it the physical separation of the two buildings, one being up the hill, one down the hill, that made it difficult for you? You mentioned that Dr Jordan had an office down at the BRI which meant that he did go to the BRI?
>
> ‘A. Yes, for a time. That stopped in the late 1980s, I think.
>
> ‘Q. You did not have such an office?
>
> ‘A. Well, I did initially, when we first started —

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[110] WIT 0555 0005 Dr Burton

[111] T90 p. 25–6 Dr Joffe

[112] T90 p. 64–5 Dr Joffe

> ‘Q. But thereafter not?
>
> ‘A. No.
>
> ‘Q. Was it the physical separation that made a difficulty?
>
> ‘A. Yes, the physical separation was real, although of course not insurmountable. The distance between the two hospitals was really quite small: 150, 200 metres, maybe. But the hill, when you were walking up it, felt as if it was almost half a mile, rather than 200 metres. It was extremely steep, so it was difficult coming back up; it was easy going down. This may sound trite, but it does make a difference, and it also makes a difference in terms of the ordinary communication that exists in a unit where consultants and various doctors can meet with each other and bump into each other in a corridor, and so on, which facilitates overall management.’[113]

114 In addition to evidence from clinicians involved in the care of children in the relevant period, the Inquiry also received evidence about the split site and service from other clinicians in Bristol.

115 Professor John Vann Jones, consultant cardiologist, and Clinical Director of Cardiac Services from 1993 to 1996, told the Inquiry:

> ‘I must say, my own feeling was that this was the wrong environment for children. As I have already said in my statement, when I did paediatric cardiology, having been an adult cardiologist and thrown into this unusual circumstance, I felt very uncomfortable with it because these youngsters have many metabolic problems that develop extremely quickly. They are tiny little things. They become acidotic very easily; they have their ventilation suppressed very easily. If you do not actually have general paediatricians in the building and you do not have a paediatric cardiologist in the building all the time, and you do not have dedicated paediatric anaesthetists you are going to have more morbidity. That problem needed to be resolved.’[114]
>
> ‘… if I am in the clinic and someone asks me to go to the ITU two storeys away I can be there in 15 seconds. Obviously you cannot do that in a building the best part of half a mile away. So these sorts of children can go dramatically wrong dramatically quickly. Any cardiac patient can. So there is no way it can have anything other than a negative impact, but I do not think it is quantifiable.’[115]

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[113] T90 p. 66–7 Dr Joffe

[114] T59 p. 164 Professor Vann Jones

[115] T59 p. 165 Professor Vann Jones

116 Dr David Hughes, consultant paediatric anaesthetist, referred in his written evidence to the Inquiry to efforts made to transfer the paediatric cardiac service to the BRHSC:

> 'I believe the first proposal was raised in the late eighties and a working party was set up to look at the implications including costings of the service. A new operating theatre and an extension to PICU was required. This proposal, supported by the National Heart Foundation did not come to fruition and nothing materialised until the issue was raised once again in the early nineties when, I believe, a proposal was put forward to develop adult cardiac services at the BRI. I think it was clear from the implications of this adult expansion that it would require extra beds and it would be necessary to transfer children's cardiac services to the BRHSC.'[116]

117 Dr Robert Johnson, a consultant anaesthetist, stated in his written evidence to the Inquiry:

> 'I did not personally provide any anaesthetic services at the BCH after 1978 but from about 1971, when I was a trainee at the BRI and worked in both the BRI and BCH, I had always believed and understood that the split site working, between the BRI and the BCH, for cardiac surgery was unsatisfactory.'[117]

118 Mr Eamonn Nicholson, a clinical perfusionist at the BRI since 1988, stated that when he was working at Guy's Hospital in the 1980s there was 'a walled-off unit within the ICU for children, with specially trained nurses allocated to that unit'.[118] He stated that when he joined the BRI in 1988 he noticed that there was no separate paediatric intensive care unit. He stated that he also noted that the ICU was on the sixth floor while the operating theatres were on the fourth floor: 'This meant that we had to transport patients and this was difficult.'[119]

119 He stated further that when he joined the BRI in 1988 he 'was puzzled that there was no back-up service provided at the Bristol Children's Hospital. Perfusionists were located only at the BRI.'[120]

120 Mr Nicholson stated that, although there was a designated children's area within the ICU:

> '70-year-olds would sometimes have to be placed there and it was generally recognised by all staff that it was not ideal to have mixed nursing.'[121]

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[116] WIT 0511 0015 Dr Hughes

[117] WIT 0403 0011 Dr Johnson

[118] WIT 0489 0015 Mr Nicholson

[119] WIT 0489 0015 Mr Nicholson

[120] WIT 0489 0015 Mr Nicholson

[121] WIT 0489 0016 Mr Nicholson

121 He concluded that:

> ‘Since the move to the Children’s Hospital in 1995 we have followed practice in Australia, with pre-operative meetings between cardiologists, surgeons, perfusionists and anaesthetists. I have found these meetings interesting. They assist in giving me insight into potential difficulties of a particular operative procedure, or a particular patient’s needs …’[122]

Comments by those involved in management and finance on the split site

122 Avon HA pointed out in its written evidence to the Inquiry that:

> ‘The Bristol and District area was not alone in having in-patient children’s care provided from a number of hospital sites. This was the case in many cities including those which had children’s hospitals which were separate from other district general hospital provision, and the location of which did not always fit with the development of specialties such as renal services, cardiac services, neurosciences and plastic surgery.’[123]

123 Avon HA stated that in 1983 the Bristol and Western District Health Authority (B&WDHA) had received advice from the Management Advisory Service of the NHS. The B&WDHA’s Planning Group undertook a series of consultations and the Division of Children’s Services ‘argued strongly for programmes towards centralisation of children’s inpatient services on the BCH site’.[124]

124 Avon HA stated that after a further review of acute and related services by B&WDHA’s Policy Planning and Resources Committee:

> ‘… at a meeting on 31st October 1986, the representatives of the Division of Children’s Services continued to press for integration of children’s services’.[125]

125 On 16 October 1990 Dr Baker wrote to Miss Deborah Evans, Contracts and Quality Manager, B&WDHA:

> ‘… paediatric cardiologists were anxious for the new “contract” to contain “some expression” of the need for children to receive cardiac surgery in a children’s

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[122] WIT 0489 0016 Mr Nicholson
[123] WIT 0074 1778 Avon HA
[124] WIT 0074 1777 Avon HA
[125] WIT 0074 1778 Avon HA

> department. This was accordingly expressed in the 1991/1992 service agreement between the B&WDHA and the UBHT.'[126]

126 In July 1993 B&DHA began a:

> '… "strategic review" of selected services for its residents … One of the key elements of change highlighted was to identify 15 hospital specialties that might benefit from some consolidation, including general paediatric surgery'.[127]

127 Avon HA stated that this proposal for a review was influenced by the paper *'Towards the Millennium: Specialist Services for Children in Bristol',* issued in February 1993.[128] The paper recommended, amongst other things: '… a move towards a single children's inpatient service in Bristol'.[129]

128 Avon HA stated that:

> 'The Authority developed and undertook an intensive programme of involvement with advisors up to the Autumn 1994. Six service area working groups were established, one looking at Acute Hospital Services … In the Acute group, six particular services were examined, including specialist children's services.'[130]

129 In its advice, dated 9 June 1994, the Bristol & District Paediatric Committee:

> '… explicitly advocated that where children's services had developed alongside their adult counterparts, they should meet a nationally-recommended standard for children's care and that could be achieved only by "realignment from organ-centred to age-centred patient care".'[131]

130 In her written evidence to the Inquiry, Miss Deborah Evans indicated that the management of cardiology and cardiac services as a single unit was regarded as an important issue for the Avon HA 'because it felt that an integrated directorate could have a direct bearing on clinical decision making for certain patients'.[132]

131 She stated that:

> 'In 1993/1994 and thereafter Bristol and District Health Authority issued a single specification for children's cardiac services (i.e. cardiology and cardiac surgery combined) and another single specification for adult cardiac services (cardiology and cardiac surgery combined).'[133]

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[126] WIT 0074 1778 Avon HA
[127] WIT 0074 1779 Avon HA
[128] WIT 0074 0160 Avon HA; there appears to be an earlier draft of this document dated September 1992 at HAA 0081 0056
[129] WIT 0074 1779 Avon HA
[130] WIT 0074 1779 Avon HA
[131] WIT 0074 1779 Avon HA
[132] WIT 0159 0022 Ms Evans
[133] WIT 0159 0022 Ms Evans

132 Dr Pitman, consultant in public health medicine at the South Western Regional Health Authority/South and West Regional Health Authority (SWRHA/S&WRHA) from 1980 to 1996, in her written evidence to the Inquiry stated that, in March 1984, the SWRHA was considering how to deal with the proposed expansion of cardiology. She referred to a draft report:

> 'At the present time, patients' lives are constantly being placed at risk by the need to transfer very young children between the Bristol Children's Hospital and Bristol Royal Infirmary every time a catheter investigation is needed.'[134]

The report proposed that the catheterisation rooms at the BRI and the BRHSC be re-equipped.

133 Dr Roylance told the Inquiry that he was aware, in 1985, of some views favouring a move of paediatric cardiac surgery to the BRHSC but:

> 'That was not a universally supported view.[135] There were still those who thought that the expertise in cardiac surgery lay at the BRI and that it might be better to import paediatric expertise into the BRI. But I was aware and by 1987, I think by then, I think it was by then or soon after, more neonates were being operated on than before which precipitated the problem and made it clearer to everyone that it would be better if the neonates were in a paediatric unit.
>
> 'So I knew, at that time, and we tried from that time, James Wisheart in particular, with my enthusiastic support, to try and find a means of achieving that desired aim, so that around 1987, I think there was no longer an argument that it would be preferable for children to be nursed in a children's hospital, at that time … So the desire was there. The achievement was much more challenging.'[136]

134 Dr Roylance explained how this was achieved:

> 'We engineered a situation, a very welcome situation, whereby, to achieve the latest increase in adult cardiac surgery, we either had to build more adult cardiac facilities at the BRI or build children's facilities at the Children's Hospital, so creating space for the adult surgery.'[137]

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[134] WIT 0317 0005 Dr Pitman and HAA 0095 0029

[135] The Inquiry did not hear a single voice raised against it

[136] T24 p. 109–10 Dr Roylance

[137] T24 p. 110 Dr Roylance

135 Dr Roylance went on, in the following exchange:

> ‘A. … we found a solution in the 1990s.
>
> ‘Q. But the solution was one which really depended on funding?
>
> ‘A. Absolutely.
>
> ‘Q. Had there been a source of funding available to move the children’s cases from the Royal Infirmary to the Children’s Hospital earlier than the 1990s, would you have taken advantage of it?
>
> ‘A. Yes, but if there were funds available for that move, we would have spent it on that move.’[138]

136 Dr Roylance was asked by Counsel to the Inquiry whether he was aware that, from 1987 to 1988, capital was potentially available (depending on the application being accepted) for the development of SRS:

> ‘… sources of funding were usually brought to my attention. I cannot tell you now whether it was. I will say that the Advisory Group recommended that priority be given to applications relating to services where significant workload expansion was expected, and I suspect that that was the reason why this was not a pathway which could be trodden.
>
> ‘You see, we were relying on a significant workload expansion in adult cardiac surgery. What we had been saying and what we were talking about, a significant workload expansion was not expected, as I understand it, in 1987 and 1988.
>
> ‘I cannot be certain, all I can use is my experience and these documents, and what is implied is that in order to get capital for expansion, one had to demonstrate a realistic expectation of that expansion. We were looking for money for translocation, not expansion.’[139]

137 In a letter of 31 January 1992 Arthur Wilson, Deputy Regional General Manager at the SWRHA, wrote to Dr Roylance concerning capital funding:[140]

> ‘I am writing to invite you to produce a proposal for cardiac services that takes into account: a) increased capacity b) unification of children’s services and c) steps to meet quality and cost concerns of purchasers.’

Mr Wilson’s letter sought the proposals by 9 March 1992 for consideration by the RHA.

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[138] T24 p. 111 Dr Roylance

[139] T24 p. 112–13 Dr Roylance

[140] UBHT 0038 0411; letter dated 31/1/91 but received 9/2/92 therefore should have been dated 31/1/92

138 Dr Roylance described his understanding of the development of paediatric cardiac surgery:

> ‘When paediatric cardiac surgery was started, it was considered that the essential expertise that was needed to be concentrated was that of cardiac surgery and they were performed right across the country by surgeons, cardiac surgeons, who performed operations on adults and children.
>
> ‘In other specialties, that is still the case, but as more and more neonates were operated upon, it became increasingly apparent that a paediatric facility was more important than a cardiac surgical facility. Therefore, paediatric cardiac surgery was, as soon as we could, moved to the Children’s Hospital to a paediatric environment, and a little time before that, adult cardiac surgery was merged managerially with adult cardiology.’[141]

139 Dr Roylance explained:

> ‘As I understand it – I think paediatricians may put a more extreme view – it was about creating a better environment in which care could take place; it was not about the success of that care. I mean, we were by no means the only unit which had a split site between paediatric cardiology and paediatric cardiac surgery. Because of the way the specialty developed, that is the case in a number of other units, I cannot tell you which ones, but I do know that that is not a unique situation by any means.’[142]

140 Dr Roylance was asked by Counsel to the Inquiry about the views of Mr Elliott, in the following exchange:

> ‘Q. Did you know that Mr Elliott had expressed the views that I have revealed in this line of questioning, that there was, as he saw it, disadvantage in the split site to the point of potential danger?
>
> ‘A. Yes, but not to the point of danger. As I have already explained to you, I did not actually see the paper written by Martin Elliott until after the appointment of Gianni Angelini, or some time around there, but he did not say it was dangerous, he said there was the potential for danger. I clearly read that in a different way from what you are suggesting. Quite clearly, I do.
>
> ‘Q. If it were suggested to you, then, revisiting my earlier question, that the service or part of the service was a potential danger to patients in a particular respect, is that something that you – as a manager unable to reach a clinical view because you

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[141] T24 p. 69 Dr Roylance

[142] T26 p. 19 Dr Roylance

> were not a clinician in that particular service – would nonetheless wish to take advice upon?
>
> ‘A. If the gist of the advice I was given throughout was that a situation was undesirable but in no way unacceptable, then I would regret the undesirability and attempt to correct it.
>
> ‘If anybody had suggested to me that they were describing a situation that was unacceptable, then I have told you what I would do about it. Just at the top there [indicating screen], I do not know what it refers to, “was totally unacceptable to me”, not “totally unacceptable”. The tone of this and the implication was that he supported our view that consolidation of the service on one site was highly desirable. He at no stage says, “and you should not be providing the service the way you are”. It is not said. I think if he thought we should not have been providing the service in the way that we were, he would have told me. He would have told somebody, not just the person providing the service.
>
> ‘Q. The last question, perhaps, before we have our afternoon break: a situation in which a service may be potentially dangerous, or is potentially dangerous: is that acceptable or unacceptable, would you say?
>
> ‘A. It depends what the words mean. The words as I understand them, it means acceptable but undesirable. You are putting to me that [it] is different. I do not believe anybody who believes that a service is dangerous and should be stopped would ever leave that ambiguity.’[143]

141 Mr Nix, in his written evidence to the Inquiry, stated that throughout the 1980s the B&WDHA had collaborated with the SWRHA in efforts to finance the expansion of cardiac surgical services. The SWRHA had set up a number of working parties in the early 1980s which made recommendations relating to the expansion of the service and for funding requirements for both capital and revenue.[144]

142 The Report of the Strategic Planning Working Party, presented to the SWRHA in March 1984, addressed a number of options for the increased provision of adult/paediatric cardiology. The preferred option was to provide a biplane cineangiograph machine[145] because:

> **‘Favourable Factors**
>
> ‘3.6.4i Avoids the high risk of transporting critically ill infants between BCH and BRI.

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[143] T88 p. 114–15 Dr Roylance

[144] WIT 0106 0040 Mr Nix

[145] This is an X-ray machine for recording angiography on cine film, and the recordings are done in two planes simultaneously

> '3.6.4ii Maintains ready access to expert Paediatric support — Neonatal, Anaesthetic, Intensive Care, Nursing, etc.
>
> **'Other Factors**
>
> '3.6.6iv This arrangement would avoid the current situation where the investigation of many urgent paediatric cases has to be deferred until the end of the routine sessions.
>
> **'Conclusion**
>
> '3.6.7 This option is the only one that enables the appropriate developments to be made in both Adult and Paediatric fields without compromising the clinical needs in either area.'[146]

143 Mr Nix stated that an assessment of the costs of transferring paediatric open-heart surgery to the BRHSC was undertaken in the late 1980s:

> '… not only was affordability an issue at the time but there was also concern about the availability of trained medical and perfusion staff to cover the two sites'.[147]

He stated that further assessment was undertaken in the early 1990s as part of a review of the need to expand the capacity for adult cardiac surgery.

144 Mr Nix indicated that other capital projects and developments were competing for scarce resources. He set out some of the major developments which took place throughout the 1980s and 1990s:

- 'Expansion of cardiac surgery from 275 cases to around 1,100 cases per annum
- 'Building of the new Bristol Eye Hospital
- 'Building of the Avon Orthopaedic Hospital
- 'Replacing several of the linear accelerators used for the treatment of cancer
- 'New general hospital at Weston Super Mare
- 'Transfer of learning disability patients into small family homes in the community
- 'Building four new operating theatres at the BRI

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[146] HAA 0095 0055 – 0056

[147] WIT 0106 0042 – 0043 Mr Nix

- ‘Developing a Bone Marrow Transplant unit for Children now dealing with about 80 cases a year

- ‘Transferring the beds for the elderly from Manor park to the BGH [Bristol General Hospital], closer to where the patients live.’[148]

145 He went on:

> ‘A further review of service provision in 1993/94 identified a financially viable plan to move paediatric open-heart surgery to the Children’s Hospital. This plan was to be financed by the purchasers providing greater funding for an expanded adult cardiac surgery service. Because of the overall size of the expansion in adult surgical services required, the possibility of transferring children’s surgery to the Children’s Hospital was investigated and found to be affordable. … Funding for the capital investment was found from the Trust’s capital, NHS Executive Regional Office capital and from charitable sources. Development work at the BRHSC started in late 1994 and finished in November 1995.’[149]

146 Mr Nix told the Inquiry that cardiologists, paediatric and adult alike, had been arguing for paediatric open-heart surgery to be moved to the BRHSC for some time by the start of the 1990s.[150]

147 Mr Nix was asked by Counsel to the Inquiry about an application for funding led by Dr Joffe, made in 1992:

> ‘Well, up until Friday evening last week, I was not aware that we had made a submission. There were no papers in any of my files related to this yet you had mentioned something to me and I spoke to Kate Orchard, the Manager of Cardiac, and she said she was asked about it at the GMC, and on Friday I spoke to Mr Wisheart and asked did he know anything about it and on Friday evening I saw a copy of a paper that had been submitted in 1992. In fact I saw two papers. The first was one that I had written which was what work would need to be undertaken to make a submission and that was dated the 9 June, and then, about a fortnight later, the very short paper had been submitted. It was sent down under a compliments slip from Dr Joffe and on that compliment slip it indicated that Mr Owen had suggested that the application should be made and that an application that had been sent in was an interim statement. I do not recall being involved.’[151]

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[148] WIT 0106 0043 – 0044 Mr Nix

[149] WIT 0106 0044 Mr Nix

[150] T23 p. 78 Mr Nix

[151] T23 p. 35–6 Mr Nix

148 Mr Nix agreed that opportunities were available for applications to be made for capital funding to the Supra Regional Services Advisory Group (SRSAG) in the late 1980s: '… clearly there were'.[152]

149 Asked whether the need to increase capacity in the BRI to meet the demand for adult cardiac surgery was the reason why paediatric cardiac surgery moved to the BRHSC, Mr Nix said:

> 'Yes, and it brought with it, because of the demands from purchasers and the need that was shown in our waiting lists and the number of emergencies, that finance was available to cope with both the cost of the capital investment and the ongoing revenue cost of running the service at the Children's and at the Royal Infirmary.'[153]

150 Mr Nix told the Inquiry that the concerns expressed by Dr Jordan in his paper of 7 December 1990 were addressed in the mid-1990s because they were allied to the need to increase the capacity for adult cardiac surgery.[154]

Comments by the Trust Board

151 Mr Robert McKinlay, Chairman of the UBHT 1994–1996, stated in his written evidence to the Inquiry:

> 'The effect of the quality of care of operating on children within the BRI is a matter for clinicians. In the discussions which took place in specifying the new children's hospital, much emphasis was given by staff to the treatment of children within an environment dedicated to children.'[155]

152 Miss Lesley Salmon, Associate General Manager of Cardiac Surgery from 1991 to 1993, then General Manager of Cardiac Services until 1994, told the Inquiry of her view of the Trust Board's concern in the following exchange:

> 'Q. … how would you characterise the attitudes, so far as you are able to, concern of the Trust Board, the directors of the Trust, to the split site throughout your period, 1991 to 1994?
>
> 'A. It was not my impression that the Trust Board in general felt that the split site for paediatric surgery was of great concern in terms of the management of the service or the quality of the service.

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[152] T23 p. 39 Mr Nix
[153] T23 p. 81 Mr Nix
[154] T23 p. 81 Mr Nix
[155] WIT 0102 0017 Mr McKinlay

> ‘Q. Were you aware of anyone who was trying to persuade them to a contrary view?
>
> ‘A. On the Board, or outside of the Board?
>
> ‘Q. No, any pressure to the Board to try and make the Board think that it was a problem?
>
> ‘A. I think that certainly the group I was a member of within the Directorate of Surgery principally, there were those individuals amongst us who felt that for various reasons it was important. Certainly I think that Janet Maher would have felt strongly. Probably the clinicians and managers of the Clinical Directors would almost certainly have felt strongly about it, and I believe did. I think that Chris Monk, the anaesthetic consultant, was also a supporter of that view. Those are the ones that spring to mind.
>
> ‘Q. What was your view?
>
> ‘A. My view was that the service should move to the Children’s Hospital.
>
> ‘Q. For the benefit of the children or the adults, or both?
>
> ‘A. Both, but principally for the children.’[156]

153 Mr Stephen Boardman, Director of Corporate Development for the UBHT, from April 1991 to July 1992, was asked by Counsel to the Inquiry to comment on Mr Wisheart’s written evidence that:

> ‘… we wished to move the open-heart paediatric surgery to the Children’s Hospital; when the plans to do this were advanced they were overtaken by new proposals to re-provide the entire Children’s Hospital.’[157]

154 Mr Boardman replied:

> ‘Can I give you the context of my answer? When I was drafting my statement, I did not recall the transfer of the split site as being a major issue at all. It is a long time ago now and I have long since left the Trust, so it is not my everyday working environment … I then reviewed the documents I still had available at home and I was surprised to find that there were references in them — these were documents for which I was responsible and these particular documents I have mentioned, the application for Trust status and the like, and I flicked through the documents, found these references, thought “That is interesting”. I had forgotten that that was going on at the time.

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[156] T31 p. 125–6 Miss Salmon

[157] JDW 0007 0020 Mr Wisheart

> 'So that is the context to me giving the answer to this.
>
> 'James' statement that he pursued it, or two goals were pursued enthusiastically, I am sure — it is very likely true that the surgeons were enthusiastic to make this move, but it never became a proposal that was actively got to the Board at a level where the Board or the predecessor of the Board, the management team, were saying, "Yes, this is a proposal which we need to devote time and effort into making it happen" with — you know, looking at the details of how we were making it happen. It never got advanced to being a major project for me to take up.'[158]

155 A first draft of a report for consideration by the Cardiac Expansion Working Party, distributed on 12 May 1994, stated:

> 'Plans for a new children's hospital are well advanced, including provision for integrated cardiac services, but the new building is unlikely to be commissioned before the end of the decade. This is too far ahead to meet immediate and medium term demand on the service.'[159]

It was noted in the report that the most recent previous report was in 1990 and that:

> 'To date it has been concluded that the cost of such relocation, involving the construction of a new cardiac theatre, additional ITU beds and additional staffing, has been prohibitive.'[160]

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[158] T33 p. 30–1 Mr Boardman

[159] JDW 0003 0185; Working Party Report *'Options for Development of Adult and Paediatric Cardiac Services in UBHT'*, 12 May 1994

[160] JDW 0003 0185; Working Party Report *'Options for Development of Adult and Paediatric Cardiac Services in UBHT'*, 12 May 1994

Chapter 10 – Outreach Cardiology Clinics

Introduction

1 This chapter addresses the organisation of peripheral, or outreach, cardiology clinics run by the Bristol cardiologists in the UBH/T catchment area. It is closely related to Chapter 11 which deals with referrals to Bristol. It begins that section of this Annex in which the evidence is set out which traces the path of a child needing heart surgery from first identification, at an outreach clinic, or by a paediatrician in a district hospital, through first contact with the Bristol hospitals, pre-operative assessment and care, surgery, surgical management of care (which is of much wider scope than events on the operating table itself), post-operative care, to counselling and, in the event of a child's death, bereavement services.

2 Communication is a theme that runs through all the chapters which follow: between Bristol doctors and local doctors, between Bristol doctors and parents, and between the doctors in Bristol themselves.

The concept of outreach clinics

3 Dr Robert Swanton, consultant cardiologist and President of the British Cardiac Society (BCS), told the Inquiry how outreach clinics work in the area in which he practises:

> 'We send a surgeon out to one of our referring centres every month, to do a sort of joint clinic, and it is very much appreciated by both units. It ensures very good communication and patients like to see their surgeons after the operation, and it works very well. It is time-consuming. It takes essentially a whole day out of the surgeon's or cardiologist's week by the time you have got down there and back again, but it is very valuable.
>
> 'I think in time, it will become less important as more of the DGHs [District General Hospitals] have established two cardiologists per hospital. A lot of these cardiologists are single cardiologists in a hospital managing a whole unit on their own with no support. They are people who need the outreach support from London or the big cities.'[1]

4 Dr Ian Baker[2] explained the concept of outreach clinics in his statement. He said:

> '"Outreach" clinics were clinics where paediatric cardiac clinicians from Bristol practised away from their base facilities at BRHSC and BRI in facilities of other Health Authorities.

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[1] T7 p. 53 Dr Swanton

[2] Formerly the District Medical Officer for B&WDHA from July 1984 to October 1991, and subsequently a Consultant in Public Health Medicine for the B&DHA from October 1991 onwards

> '"Outreach" clinics can be considered as serving: children and parents; referring paediatricians; the development of cardiac services in Bristol; and Health Authorities needing access to paediatric cardiac services.'[3]

5 The 1987 *'Annual Report for Paediatric Cardiology and Cardiac Surgery'* at Bristol said the following about outreach clinics:

> 'During the 1970s, joint clinics with the local consultant paediatricians were established throughout the South Western Region … At the invitation of consultant paediatricians in South Wales, joint clinics were also established in Abergavenny and Newport in 1986 and in Swansea, Carmarthen and Haverford West in 1987. Apart from the obvious benefit of convenience for the families and economy for the host Health Authority, these clinics have an important teaching function for the local Registrars, SHOs and visiting students during their paediatric training in District General Hospitals.'[4]

6 Dr Hyam Joffe, consultant cardiologist, explained the thinking behind Bristol's outreach clinics:

> 'The peripheral clinic concept was highly successful in fulfilling the following objectives close to the children's homes, instead of the family having to make frequent long trips to Bristol:
>
> - 'assessing new non-urgent patients with suspected cardiac abnormalities, referred by consultant paediatricians,
> - 'maintaining observation on previously diagnosed cases to monitor medication, if required, and to assess further progress,
> - 'ensuring timely referral for cardiac catheterisation and/or surgical intervention due to evolutionary changes in the nature of the condition,
> - 'continuing short- and long-term observation on post-operative cases after the initial one or two assessments by the surgeons in Bristol, …
> - 'updating paediatricians throughout the region of the latest advances in the ever-changing medical and surgical treatment of cardiac conditions,
> - 'teaching clinical signs, ECG and chest X-ray features, aspects of basic echocardiography and management of children with cardiac disease to medical students and, especially, GP trainees, paediatric SHOs, registrars and SRs, who frequently joined the clinics.'[5]

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[3] WIT 0074 0020 Dr Baker

[4] UBHT 0166 0006; *'Annual Report for Paediatric Cardiology and Cardiac Surgery'*, 1987

[5] WIT 0097 0143 – 0144 Dr Joffe

7 Mr James Wisheart, consultant cardiac surgeon, explained that:

> 'These visits to other centres enabled good professional relationships to be established between the referring paediatricians and the cardiological team in Bristol.'[6]

8 Building relationships with local paediatricians was also considered important, as well as fulfilling an educative role. Dr Baker said of referring paediatricians:

> 'Access to paediatric cardiological and surgical advice and services was achieved through these clinics in the South Western Region and parts of the Wessex Region from 1984.'[7]

Clinics in the South West and South Wales

9 Dr Joffe said:

> 'When I started in Bristol in 1980, Dr Jordan had already organised the "outreach" or peripheral clinics throughout the South Western Region and South East Wales. Between the two of us, we continued to provide clinics in Gloucester, Cheltenham, Swindon, Bath, Newport, Taunton, Barnstaple, Exeter, Torbay and Truro, with occasional visits to Plymouth.'[8]

10 Dr Stephen Jordan, consultant cardiologist, explained the arrangements that had existed in the South West, basically unchanged, since 1984. He said:

> 'All other hospitals in [the South West] Region with the exception of Yeovil were visited on a regular basis by one of the cardiologists doing a cardiological clinic, usually with one or more of the paediatricians and typically occupying all day once a month. Plymouth was otherwise the only exception as I visited only once or twice a year and the other clinics there were done by consultants from Southampton.
>
> 'The clinics in [the South West] Region were: Cheltenham, Gloucester (Dr Martin, morning and afternoon respectively), Taunton (Dr Jordan, all day), Exeter (Dr Martin, all day), Torbay (Dr Joffe), Plymouth (Dr Jordan, afternoon), Truro (Dr Jordan, all day) and Barnstaple (Dr Martin, afternoon or all day).'[9]

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[6] WIT 0120 0069 Mr Wisheart

[7] WIT 0074 0021 Dr Baker

[8] WIT 0097 0142 Dr Joffe

[9] WIT 0099 0015 Dr Jordan

11 Dr Joffe charted the development of the outreach clinics in Wales in his statement:

> 'In the mid 1980s, several local consultant paediatricians in South Wales individually approached the Bristol paediatric cardiologists to request that Bristol provide a "regional" paediatric cardiological and cardiac surgical service for their patients. The paediatric departments had loosened their connections with London centres through, for example, retirement of the visiting paediatric cardiologist from Hammersmith; a specifically paediatric cardiac surgical centre in Wales did not then exist. …
>
> 'The additional peripheral clinics were started in Abergavenny in 1986, in Swansea, Carmarthen, Haverford West and Merthyr Tydfil in 1987, and in Neath and Bridgend in 1989. These clinics have continued successfully until the mid-1990s. With the establishment of the Cardiff paediatric cardiology and cardiac surgery unit, some paediatric departments have established a connection with Cardiff. Abergavenny, Bridgend, Neath and Swansea have maintained a relationship with Bristol until today.'[10]

12 Dr A Palit, a consultant paediatrician at Pembrokeshire and Derwen NHS Trust in Wales, told the Inquiry that the:

> '… decision to send our children to Bristol was very easy because there were no other centres nearby us, who could give us a regular service. After the death of Dr L G Davies, I approached Dr Steve Jordan (a very eminent Paediatric Cardiologist), who was extremely helpful and supportive and offered his services immediately.'[11]

13 Dr Jordan confirmed that in a number of places in Wales, Dr K Hallidie-Smith had conducted clinics from Hammersmith Hospital and that on her retirement Bristol took over a number of her clinics.[12]

14 As to the clinics run by Dr Leslie Davies, Dr Jordan said that Bristol started to pick up some of his work before he died, because what paediatric cardiac surgery there had been at that time in Cardiff had stopped before then.[13]

15 Dr NK Agarwal[14] explained how, in 1982 or 1983, at the suggestion of a colleague, he transferred a premature infant from Swansea to the BRHSC. He said:

> 'Until this time, to my knowledge no paediatric cardiac patients had been sent to Bristol, however from this time onwards myself and my colleagues in Swansea started to send children requiring cardiac care to Bristol cardiologists … After the

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[10] WIT 0097 0143 Dr Joffe

[11] REF 0001 0092; letter from Dr Palit to the Inquiry

[12] T79 p. 134 Dr Jordan

[13] T79 p. 134 Dr Jordan

[14] Consultant paediatrician, Singleton Hospital, Swansea

> death of Dr L G Davies … I persuaded Dr Hyam Joffe … to hold regular clinics with us in Swansea starting some time in 1986.'[15]

16 Dr Baker noted that the paediatricians working in Dr Davies' health authority, that is Gwent Health Authority:

> '… found referral to Bristol as being effective and a good service …
>
> 'The Chief Administrative Medical Officer for Gwent, Dr Harrett offered honorary contracts to Drs H Joffe and S Jordan for clinics in Gwent.'[16]

17 Dr Jordan said that in South Wales the Bristol cardiologists visited clinics:

> '… in Newport (Dr Jordan, afternoon), East Glamorgan (Dr Jordan, all day), Swansea (Dr Joffe, all day), Bridgend (Dr Martin), Carmarthen (afternoon, Dr Jordan) and Haverford West (Dr Jordan, morning or all day).'[17]

18 There was some correspondence on the cost of running such clinics. For example, in a letter dated 24 February 1987 to Ms Jerrard, in the Medical Personnel Department at District Headquarters, Dr Jordan discussed the clinic at Newport in Gwent Health Authority. He wrote:

> 'In general the main effect of this clinic will not be to increase the numbers of patients being treated in Bristol but to avoid travelling for children and their parents. However, I think it does underline the necessity for the Bristol and Weston Health District with the South West Regional Health Authority to ensure that the financial arrangements with the Welsh Office are adequate.'[18]

19 Later that year, on 8 May, Dr Baker said in a letter to Mr Wisheart, Mr Dhasmana, Dr Jordan and Dr Joffe:

> '… several London hospitals as well as Southampton, have cardiologists who are active in holding clinics in South and Mid Wales and referring patients to their own centres for cardiac surgery. Unless the Welsh Office and the constituent authorities decide where they wish to spend their resources and organise the referral patterns through the relevant cardiologist, then we cannot be confident about the volume of service which will be required from our units here in Bristol. If this is not agreed, then we cannot sensibly determine the implications for our services in terms of space and staffing nor can we make appropriate charges upon the Welsh Office or any other DHSS funding source to cover the costs of the service.'[19]

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[15] REF 0001 0085; letter from Dr Agarwal to the Inquiry

[16] WIT 0074 0022 Dr Baker

[17] WIT 0099 0015 Dr Jordan

[18] WIT 0074 0449 Dr Baker

[19] UBHT 0092 0002; letter from Dr Baker dated 8 May 1987

20 The Bristol cardiologists also conducted clinics in the West Glamorgan Health Authority and the Mid Glamorgan Health Authority.[20]

Conduct of the clinics

21 Dr Barry Keeton[21] explained that outreach clinics could cause communication problems between colleagues:

> 'It is difficult when one is out in the peripheral clinics, which may have you in the car for three or four hours. Today with mobile phones it is easier to communicate with one's colleagues, but it would not be unusual for me to be phoned at a peripheral clinic by the surgeon to talk about something, and I would feel that was proper and correct.'[22]

22 Most of the clinicians who conducted the outreach clinics commented on the length of time the clinics took.

23 Dr Jordan said:

> 'As far as the clinics which I personally carried out (and I believe the same applied to those held by my two colleagues) they were busy clinics, often extending until 7pm or later in the evening and even so the numbers of patients seen often meant that the time available for each was less than ideal. (Unless continued efforts were made, the booking clerks tended to book at the same rate as general paediatric clinics with about 12–15 patients per hour.) One of my main principles was that we should not allow waiting lists for clinics to develop even if it meant doing extra clinics when the load demanded it. In consequence, we were generally able to see any patient referred (mostly from local paediatricians) within a month.'[23]

24 Dr Jordan's oral evidence included this exchange:

> 'Q. These clinics would last all day, would they, wherever you were?
>
> 'A. Yes, I suppose typically the clinic in Truro, for example, I would actually start at half 8 which meant getting up and leaving Bristol at half 5 or so. The clinic itself would go on usually until about 7, 7.30. I would have to do a certain amount of clearing up afterwards, and then get myself back to Bristol, usually via one of the fish and chip shops on the way for sustenance.

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[20] WIT 0074 0024 Dr Baker

[21] Consultant paediatric cardiologist, Southampton General Hospital, and one of the Inquiry's experts

[22] T51 p. 145 Dr Keeton

[23] WIT 0099 0016 Dr Jordan

> ‘Q. So these were long days?
>
> ‘A. They were long days. They were not the end of the day, either, because it was not infrequently the case that I would either have a call when I was down there to say “When you come back to Bristol, can you pop into the Children’s Hospital”, occasionally into the BRI, and see someone, and I would have to continue even after I got back to Bristol.
>
> ‘Q. So in the course of such a clinic, you can easily see 100 patients, perhaps?
>
> ‘A. I think 100 is a bit of an exaggeration. The Truro clinic included some time for doing echocardiography, so the numbers would not be that great, but I recall, when Dr Hayes came here, I actually went down with her for the first clinic, because it was one place where she did not know any people and we actually sat there in two separate rooms seeing patients until 7 o’clock, so heaven knows what time I would have got away if I had been there on my own.’[24]

25 Dr Robin Martin, who also conducted outreach clinics, commented on the same issue. His evidence to the Inquiry included this exchange:

> ‘Q. … the peripheral clinics, from your description, they take all day?
>
> ‘A. Most of the peripheral clinics are all day consultation plus you have obviously the travelling times on top.
>
> ‘Q. So because of the travelling times, because it is all day, it is unlikely, I suspect, that on those days you managed to get into either the BRI or BCH, or do you start there or finish there?
>
> ‘A. I might well. Most of the times I would probably not be at either place before the clinic started. That just would not be feasible. If I was on call, which you quite often would be on call with one of your colleagues covering you on the day whilst you are out, then I would call back to my home centre, which I would view as the Children’s Hospital, in the evening and see any patients that were there.
>
> ‘Q. In all of this workload which you have described … did you have the assistance of any junior staff?
>
> ‘A. Not “on the road”, if you like, when I went to the peripheral clinics. Those were totally consultant-based usually, sometimes in conjunction with local paediatricians, so it was very important for building links locally there.’[25]

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[24] T79 p. 126–7 Dr Jordan

[25] T77 p. 43–4 Dr Martin

The involvement of local clinicians

26 Dr Jordan also commented on the input of local clinicians:

> ‘In most clinics the paediatricians joined us which although considered to be somewhat wasteful in terms of staffing was an ideal arrangement as it allowed both the cardiologists to learn from the specialised knowledge of the paediatricians and the paediatricians to keep abreast of the way which we were managing patients.
>
> ‘Mr Wisheart attended a few of the clinics but it was more difficult for him to fit this in with his operating schedule and gradually he came less, and usually only for part of a clinic …
>
> ‘Great efforts were made by the cardiologists and the cardiac surgeons to maintain lines of communication with paediatricians. I personally dictated all my own discharge summaries and copies of letters were also sent. Both of these contained full details of treatment, outcomes and future plans …
>
> ‘The paediatric cardiologists and to a lesser extent the surgeons were frequently asked to join in post graduate meetings in peripheral hospitals and present papers or clinical cases at meetings.’[26]

27 Dr Alan Day[27] said:

> ‘I have established very close working links with Dr Martin and normally see him when he comes to this clinic and, if possible, sit in on consultations about my patients. In addition we have excellent telephone links, both with himself and colleagues, and I have been impressed by the standard of the cardiac diagnostic services.’[28]

28 Dr David Challacombe[29] recalled:

> ‘My contacts with the paediatric cardiac surgical services at the BCH and BRI were mainly through the paediatric cardiologists, who gave an excellent service to patients and parents. After patients were seen at the joint cardiac clinics in Taunton, arrangements were made for them to be admitted to the BCH for cardiological investigations. My next contact with them would have been at the next cardiac clinic in Taunton and I would have received a discharge letter from the cardiologists with details of the operation performed and the patient’s post-operative condition.’[30]

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[26] WIT 0099 0016 Dr Jordan

[27] Consultant paediatrician, Cheltenham General Hospital

[28] REF 0001 0012; letter from Dr Day to the Inquiry

[29] Consultant paediatrician, Taunton and Somerset Hospital

[30] REF 0001 0030; letter from Dr Challacombe to the Inquiry

29 Dr John Tripp[31] said:

> 'We enjoyed a very close working relationship with the Paediatric Cardiologist from the BRI. In the early years I did one or two joint clinics with Mr James Wisheart in addition to frequent joint clinics with Dr Hyam Joffe and Dr Stephen Jordan. Actually doing joint clinics has become rarer over the years and is now not the way these clinics are conducted.'[32]

The involvement of the surgeons

30 Mr Wisheart explained the input of the Bristol surgeons:

> 'Of the two surgeons, I attended outpatient clinics in Taunton on a quarterly basis and in Exeter, on a six-monthly basis; at each place this was a joint clinic with the paediatric cardiologist and the local paediatricians.'[33]

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[31] Senior Lecturer in Child Health, Royal Devon and Exeter Healthcare NHS Trust

[32] REF 0001 0062; letter from Dr Tripp to the Inquiry

[33] WIT 0120 0069 Mr Wisheart

Chapter 11 – Referrals

Introduction

1 The aim of this chapter is to set out the extent to which referrals to Bristol from its catchment area followed the pattern that might have been expected, and to present the evidence as to the pattern of referrals from the Bristol cardiologists and surgeons to other centres. The position in South Wales will be considered separately, since distinct factors such as the role of the Welsh Office and the development of a specialist paediatric cardiac unit in Cardiff influenced and altered referral patterns.

2 During the period of the Inquiry's Terms of Reference, the BRI and the BRHSC provided a paediatric cardiac service to a large geographical area, encompassing much of the South West of England and South Wales. This area is referred to in this chapter as the Bristol 'catchment area'.

3 Bristol had historically provided a service to the catchment area through peripheral or 'outreach' cardiology clinics conducted by the Bristol-based cardiologists, and by accepting referrals to Bristol from the catchment area. These arrangements were, in part, formalised for the youngest patients by the designation of Bristol as a Supra Regional Centre (SRC) for Neonatal and Infant Cardiac Surgery (NICS) from 1984 until 31 March 1994.[1] The function and organisation of the outreach clinics are dealt with in Chapter 10.

4 On the establishment of the Supra Regional Service (SRS), initially nine centres were designated to provide NICS: Bristol; Birmingham Children's Hospital; The Royal Liverpool Children's Hospital; Killingbeck Hospital, Leeds; The Freeman Hospital, Newcastle; Southampton General Hospital; Great Ormond Street Hospital for Sick Children (GOS), London; Brompton Hospital, London; and Guy's Hospital, London. From a geographical point of view, Bristol was the obvious referral destination for much of South Wales and the South West of England. However, referrals did not always follow this pattern.

5 The table below shows occupied bed days (OBDs) for NICS by region of referral based on 1992–1993 data[2] and illustrates that referrals to centres outside the geographical catchment area was not something peculiar to Bristol.

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[1] Detail of the designation and de-designation of Bristol is set out in Chapter 7

[2] The figures are taken from an annex to a letter sent by Sir Alan Langlands to regional general managers in November 1993 (EL(93)100). See DOH 0002 0249 and DOH 0002 0253

Table 1: Occupied bed days for neonatal and infant cardiac surgery 1992–1993 by region of referral

	Birmingham	**Freeman**	**Guy's**	**GOS**	**Leeds**	**Brompton**	**Harefield**	**Bristol**	**Alder Hey**	**Southampton**
Northern	9	1832	-	13	-	-	-	-	117	-
Yorkshire	19	16	-	-	2162	-	-	-	-	-
Trent	202	8	-	135	1057	50	-	-	7	-
E Anglian	-	-	305	693	-	237	44	-	-	-
NW Thames	-	-	198	1082	1	505	919	-	-	-
NE Thames	-	-	362	1796	-	706	85	-	-	-
SE Thames	-	-	1452	196	-	509	-	-	-	-
SW Thames	-	-	173	239	-	936	57	-	-	34
Wessex	-	-	-	52	-	-	-	127	-	1589
Oxford	19	-	27	316	-	28	108	-	-	44
S Western	10	-	-	-	-	5	-	2794	-	346
W Midlands	5018	-	-	-	-	5	-	-	74	-
Mersey	60	-	-	6	-	-	-	-	1971	-
N Western	268	-	-	-	132	-	-	-	1460	-
Others (Scotland, Wales, overseas)	223	13	48	145	-	342	47	807	384	69
Totals	5828	1869	2565	4673	3352	3323	1260	3728	4013	2082

6 The Inquiry heard that, generally, referrals would be from a paediatrician within the catchment area to a Bristol cardiologist (Dr Hyam Joffe, Dr Stephen Jordan and latterly Dr Robin Martin and Dr Alison Hayes) for an opinion or investigation. The cardiologist would see the child either at the BRHSC or at an outreach clinic.

7 If the cardiologist considered surgery was likely to be required, then the child would be referred to a paediatric cardiac surgeon. Usually a child referred to a Bristol cardiologist who required surgery would be referred on by that cardiologist to one or other of the Bristol surgeons, Mr James Wisheart or Mr Janardan Dhasmana. However, on occasion the Bristol cardiologist, or the Bristol cardiologist in conjunction with the Bristol surgeon(s), would refer a child on to another centre for surgery. This is considered in more detail later in this chapter.

8 In setting out the evidence on the extent to which the referrals to and from Bristol followed, or diverged from, the expected pattern, this chapter will consider the factors that may have influenced the pattern. They include:

- referring consultants' personal relationships with cardiologists;
- historical factors (e.g. referring consultants following an established pattern of referral to Bristol or elsewhere);
- contractual constraints;
- waiting lists at Bristol and at other potential alternative centres;
- financial incentives to refer patients in the catchment area to centres other than Bristol;
- views held by referring consultants as to the standards of care at Bristol and other centres;
- special cases such as children with Down's syndrome, children being considered for heart or heart-lung transplant or (after October 1993 in particular) neonatal Switches; and
- requests by parents.

9 This chapter will set out the information that was available to referring clinicians and parents on which to base their decisions on referral. This will include an examination of the extent to which those making referrals had available to them information about the standards of care available at Bristol and the other centres.

10 This chapter will also set out the information that was provided to parents on the referral of their child, whether to Bristol or elsewhere; about why their child was being referred to a particular centre; and whether and in what circumstances referral to centres other than Bristol was offered to parents as an alternative or substitute for Bristol.

11 In July 1999 the Inquiry wrote to consultant paediatricians and cardiologists who had been based within the Bristol catchment area, in 19 NHS trusts, during the period of the Inquiry's Terms of Reference, seeking their comments on their own referral practices. Most of those who replied and were able to provide evidence falling within the Terms of Reference are, or were, consultant paediatricians in hospitals in the South West of England and in South Wales.[3] Their comments and those of parents were a valuable source of information.

12 The Inquiry initially contacted 29 NHS trusts, seeking the names of referring clinicians. As a result, the Inquiry wrote to 88 clinicians employed in 19 NHS trusts. Eighty-one clinicians replied. However, of those 81, nine fell outside the Inquiry's Terms of Reference, either because they were not in post in 1984–1995 or because they dealt only with adults. Thus, the total number of relevant replies was 72.[4]

13 The Inquiry commissioned a statistical analysis of Hospital Episode Statistics (HES) for Bristol for the years 1991–1995 from Dr Paul Aylin.[5]

14 Dr Aylin was asked to look at referral patterns to the UBHT from its catchment area, and to compare them to referral patterns to other centres from their respective catchment areas. The question of different patterns of referral depending on differing socio-economic status was also addressed. The main finding of this analysis, which focused on open-heart operations between 1991 and 1995, was that the ratio of the residents going out of the UBHT catchment area for surgery compared to those coming in from other areas, is high in Bristol.[6] As regards children aged under 1 year, there were none from England *outside* the catchment area that came to the UBHT to be operated on.[7] However, a third of children under 1 year *within* the Bristol catchment area were being treated in centres elsewhere in England. With regard to socio-economic status, there appeared to be a tendency for higher proportions of under-1-year-old children who were from affluent areas to be treated elsewhere for open-heart operations, but other centres in England also displayed this trend.

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[3] The Inquiry wrote to 88 clinicians in Bath & West Community NHS Trust, Bro Morgannwg NHS Trust, East Gloucestershire NHS Trust, Gloucestershire Royal NHS Trust, Gwent Healthcare NHS Trust, North Glamorgan NHS Trust, Northern Devon Healthcare NHS Trust, Pembrokeshire & Derwen NHS Trust, Plymouth Hospitals NHS Trust, Pontypridd & Rhondda NHS Trust, Royal Cornwall Hospitals NHS Trust, Royal Devon & Exeter Healthcare NHS Trust, Royal United Hospital Bath NHS Trust, South Devon Healthcare NHS Trust, Swansea NHS Trust, Swindon & Marlborough NHS Trust, Taunton & Somerset NHS Trust, University Hospital of Wales Healthcare NHS Trust, and Weston Area NHS Health Trust

[4] Three clinicians commented but were barely within the Terms of Reference (one worked in Taunton for a month in 1995, one worked in Gloucester from March 1995 and one retired in May 1984)

[5] Analysis of Hospital Episode Statistics, Aylin et al., 1999. See Annex B

[6] Dr Aylin added a caveat that the findings be treated with caution because of the difficulties of defining catchment areas. See INQ 0013 0045

[7] Table 1, para 5 above shows a figure for referrals to Bristol from Wessex. It should be noted, however, that Dr Aylin's report focused on open procedures only. So too should his caveat about the difficulty in defining catchment areas. See INQ 0013 0045

Referrals to Bristol – referral procedure, the catchment area and finance

Referral procedure

15 Dr Joffe explained the referral procedure:

> ‘It was very rare for a child with suspected heart disease to be referred directly to paediatric cardiac surgeons from GPs, consultant paediatricians, or by self-referral. … The vast majority of such patients were referred initially by GPs, or medical staff in maternity units, to a consultant paediatrician in their area. The local paediatrician would be responsible for referring the patient to a paediatric cardiologist, either immediately, if the child was very ill, or was thought to need therapeutic intervention soon, or to a regular peripheral cardiology clinic in their area in the future … The only general practitioners who referred children with suspected, non-urgent heart abnormalities directly to the paediatric cardiologists' OPD [outpatient department] sessions in BCH were those who practised in the catchment areas of the four Districts of the Avon Area Health Authorities; later, the four local Trusts. The paediatricians in Bristol were by-passed because the paediatric cardiologists were more readily accessible to local families.’[8]

16 Mr Wisheart told the Inquiry that ‘All paediatric cardiac referrals came through the paediatric cardiologists’[9] and Mr Dhasmana agreed: ‘Children … were referred to paediatric cardiologists at Bristol in the first instance.’[10]

The catchment area

17 Bristol had historically provided a paediatric cardiac service to its catchment area. As the 1982 memorandum[11] prepared by Dr Joffe, Dr Jordan and Mr Wisheart put it:

> ‘The paediatric cardiology service already functions as the de facto Regional and Supra Regional Centre (although not yet officially recognised as such), drawing 28% of new referrals to the unit from Avon, 48% from the rest of the SW Region and 24% from South Wales, North Wessex and elsewhere. …
>
> ‘The long term management of patients is supervised near their homes through a system of Consultant Cardiac Clinics developed over many years and probably more comprehensive than in any other paediatric cardiology service in England. Regular peripheral clinics are held in Bath, Swindon, Cheltenham, Gloucester,

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[8] WIT 0097 0289 Dr Joffe

[9] WIT 0120 0116 Mr Wisheart

[10] WIT 0084 0062 Mr Dhasmana

[11] Memorandum on the Designation of Bristol as a Supra Regional Centre (SRC) in Neonatal and Infant Cardiology and Cardiac Surgery, July 1982, JDW 0001 0150 – 0152, and see further Chapter 7 where designation of Bristol as a Supra Regional Centre is discussed

> Taunton, Barnstaple, Exeter, Torquay, Plymouth and Truro. Close liaison exists with paediatricians in all these centres, who would resist any curtailment in the services they and their patients receive.'

18 Mr Wisheart said that referrals to the Bristol cardiologists came from:

- 'All the District General Hospitals in the old South Western RHA territory, except … Plymouth, who referred most of the children to Southampton, Yeovil who referred a proportion of their children to Southampton.
- 'Bath and Swindon in the old Wessex Regional Health Authority territory. I do not know whether they sent all their children to Bristol, but I believe that Bath did send virtually all its patients to Bristol, while Swindon sent a significant proportion of its referrals to Oxford, or possibly Southampton.
- 'A number of District General Hospitals in South Wales. The number of hospitals in South Wales referring to Bristol has varied over the period 1984 to 1995. There were some centres referring in 1984; this increased through the mid and late 80s when there was no cardiological facility in Cardiff. After the setting up [of] the paediatric cardiological facility there, the number of DGHs using Bristol decreased.
- 'The General Practices, which before 1991 were within the Bristol and Weston Health Authority, and possibly also the Southmead and Frenchay Health Authorities. After 1991 the practices within the corresponding Trusts.'[12]

19 Dr Jordan[13] and Dr Joffe each provided the Inquiry with a list of the hospitals from which children were referred to them.[14] The hospitals named by them were:

South Western Region:	Gloucestershire Royal Hospital (Gloucester)
	Cheltenham General Hospital (Cheltenham)
	Musgrove Park Hospital (Taunton)
	Royal Devon and Exeter Hospital (Exeter)
	North Devon District Hospital (Barnstaple)
	Torbay Hospital (Torquay)

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[12] WIT 0120 0116 Mr Wisheart

[13] Dr Jordan told the Inquiry: 'Essentially all patients from consultant paediatricians in [these] hospitals were sent to Bristol', although in relation to the Royal Devon and Exeter he said 'possibly not all Dr Kennaird's "cold" referrals', and in relation to Swindon 'latterly some were sent to Oxford'. See WIT 0099 0035 Dr Jordan

[14] Dr Jordan's list is at WIT 0099 0035 and Dr Joffe's at WIT 0097 0290

	Royal Cornwall Hospital (Truro)
	Derriford Hospital (Plymouth)
Wessex:	Royal United Hospital (Bath)
	Princess Margaret Hospital (Swindon)
South Wales:	Royal Gwent Hospital (Newport)
	East Glamorgan Hospital (Mid Glamorgan)
	Princess of Wales Hospital (Bridgend)
	Morriston (formerly Singelton) Hospital (Swansea)
	West Wales General Hospital (Carmarthen)
	Withybush Hospital (Haverfordwest)
	Neath General Hospital (Neath)
	Nevill Hall Hospital (Abergavenny)[15]

Finance

20 The NICS service (for under-1s) was funded through the mechanism of the Supra Regional Services Advisory Group (SRSAG), following Bristol's designation as an SRC for NICS in 1984.

21 In relation to paediatric services for the over-1s, Mr Graham Nix explained that at the beginning of the period of the Terms of Reference (1984), funding was received 'from government and [went] to the Regional Health Authority for the South West Region. That money was allocated out to each of the Districts of which Bristol & Weston Health Authority was one.'[16]

22 A report of a Strategic Planning Working Party in 1983[17] recorded an excess of demand over supply for open cardiac surgery generally (i.e. adults and paediatrics) in the South West Region in 1982. Mr Nix emphasised that the report 'refers to the fact that the South West Region should continue to send patients to London as well'.[18]

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[15] See also figures for referrals from the catchment area and 'outreach' clinics in the Annual Reports of the Bristol Paediatric Cardiology and Cardiac Surgery Unit for 1987 (UBHT 0166 0001 – 0014) and 1988 (UBHT 0124 0006 – 0016)

[16] T22 p. 17 Mr Nix

[17] UBHT 0266 0415; report of a Strategic Planning Working Party dated 14 February 1983

[18] T22 p. 26 Mr Nix

However, he pointed out that at that time there were difficulties in identifying the numbers of patients who were referred from the region to London:

> ‘Within the South West Region we, all the health authorities, had worked together to use the same computer systems, so it was possible to access data about patient flows, so we were in the infancy around that time as well, but at least we could access information. There was not the sophistication that exists now where we know where every patient comes from’

but as for London

> ‘They are in a completely different region so you would actually have had to have gone to those hospitals and said “Do you care for any of the patients in the South West?” and with a lot of the hospitals in this country, they would not have had any idea where their patients were coming from. It would have been a manual exercise, probably, to have gone through every set of notes to find out where those patients’ residential address was.’[19]

23 The costs of treating patients from outside the Bristol & Weston District Health Authority (B&WDHA) were charged to the referring district by means of the Resource Allocation Working Party (RAWP) cross-boundary flow mechanism.[20] The report of the Strategic Planning Working Party noted that districts providing regional specialties were deemed to have the financial resources for providing these specialties within their existing allocation.[21] Mr Nix explained, however, that data on the cross-boundary flow was probably two years old, if not older.[22] This meant that expansion of a service took a long time to be reflected in the RAWP funding mechanism.[23] Mr Nix told the Inquiry that the RAWP mechanism was ‘basically incapable’ of funding regional specialties.[24] Thus, according to Mr Nix, in order to fund regional specialties the RHA had to agree to give some special help to the DHA that happened to host the regional specialty.[25] Assistance did come from the RHA. For example, on 11 July 1983,[26] the South Western Regional Health Authority (SWRHA) agreed to a one-off three-year funding package to B&WDHA for the three years beginning with 1984/85, in order to finance a further expansion of the cardiac capability at Bristol.[27]

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[19] T22 p. 27–8 Mr Nix. A Working Party report in 1984 recorded that there were facilities for 375 open (adult and paediatric combined) cardiac operations in Bristol in 1984, which was less than two thirds the number of such operations being carried out on residents of the South West Region. See UBHT 0295 0276 and T22 p. 38–40 Mr Nix

[20] T22 p. 60 Mr Nix. These issues are dealt with in more detail in Chapter 6

[21] UBHT 0266 0417; report of the Strategic Planning Working Party dated 14 February 1983

[22] T22 p. 30 Mr Nix

[23] T22 p. 30 Mr Nix

[24] T22 p. 30 Mr Nix

[25] T22 p. 31 Mr Nix

[26] Before the years of the Inquiry’s Terms of Reference

[27] UBHT 0295 0276. See Chapter 6 for more detailed consideration of these issues

24 The Inquiry heard that there was, at least before 1 April 1991, a theoretical financial incentive for hospitals within the catchment area, but outside the District, to refer cases to London rather than Bristol.[28] This was because of the way that certain of the London hospitals 'charged' referring districts through the RAWP formula. The Inquiry heard evidence that London hospital statistics did not regard cardiac surgery as a separate specialty. Their RAWP 'recharge' was based either on the cost per case of thoracic or general surgery, which led to a lower amount than was 'recharged' by Bristol for cardiac surgery, which was treated by Bristol as a separate, more costly specialty.[29] The Special Health Authorities (SHA) such as the Brompton, Hammersmith and Great Ormond Street received separate funding not included in the RAWP allocations and the services they provided were 'free'. Hence it was cheaper to make referrals to London. This did not, however, mean that the actual cost of the operation in the London hospital was necessarily lower than in Bristol. Whatever the actual costs were, however, there was, in theory, a financial incentive to refer to London.[30] However, the Inquiry heard no evidence from referring clinicians that this influenced their own referral decisions.

25 In 1990/91 charging for inter-district cross-boundary flows was introduced, and contracts were introduced from 1 April 1991.[31] As a result of changes introduced following the NHS Review '*Working for Patients*', the resource allocation system changed on 1 April 1991. From then on, allocations were calculated for the purchasers that contracted services from providers.[32]

26 The funding of referrals from Wales is dealt with later in this chapter.[33]

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[28] T22 p. 62–3 Mr Nix

[29] T22 p. 60–1. Mr Nix was discussing a document from the Plymouth Health Authority, concerned with the needs of Devon and Cornwall residents for cardiac surgery, dated 9 September 1985; UBHT 0295 0516. Mr Nix told the Inquiry that at this time the Bristol 'recharge' for an adult open cardiac operation would be the same as a paediatric open-heart operation

[30] T22 p. 62–3 Mr Nix

[31] T22 p. 142 Mr Nix

[32] See further Chapter 6

[33] See para 144

Referrals to Bristol – information available to referring clinicians about standards at Bristol or elsewhere and factors influencing referral patterns

27 Mr Steven Owen[34] told the Inquiry:

> ‘I was constantly being told that clinicians had their favourite units, they established working relationships with the people, and in practice, if they referred to unit A, whatever other units were or were not doing, they would in all probability continue to refer to unit A.’[35]

28 Professor David Baum, then President of the Royal College of Paediatrics and Child Health (RCPCH), also explained the culture in relation to referrals at the time of the Inquiry’s Terms of Reference:

> ‘My memory of the context of the time is that this was not a culture – which I think is a desirable culture, but it was not the culture – of, “This has been the quality of my clinical performance with these outcome measures for the last five years, those are my cards, do you like them or do you want somebody else’s cards?” It was very much more broadly an atmospheric of, “This is a good guy, this is not such a good guy”. But within that has to be titrated the urgency of the matter, so if the matter was urgent or were urgent tomorrow, there would be the other consideration of, “Is it on my patch or am I going to look at the cards to such a degree I am going to send the patient to another patch?” … in 1990/1994, as a paediatrician, if I feel this child is unwell and there is a cardiological problem of some severity, it would not, I believe, have entered my consciousness to think, “What is the quality, outcome, performance, audit, of my colleague cardiologists?” I would say, “There are competent consultant-trained cardiologists on this corridor who are my colleagues who I trust through their training and I trust them as individuals, that I will refer the care of the baby”.’[36]

29 Asked whether his answer would have been any different if he had been a paediatrician in a district general hospital who was referring children to a paediatric cardiologist in another hospital, Professor Baum said:

> ‘… it would have been different, but the difference would have still hung on an atmospheric of quality of service, rather than on any published measured audit of accuracy of diagnostic skills.’

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[34] Administrative Secretary of the SRSAG from January 1992–February 1996

[35] T12 p. 40 Mr Owen

[36] T18 p. 71–2 Professor Baum

He said that the information on which he would have based judgments was:

> ‘Many strands. They would include a reputation of diagnostic skills. And how does that reputation get about? Well, there are the value of clinical meetings, the value of first- and second-hand discussions, the gossip network. So there would be diagnostic skills; there would be matters of professional courtesy; again, the gossip vine of how they are with parents who are worried about their sick child; how they are in terms of their relationship with their firm, with their juniors, as trainers, with their colleagues. There would be an element of their efficiency professionally, of how quickly they could accommodate what I am saying, “This is an emergency”, and how far they will put themselves out to come to see the child in my clinic in the DGH or to arrange transport and so forth, and many other elements. So it is professional diagnostic skills and other elements of professionalism.’[37]

30 Dr William Reith, Honorary Secretary of the Royal College of General Practitioners (RCGP), told the Inquiry that referrals by GPs directly to paediatric cardiologists would be rare. A GP would rarely encounter a child with a congenital heart defect in his or her practice due to the rarity of the condition. The average list size would only contain ten patients of all ages affected by congenital heart disease, with one new case arising about every five years. Dr Reith said that as the initial diagnosis of a heart defect would be likely to be made by a paediatrician or a paediatric cardiologist, by the time a GP had contact with the child, it might well be that both diagnosis and a course of treatment, even surgery, had taken place.[38]

31 Asked, in the event that a GP was considering whether to refer to a paediatrician, on what data or information the GP’s judgment as to the adequacy of the service likely to be provided by that paediatrician would have been based, Dr Reith told the Inquiry:

> ‘Not very much, in all honesty. I mean, much of the general practitioner’s decision to refer will be on the basis of personal knowledge. Over time, a general practitioner will get to form a view, an opinion, on the range of abilities and indeed the range of specialisation of consultant colleagues, and again, different specialties have evolved at different rates, so, for example, in surgery, there was some specialisation some time ago, a number of years ago, in many centres into surgeons specialising in breast surgery, thyroid surgery and that sort of thing. In the surgical condition of ophthalmology, it is only now there is specialisation into those dealing with retinal problems, and so on, so again it must be taken in that context.
>
> ‘Whether or not one would refer in the particular instance to a paediatrician or a paediatric cardiologist would depend to an extent on local practice. Probably, a large chunk of the population and their GPs do not have immediate access to a major hospital and many of them will be seen through district general hospitals which will tend to have a general paediatrician rather than a paediatric cardiologist. That again, I am sure you will appreciate, is due to population size and

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[37] T18 p. 70–4 Professor Baum

[38] WIT 0059 0010 Dr Reith

> so on. So there are many parts of the country where a general practitioner will refer on to a general paediatrician. There may be five or six paediatricians in the hospital and perhaps one or two of them might have a special interest in paediatric cardiology. That would not be the whole nature of their work, but obviously they have a particular interest in that.[39]

Sources of information available to referring clinicians

32 The Bristol surgeons and cardiologists explained the information that was available to referring clinicians, on which they might base a decision to refer a child to a particular unit. In particular, they addressed whether the Annual Reports of the Paediatric Cardiology and Cardiac Surgery Unit at Bristol would have been sent or made available to referring clinicians.

33 Dr Joffe said:

> '… information about individual cases was conveyed to the referring clinicians by comprehensive case summaries and by discussions at the peripheral clinics. A copy of the summaries was also sent to the GPs. I believe the [Bristol's] Annual Reports from 1987 to 1990 were circulated to the referring paediatricians from our department. In addition, the paediatric cardiologists took the opportunity to show the facilities at BCH … to various consultant paediatricians during the South West Paediatric Club meetings, held in Bristol on one of the two meetings each year, or on any other occasion.'[40]

34 Dr Joffe was asked to whom the Annual Reports would have been sent. His evidence included this exchange:

> 'The idea was to send the reports to the then District Health Authority, both the local one and peripheral centres, particularly to the … paediatricians around the region with whom we were related, so to say, by virtue of the peripheral clinics that we held at these various centres and we wanted them to have a view of what we were doing and of our figures and our enterprises.
>
> 'Q. You say the idea was to send the reports to the then District Health Authority, both the local ones and the peripheral centres. That was what you described as the idea; was it also the reality or not?
>
> 'A. Yes, we sent them out.

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[39] T16 p. 41–2 Dr Reith

[40] WIT 0097 0291 Dr Joffe

> ‘Q. Do you know whether they went to individual paediatricians who might refer cases to Bristol?
>
> ‘A. I believe so. I really cannot recall exactly how the mechanism worked, but I believe my secretary or a secretary within the cardiology department would have been asked to send these reports to … the referring paediatricians.’[41]

35 However, Dr Joffe also stated in his written statement:

> ‘As far as I understand the situation, there was no formal structure or requirement for the BRI and the BCH to convey information on the standards of treatment and care in their various departments to referring clinicians or to members of the public. I believe this was the case throughout the NHS and applied to services under the management of the B&WDHA during the 1980s and to UBHT in the early 1990s. This was also true for most, if not all, designated paediatric cardiac centres in the country.’[42]

He added that the Annual Report for 1989/90:

> ‘… included results for open and closed heart surgery for children over and under one year of age, and a comparison of the mortality rates in Bristol with the average UK results. As far as I am aware, Bristol was one of the first supra regional centres to make such comparisons available to clinicians, on a wide enough basis to put them virtually into the “public” domain. Unfortunately, these annual reports ceased when I became more heavily committed as Clinical Director of Children’s Services from early 1991.’[43]

36 Dr Jordan also commented on the information available to referring clinicians. He said that Mr Wisheart personally provided him with information about the surgeons’ results, for the purposes of preparing his Annual Report on paediatric cardiology to the management of the Children’s Hospital.[44] But, he said:

> ‘There was no consistent publishing of results either from Bristol or from the country in general. Paediatricians did receive feedback from parents, but this was likely more to refer to the general care they received than the actual overall comparisons of surgical results.’[45]

37 In his oral evidence, Dr Jordan said that referring paediatricians would probably not have known that there was an Annual Report produced and therefore would not have requested a copy.[46] His evidence was that the Annual Report was first produced in 1987, but that it was essentially for ‘internal consumption’ at the BRHSC and that

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[41] T90 p. 16–17 Dr Joffe

[42] WIT 0097 0157 – 0158 Dr Joffe

[43] WIT 0097 0159 Dr Joffe

[44] WIT 0099 0033 Dr Jordan

[45] WIT 0099 0036 Dr Jordan

[46] T79 p. 153 Dr Jordan

whilst the 1987 report was disseminated more widely outside the hospital as 'a bit of advertising', later reports were not sent out.[47] This is in contradistinction to the evidence of Dr Joffe, referred to above.

38 Dr Jordan also said:

> 'I would have felt able, if someone said, "Can you give me a rough breakdown of how you stand in relation to the whole of the UK?" I would have been quite happy – and I may well have done this – to say "According to the figures that are actually reported to the UK register. I think, as you know, it is not actually comprehensive, there are a number of units that did not supply their data, but if you want to know how we stand, the answer is — the worst side of it is our mortality for open-heart surgery under the age of one year was higher than the national average and the figures, whatever they are, the totals over a year were similar and the totals for closed-heart surgery were rather better." I would not have had any objection or any difficulty in making that sort of statement if I had been asked "How do we stand as far as figures are concerned?"'[48]

In answer to a question from the Inquiry Chairman, Dr Jordan elaborated further on the point:

> 'Q. If an observer having heard your evidence formed a picture that you were someone who, recognising that there were some problems in Bristol, fought within Bristol to effect change while outside quietly suggested or warned people off; would that observer have any right to hold that view?
>
> 'A. There is some truth in it. I will perhaps give you an example: shortly before I retired[49] I had discussions with cardiologists in South Wales, I think this has sort of been obliquely referred to. Basically they were obviously considering whether they should continue to send patients to Bristol and take on a new cardiologist from Bristol, there was going to be a change anyway and they were being offered, in fact being encouraged to use the service in Cardiff instead. The thing I said to all of them, and I used very similar words but not necessarily identical ones were "You have asked my advice and what you are asking is really what is best for our patients. If I thought that the centre in Bristol was absolutely the best centre in the UK and there was no way that anyone else was going to produce comparable or better results, I would say to you, 'Do not try an untried unit in Cardiff'. Frankly, I do not think I am in a position to say that to you and therefore you will have to make up your mind whether you want to try a new unit or stick with Bristol." I think that is the sort of, if you like, comment I made which indicated that I was not going to go around blindly saying "Bristol is wonderful, keep on sending your patients there".'[50]

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[47] T79 p. 140–1 Dr Jordan

[48] T79 p. 151–2 Dr Jordan

[49] Dr Jordan retired in May 1993. See WIT 0099 0010 Dr Jordan

[50] T79 p. 188–9 Dr Jordan

39 Dr Joffe's evidence included this exchange:

> 'Q. Dr Jordan, in his evidence to us, in describing the 1980s, when he was asked about Bristol and the performance of Bristol, gently, I think, indicated in reply that Bristol was not the very best of cardiac centres. Would you have said the same had you been asked, let us say, by a referring paediatrician in those years?
>
> 'A. Yes.
>
> 'Q. Did you in fact do so?
>
> 'A. Yes, if asked, I would have done so, certainly.'[51]

40 Mr Wisheart said that the outreach clinics:

> '… enabled good professional relationships to be established between the referring paediatricians and the cardiological team in Bristol. It is my understanding that the referring clinicians were not in receipt of written information about the results of the work in Bristol; I did not send them my annual statistical summary or report and I do not believe that the cardiologists did either … I think that the most important exchanges of information were informal and took place in the clinics in relation to particular patients. The paediatric cardiologists, and to a much lesser extent myself, also gave talks in various post graduate centres and it would have been usual to present information and statistics on the results of work at such meetings.'[52]

41 Mr Wisheart went on:

> 'To the best of my knowledge the publication in January 1996 of the results in Bristol for paediatric cardiac surgery between 1990 and 1995 were quite unprecedented in the UK. This placed into the public arena the detailed discussions of all the paediatric cardiac surgical operations in Bristol in that period with figures from the UKCSR [UK Cardiac Surgical Register] for comparison.'[53]

42 Mr Dhasmana was also asked about the Annual Reports and whom they were intended for. He replied:

> 'I think the Annual Report was mainly produced by the paediatric cardiology department and the last one I was aware of was up to 1990. … so they would have circulated it amongst cardiac surgeons, their own colleagues and probably the Trust, and I would like to think to clinics where they were going to in the periphery.'[54]

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[51] T90 p. 53 Dr Joffe

[52] WIT 0120 0069 Mr Wisheart

[53] WIT 0120 0070 Mr Wisheart

[54] T86 p. 137 Mr Dhasmana

43 The pattern which emerged from the letters from those referring clinicians who responded to the Inquiry's initial request for information about referral practice was that they had little or no hard evidence of the results at Bristol or elsewhere. Many respondents (26) made the point that they had no data on which to base conclusions about the quality of care at any particular centre, let alone to make proper comparisons with other centres. The written evidence from referring clinicians included the following examples.

44 Dr M Webb:[55]

> 'The informal sources of information would have been on feedback through patients, and there was no concern being expressed by those patients I did see again. However most patients referred into the cardiology service would then remain within that service for subsequent follow up and I would not necessarily have been aware of significant morbidity, or even mortality, unless patients had continued to be followed up by me for other reasons – patients in this latter category would have been very few in number indeed.'

45 Dr R Trefor Jones:[56]

> 'With respect to the sources of information available regarding standards of treatment and care, this is a wider issue and in fact, there is no adequate information system available for the standard of care anywhere. … It is usually by word of mouth by other colleagues that one establishes what standard of care is in other units. There is always an assumption of course, that units such as Great Ormond Street, The Brompton Hospital, Guy's Hospital, Birmingham Children's and Alder Hey in Liverpool all have very high standards.'

46 Dr P Edwards:[57]

> 'The sources of information available in the years referred to: 1984–1994, were essentially informal, and essentially included our visiting Paediatric Cardiologist and general Paediatric Consultant colleagues, mainly in South Wales, many of whom during this period obtained a service from Bristol.'

47 Dr A Griffiths:[58]

> 'Bristol have always given us a good service and to the best of my knowledge we have had no problems with the children whom we have referred. We have however been highly dependent on the advice given to us by the Bristol cardiologists.'

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[55] Consultant paediatrician, Gloucestershire Royal Hospital, REF 0001 0008 – 0009

[56] Consultant paediatrician, Princess of Wales Hospital, Bridgend, REF 0001 0115

[57] Consultant paediatrician, Princess of Wales Hospital, Bridgend, REF 0001 0109

[58] Consultant paediatrician, Nevill Hall Hospital, Abergavenny, REF 0001 0129

48 Two referring clinicians told the Inquiry they were aware of data on outcomes at Bristol. Dr Dewi Evans told the Inquiry:

> 'I recall a report from Dr Joffe sometime in the mid 1990s regarding results. I think the report was commissioned specifically when concerns had been expressed regarding high mortality rates for certain procedures.'[59]

49 Dr T Perham said that information on standards of care may have been available at the South West Paediatric Club:

> 'I cannot definitely remember any discussions regarding this item but have some memory of delivery of a paper by the paediatric medical cardiologists from Bristol on the results of their treatment that was delivered to the club some years ago. I have a feeling that it related to the question of early intervention versus late intervention …'[60]

50 None of the referring clinicians in their initial letters to the Inquiry said that they had seen, or had requested, a copy of an Annual Report from Bristol. However, in light of the uncertain evidence heard by the Inquiry on this point, the 69 referring clinicians that were in post at the relevant time[61] were specifically asked to address whether they had seen or requested a copy of these reports.

51 The Inquiry received replies from 65 referring clinicians. Of those, 64 said, with varying degrees of certainty, that they had not seen the Annual Reports. Some were sure that they had not seen copies, but a number made the point that they were now relying on their memories of events up to 13 years ago.

52 For example Dr Bosley[62] told the Inquiry:

> 'I have received reports from the Bristol Cardiology Service, but I can only be sure of receiving them in more recent years and feel really very unsure regarding these particular [reports] of over 10 years ago'.

53 Dr R Jones:[63]

> 'I do have a copy of the Bristol Audit Report for Cardiac Surgery from 1996/1997, which I believe is the first such report that I was ever sent.'

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[59] Consultant paediatrician, Singleton Hospital, Swansea, REF 0001 0087 – 0088. Dr Evans said in his letter that this was 'many years after' he had elected to send his patients to Cardiff, which he did in 1991

[60] Consultant paediatrician, Derriford Hospital, Plymouth, REF 0001 0147

[61] Those clinicians whose practice fell within the Terms of Reference *and* who were in post at a time when or not long after the reports were likely to have been sent (letters were not sent to clinicians who left post before 1987, or did not arrive in post until 1992 or later)

[62] Consultant paediatrician, North Devon District Hospital, Barnstaple, REF 0002 0015 Dr Bosley

[63] Consultant paediatrician, Derriford Hospital, Plymouth, REF 0002 0030 Dr Jones

54 Dr A Palit:[64]

> 'I did not receive at any time the Annual Report for the Department of Paediatric Cardiology/Surgery. Neither did I expect it. Even if I had received these reports, I wouldn't have read them for the following reasons:
>
> '1. Statistics produced from a different set up can be totally misleading.
>
> '2. Apart from Cardiology, I also do the following special clinics with visitors from tertiary centres:- Genetics, Paediatric Surgery, Gastroenterology, Neurology, Nephrology, Respiratory Disorder/Cystic Fibrosis, Endocrinology.
>
> 'If I were to read the Annual Reports of each of these specialist departments and try to make any meaningful conclusion out of them, I would be doing no other work at all!'

55 However, Dr P Rudd[65] said:

> 'I believe that I have seen at least one of these reports. I remember hearing a presentation at the Southwest Paediatric Club given by Dr Jordan during this period in which he discussed the annual report and the results of paediatric surgery. I think that this was probably in 1986 or 1987/88. I seem to remember that the report was circulated at that meeting. I believe that more than one report was circulated to me at my hospital address but I cannot be certain about this.'

The role of the referring clinician

56 The letters from referring clinicians provide evidence on the factors influencing their referral patterns. However, it should be noted that six referring clinicians expressed the view that it was not part of their role to monitor or assess standards at Bristol or elsewhere. Many made the point that a consultant paediatrician would only rarely expect to see congenital heart defects in their practice.

57 Dr R Prosser:[66]

> 'I do not feel that a General Paediatrician in a District General Hospital is in a position to compare the level of excellence of different Units in the country especially when considering the variety and rarity of some of the conditions and the lack of any specific directive from any other source.'

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[64] Consultant paediatrician, Withybush General Hospital, Haverfordwest, REF 0002 0005 Dr Palit

[65] Consultant paediatrician, Royal United Hospital, Bath, REF 0002 0031 Dr Rudd

[66] Consultant paediatrician, formerly at Royal Gwent Hospital, Newport, REF 0001 0132 Dr Prosser

58 Dr A McNinch:[67]

> ‘I knew of successes and failures but I never formed the opinion that results from Bristol were “poorer than expected” in comparison to those from other units, nor did I feel able to make such a comparison. I do recall the subject being discussed at one of the monthly meetings between the Exeter consultant paediatricians, probably in the early 1990s, one of my colleagues said that he was concerned that some of the results were poorer than he would have expected but I argued that he was in no position to make judgement because the evidence was anecdotal and involved small numbers.’

59 Dr D Stevens:[68]

> ‘We expected, and still expect, regional centres not to differ significantly in the standard of care and results.’

60 Dr N Gilbertson noted that a change in practice had taken place in recent years:[69]

> ‘I would not have seen it as my place as a District General Paediatrician to be overseeing the performance of the regional centre. However, my practice has now changed and I do expect those centres to whom I refer children to provide me with data confirming that their standards of practice are in keeping with national standards.’

Evidence of influences on referral patterns

Relationships with the cardiologists

61 Many (29) of the referring paediatricians stressed that they referred patients to the Bristol cardiologists, and not to the surgeons.

62 Dr Trefor Jones said:

> ‘I think it is important to realise that general paediatricians in district general hospitals require first and foremost, a service of a paediatric cardiologist, not a paediatric cardiac surgeon.’ [70]

63 Dr P Edwards stated:

> ‘The principal linkage for a general paediatrician such as myself in respect of paediatric cardiology services is the Consultant Paediatric Cardiologist, and not the Surgeon. I was, and remain, extremely pleased at the level of service that Dr Martin provided.’[71]

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[67] Consultant paediatrician, Royal Devon and Exeter Hospital, Exeter, REF 0001 0046

[68] Consultant paediatrician, Gloucestershire Royal Hospital, Gloucester, REF 0001 0007

[69] Consultant paediatrician, Royal Cornwall Hospital, Treliske, Truro, REF 0001 0038

[70] REF 0001 0114; letter from Dr Jones

[71] REF 0001 0109; letter from Dr Edwards

64 Thus, the relationship between referring clinicians and the cardiologists at the BRHSC, and the regard in which the cardiologists were held, would appear to have been an important factor influencing referral patterns to Bristol. These links were forged, and strengthened, by the holding of outreach clinics.

65 Dr J Morgan's[72] evidence was typical: the key referral factor for him was the working relationship that he had with the Bristol cardiologist who held a local outreach clinic.

66 The Inquiry received evidence that once the paediatrician had made a referral to a cardiologist, the paediatrician would expect any subsequent referral to a surgeon to be a matter for the cardiologist.

67 An example of this was the evidence of Dr S Ferguson:[73]

> '… the referral for surgery was very much from the Cardiologist and not directly from myself as a general paediatrician. My role was to try and detect heart problems and then ask for a cardiology opinion from Dr Jordan who I might add was perceived here in Newport as a hard working, dedicated, senior clinician who was held in high regard by myself and my colleagues here.'

68 Dr S Lenton's[74] evidence was to the effect that, while any reference to a surgeon was a matter for the cardiologist, the referring paediatrician who referred a patient to a Bristol cardiologist would have been almost certain that in practice, if the patient needed surgery, he or she would be referred on, in turn, to a Bristol surgeon. Dr Lenton said:

> 'Once referred to Bristol for assessment it was automatic that the surgeons would operate in Bristol rather than transferring the child elsewhere.'

69 Commenting on the view expressed by Dr Lenton, Dr Jordan said:

> 'It is over 99 per cent accurate. … I/we did refer patients to other centres. I think the commonest reason was when we had doubts about the diagnosis or the problem of diagnosis together with the actual management, and merely wanted a second opinion, if you like, there were some operations at different times, not very many by the time I retired, that were only done in a few centres. For example, replacing the aortic valve by taking the patient's pulmonary valve and using that, and then putting a homograft in the aortic area. I believe that is now done in Bristol, but it was not, I think, done during my time. So that would be an example of a procedure that was known to be done elsewhere and not available in Bristol. I mean, I can continue. I did actually, I think, make a list of these and I think it ran to about ten possibilities. There were other things. There were social reasons, and I suppose the other important group, really, were the parents who were unhappy with the advice

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[72] Consultant paediatrician, East Glamorgan General Hospital, Mid Glamorgan, REF 0001 0136 – 0138

[73] Consultant paediatrician, Royal Gwent Hospital, Newport, REF 0001 0126 – 0127

[74] Consultant community paediatrician, Bath West Community NHS Trust, Bath, REF 0001 0017

> that they were given, and said, you know, "Can we go and see someone else and see what they have to say about it?"'[75]

Contracts

70 The use of contracts or service agreements, introduced by the 1991 reforms of the NHS, was not in place in the early years of the Inquiry's Terms of Reference. The Inquiry received evidence that the introduction of contracts did have an influence on referral patterns, by making it more difficult for a clinician to refer a patient to a centre other than that with which the contract was held. The evidence included the following comments from referring clinicians.

71 Dr M Quinn:[76]

> 'The Royal Devon and Exeter Healthcare NHS Trust held a contract for paediatric cardiac surgical services with Bristol. This together with the fact that Bristol was the regional centre for cardiac surgical services influenced me to continue to make referrals along this path.'

72 Dr R Orme:[77]

> 'Contracts did, however, make it significantly more difficult to refer patients to other centres, even if one were so minded. This could only be done through the means of an Extra Contractual Referral for which the Health Authority would have to pay. In practice one would have had to have been able to show that the treatment necessary could not have been provided by the Centre holding the contract.'

Geographical convenience

73 Dr C Vulliamy:[78]

> 'Strong links had been established with the Paediatric Cardiologists between North Gwent and Bristol. That was geographically convenient and supported by a well-established retrieval service.'

Supra regional status

74 Some referring clinicians mentioned, and appeared to place reliance on, the fact that Bristol was a designated SRC or NICS.

75 Dr Stevens[79] referred to Bristol being:

> '… approved by the NHS as a regional [*sic*] centre for paediatric cardiac surgery'.

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[75] T79 p. 129–30 Dr Jordan. The issue of referrals elsewhere by Bristol clinicians is dealt with in more detail below

[76] Consultant paediatrician, Royal Devon and Exeter Hospital, Exeter, REF 0001 0058

[77] Consultant paediatrician, Royal Devon and Exeter Healthcare NHS Trust, REF 0001 0056 – 0057

[78] Consultant paediatrician, Breconshire War Memorial Hospital, Powys, REF 0001 0095

[79] Consultant paediatrician, Gloucestershire Royal Hospital, Gloucester, REF 0001 0005

Dr Stevens also made the point that 'no reservations' were expressed either by the SWRHA or the NHS Executive about the standard of paediatric cardiac surgery at Bristol.

Established pattern

76 A theme which recurred in the referring clinicians' correspondence was that they tended, upon taking up a consultant's post, to find that a link between their centre and a cardiologist at a particular unit was already established, such that thereafter they themselves followed the pattern of referral already in place.

77 Dr D Challacombe[80] was typical:

> 'By tradition, children needing cardiac surgery or investigation from West Somerset were referred to cardiologists from Bristol, while those from East Somerset went to Southampton. I continued this tradition in West Somerset as I had no reason to be dissatisfied by the service given to my patients.'

78 Dr S Maguire:[81]

> 'When I came into post in 1991 there was a well established outreach cardiac clinic from Bristol. My clinical colleagues were very satisfied with the service we received and I was also happy therefore we maintained the referrals.'

79 Sometimes clinicians on taking up a new post continued a referral pattern to a particular centre that they themselves had previously developed links with. For example, Dr L Smith[82] told the Inquiry that he saw few children with cardiac problems, but those whom he did see he 'almost exclusively referred to the Brompton Hospital where I had an extensive historical association and knew the service to be of high quality'.

Down's syndrome

80 The Inquiry received evidence from both parents and clinicians that the Bristol centre was regarded as more prepared than at least some other centres to operate on children with Down's syndrome.

81 Dr A Salisbury[83] told the Inquiry that he felt that the Bristol team were 'very sympathetic' to the assessment and surgical treatment of children with Down's syndrome. As a result he referred practically all such cases to Bristol, whereas in general his referrals were split between Bristol and Oxford.

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[80] Consultant paediatrician, Taunton and Somerset Hospital, Taunton, REF 0001 0030

[81] Consultant paediatrician, Royal Gwent Hospital, Newport, REF 0001 0130

[82] Consultant cardiologist, Royal Devon and Exeter Hospital, Exeter, REF 0001 0061

[83] Consultant paediatrician, Princess Margaret Hospital, Swindon, REF 0001 0029

82 Sheila Forsythe, whose son Andrew has Down's syndrome, said:

> 'We actually felt that we were extremely lucky, in that we lived virtually on the hospital doorstep of a regional cardiac centre and we had absolutely no doubts and trusted Dr Joffe and trusted Mr Wisheart implicitly. We did not even think to question where we were being referred to. … I had had contact with a lady who subsequently did actually set up the Down's Heart Group who knew a very global picture of Down's syndrome. She was asking the question, should she or should she not have surgery for her child. She had asked the question in the Down's Syndrome Association national newsletter and had a very wide variety of input from parents. Some was very, very positive and some was very, very negative. Also, at the time, she obviously had contact with families who were not having surgery because they had not been referred by the cardiologists so presumably their children were within the optimum surgical — there was an ability to offer surgery for them, but it was because of the discrimination of the cardiologists in those — there were two centres that we knew of, that children with Down's syndrome were not being referred. So with that, for a quick afternoon, to sort of go out and find out all this, we then had no qualms about having surgery for Andrew.
>
> 'Q. So the picture that you were given was that in some parts of the country Andrew would not have had the offer of surgery?
>
> 'A. That is right.
>
> 'Q. That was the information that you had, that he was being given in Bristol?
>
> 'A. That is right.
>
> 'Q. The reason he might not have been offered elsewhere appeared from the enquiries you were making to be because he was a Down's syndrome child?
>
> 'A. That is right.
>
> 'Q. Was there any sense of hesitation at all in Bristol in offering an operation?
>
> 'A. Absolutely not.
>
> 'Q. Was there any sense, to you, that the Bristol unit treated Down's syndrome children in any different way than they might treat other children?
>
> 'A. Absolutely not.'[84]

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[84] T95 p. 62–4 Sheila Forsythe

The split service/site

83 A number of referring clinicians (six) were aware of some shortcomings at Bristol, related to the split service/site at Bristol. Dr T Perham[85] said:

> '… my impression … is of a somewhat disjointed service which particularly seemed to be the result of problems related to a split site delivery.'

84 Professor J Osborne:[86]

> 'I knew they were operating under difficult circumstances on a split site.'

85 Dr Vulliamy:[87]

> 'I had held the Paediatric Cardiac Surgical Services in Bristol in high regard though I was aware there had been limitations on the type of procedure that would be undertaken. The separation between the BCH and BRI seemed to present some practical difficulties.'

Waiting lists

86 Other referring paediatricians (14) pointed out that referrals would be made to other centres if there was no bed available at Bristol. [88]

87 One, Dr T French,[89] was critical of the waiting list at Bristol:

> 'My only reservation about the paediatric cardiac surgery for children in Bristol was the timeliness of operations for elective, non-emergency treatment. Parents, children and others were disappointed when planned arrangements had to be deferred because of lack of surgical time.'

88 However, Dr A Griffiths told the Inquiry that patients referred to Bristol 'had their surgery within a very acceptable timescale'.[90]

89 Dr P Rowlandson[91] pointed out that delays were not peculiar to Bristol. He explained that, from Swindon, patients were referred to either Bristol or Oxford:

> '… when Oxford had appointed a paediatric cardiac surgeon the choice was still Bristol for many patients because of lack of beds in Oxford. Bristol too often had a problem finding a bed. The whole service seemed chronically under resourced.'

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[85] Consultant paediatrician, Derriford Hospital, Plymouth, REF 0001 0147

[86] Consultant paediatrician, Royal United Hospital, Bath, REF 0001 0021

[87] Consultant paediatrician, Breconshire War Memorial Hospital, Powys, REF 0001 0095

[88] See Chapter 12 for discussion of the waiting list

[89] Consultant paediatrician, Yeovil District Hospital, and Taunton and Somerset Hospital, REF 0001 0032

[90] REF 0001 0128

[91] Consultant paediatrician, Princess Margaret Hospital, Swindon, REF 0001 0036

90 Dr Quinn[92] told the Inquiry:

> 'Children were occasionally referred to centres … to Birmingham and Southampton but only because Bristol was unable to look after them.'

Awareness of standards at Bristol

91 Few of the referring paediatricians told the Inquiry that they knew or had heard anything adverse about standards of care at Bristol.

92 Most referring paediatricians told the Inquiry that their impression was that services at the BRI were satisfactory and that they had no concerns regarding the treatment offered there, except for the comments on the split site, referred to earlier. As noted above, many referring paediatricians formed their impressions without the benefit of hard data about Bristol's relative or absolute performance.

93 Dr J Tyrrell:[93]

> 'I have always felt that we have had an excellent service from the paediatric cardiologists, particularly Dr Joffe … He is an exceptionally kind man who is very skilful and explains problems in details to the patients.'

94 Dr Trefor Jones:[94]

> 'My experience of the Unit at Bristol has always been satisfactory and the children whom I have had under my care, from the years 1984–1995, who underwent paediatric cardiac surgery there have done well.'

95 Dr P Rudd:[95]

> 'It was my impression that the paediatric cardiac surgical service between 1986 and 1995 was of high quality.'

Concerns about standards at Bristol

96 The evidence of seven referring clinicians suggests some were aware of concerns about Bristol, albeit not supported by hard data.

97 Dr R Verrier Jones[96] dated his awareness of such concerns to 'the end of the 80s'. He said that by then '… there were some adverse comments being expressed about Bristol but it was only hearsay'.

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[92] Consultant paediatrician at the Royal Devon and Exeter NHS Trust, Exeter, REF 0001 0059

[93] Consultant paediatrician, Royal United Hospital, Bath, REF 0001 0025

[94] Consultant paediatrician, Princess of Wales Hospital, Bridgend, REF 0001 0114

[95] Consultant paediatrician, Royal United Hospital, Bath, REF 0001 0023

[96] Consultant paediatrician, formerly at Llandough Hospital, Penarth, South Glamorgan, REF 0001 0105

98 Dr J Tripp:[97]

> 'I did raise with my own colleagues and with the Trust Executive the possibility that we should consider transferring the contract from the BRI to Southampton. This was based partly on concerns about surgical results, even though these were based on hearsay rather than on data and partly on the costs which appear to be more favourable at Southampton.'

99 Dr W Forbes:[98]

> 'I knew that Mr Dhasmana had unsuccessfully attempted several switch operations for transposition but not on any of my patients.'

100 Dr G Taylor[99] was one of the few paediatricians to tell the Inquiry that he was aware of rumours in the early 1990s that, as he put it, 'all was not well at Bristol'. He told the Inquiry that he could not recollect the precise source of the rumour, but that it was significant enough for him to discuss with Dr Jordan. Dr Taylor said that he 'received reassurance [i.e. from Dr Jordan] that the situation was under review and that there was no cause for concern'.

101 Dr Jordan was asked about Dr Taylor's evidence. Dr Jordan said:

> 'We used to have sort of what one might call general discussions and I cannot recall Dr Taylor standing out from other paediatricians that I did clinics with as particularly pursuing any sort of discussion of this sort. … All I can say is that we did discuss very generally not only our plans but also our results and to some extent the discussion included a "warts and all" approach to it so it may well be I had actually, you know, talked about things that were of concern to us as well … for example that we still had not, right up to the time that I retired, got the cardiac surgery moved up the road. That is of particular importance to paediatricians because paediatricians are really very keen on the idea that children should be looked after in a paediatric environment.'[100]

102 Asked whether such a 'warts and all' discussion with paediatricians would have included discussion of particular procedures being carried out at Bristol, Dr Jordan said:

> 'I think it would only be if I was specifically asked. Bear in mind that if we are dealing with transposition with intact intraventricular septum … paediatricians … would see one case in every five years or something like that. I do not think it is reasonable to suppose that Dr Taylor specifically had a problem over his patients or indeed from any information that he would have got from what I might call reliable

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[97] Consultant paediatrician, Royal Devon and Exeter Hospital, Exeter, REF 0001 0063

[98] Consultant paediatrician, Swansea, REF 0001 0089

[99] Consultant paediatrician, Royal Cornwall Hospital, Treliske, Truro, REF 0001 0042

[100] T79 p. 142–3 Dr Jordan

> sources. … I think it would be very difficult for a paediatrician to form a view on his own about, for example, what our success rate was in neonatal Arterial Switch operation.’[101]

103 In the light of the evidence of Dr Phillip Hammond[102] in particular, the evidence from Bath paediatricians is of interest.

104 Dr Hammond suggested that unnamed doctors in Bath were aware of the ‘problems’ at Bristol before they reached public attention. He told the Inquiry:

> ‘From sources within the Trust I was told … that the problem was now so grave (in 1992) that I should attempt to alter the referral pattern of the GPs I knew for children with complex heart conditions such that Bristol would be bypassed. This apparently already happened with areas/referring doctors “in the know”.’[103]

105 He also told the Inquiry that, following evidence given to the Inquiry by Miss Catherine Hawkins, *‘Private Eye’* had been contacted by consultants at Bath Royal United Hospital:

> ‘I have since been sent information to *“Private Eye”* anonymously that some of the doctors in Bath did try to raise concerns with Region about the Bristol service, possibly before 1992 …’[104]

106 The Inquiry heard from six paediatricians in Bath.[105] Dr Lenton, who was in Bath throughout the period, told the Inquiry:

> ‘I was only aware that there might be a problem with the cardiac services offered in Bristol due to indirect feedback via SHOs [senior house officers] and specialist registrars who had previously worked in UBHT.’

However, Dr Lenton did not suggest that he had any direct evidence of poor standards at Bristol and told the Inquiry that he ‘had assumed that the … service … was about average’. The only other ‘concerns’ expressed were by Professor Osborne, who was in Bath throughout the period, and Dr Tyrrell who was in Bath from 1992. Both told the Inquiry that they were aware that Bristol had a split site.

107 All six Bath paediatricians confirmed that they referred children to Bristol during the period. Dr Hutchinson, who had been working in Bath from 1991, told the Inquiry that he had ‘no inkling of any problems … At no time did I have any reason to be other than fully confident in the surgery services’.[106] Dr Cain, who had been a consultant

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[101] T79 p. 144–5 Dr Jordan

[102] GP assistant, Keynsham, and columnist ‘MD’ for *‘Private Eye’*

[103] WIT 0283 0004 Dr Hammond

[104] T64 p. 21 Dr Hammond

[105] Dr T Hutchinson (REF 0001 0016), Dr S Lenton (REF 0001 0017 – 0018), Dr ARR Cain (REF 0001 0019), Professor JP Osborne (REF 0001 0020 – 0022), Dr PT Rudd (REF 0001 0023 – 0024) and Dr J Tyrrell (REF 0001 0025 – 0026)

[106] Consultant community paediatrician, Bath West Community NHS Trust, REF 0001 0016

paediatrician at Bath from 1973, said that he ‘had nothing but praise for the service’ and had ‘no reason to refer children other than to Bristol’.[107] Dr Rudd, who was in Bath from 1986, said his impression was that the service at Bristol ‘was of high quality … because we had no concerns about the quality of care being provided in Bristol, this centre seemed to be the obvious choice’.[108]

108 The Bath clinicians also stressed the importance of their relationships with the Bristol cardiologists.

109 Professor Osborne stated:

> ‘I think it is important for background information, to know that I held and hold Dr Joffe in the highest possible esteem as a clinician and as a paediatrician. He is one of the kindest and most compassionate people I know.’[109]

110 Dr Rudd:

> ‘I had close contact with … Dr Joffe. I was impressed with the very high quality of care that he was able to offer.’[110]

111 Dr Tyrrell:

> ‘I have always felt that we have had an excellent service from the paediatric cardiologists, particularly Dr Joffe. … He is an exceptionally kind man who is very skilfull and explains problems in detail to the patients.’[111]

Information provided to parents/choice of treatment centres

112 Mr Wisheart said:

> ‘With regard to the general public there really was no significant channel of communication. Individual patients and their families gained detailed and precise information in the pre-operative discussions with their surgeons and cardiologists. The patient information unit of the Trust made an important contribution to the provision of information to patients, but I do not believe that it made information available about the standards of treatment attained at the BRI. Talks were given to bodies such as the Bristol and South West Children’s Heart Circle and occasionally talks were given at the health centres.’[112]

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[107] Consultant paediatrician, Royal United Hospital, Bath, REF 0001 0019

[108] Consultant paediatrician, Royal United Hospital, Bath, REF 0001 0023 – 0024

[109] REF 0001 0020; letter from Professor Osborne

[110] REF 0001 0024; letter from Dr Rudd

[111] REF 0001 0025; letter from Dr Tyrrell

[112] WIT 0120 0069 – 0070 Mr Wisheart

113 Dr N Agarwal[113] told the Inquiry that:

> 'Parents were always offered the choice, consequently some children were sent to other centres but most accepted the advice and were sent to Bristol.'

114 Eileen Martyr, whose son, Aaron, was referred to Bristol from Treliske Hospital, explained that shortly after his birth she was told that her 'son would be transferred to a hospital in Bristol … There was no suggestion of Aaron going anywhere other than Bristol'. She told the Inquiry of conversations with clinicians in Treliske:

> 'At some stage after our meeting with Mr Wisheart, Dr Taylor made a passing comment that, if Aaron was being treated at Great Ormond Street Hospital, the operation would have been done almost straight away. That stuck in both our minds. We later asked Dr Eades whether she thought it would be a good idea if we paid for the operation privately, and then it would be done straight away. She told us that Mr Wisheart was "the best surgeon in Britain" and that to have the operation done privately would be a waste of money.'[114]

115 One mother, whose child was transferred to Bristol from Gloucestershire Royal Hospital, said:

> 'The possibility of [my child] being dealt with anywhere other than Bristol and by Bristol surgeons was not, at any time, discussed; neither was I concerned about that because I had confidence in Dr Martin and subsequently Dr Dhasmana who would do the operation on [my child] . I believe [my child] was too ill to be moved anyway.'

116 Penelope Plackett, mother of Sophie, said:

> 'I saw Dr Orme in outpatients at the Royal Devon and Exeter Hospital … He told me of a child from the Exeter area who had undergone the same operation and was now living a normal life. He said the results at Bristol were excellent. Although there were "risks" as with any operation, Sophie would have a normal life if she survived. He told me this several times. He did not quantify the risks or specify what they were.'[116]

117 The Inquiry also received evidence from parents who were offered the choice of more than one centre. For example, Justine Eastwood, mother of Oliver, was told at Cheltenham General Hospital that she had a choice:

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[113] Consultant paediatrician, Singleton Hospital, Swansea, REF 0001 0086

[114] WIT 0174 0006 Eileen Martyr

[116] WIT 0012 0003 Penelope Plackett

> ‘The doctor explained to me that Oliver would have to be transferred to a specialist centre. He explained that the hospitals that specialised in heart problems were in Bristol, Birmingham and Oxford. We were told that Oliver could be transferred to any one of these centres and we opted for Bristol because we felt it would be easier for my parents to come and visit Oliver as they could fly into Bristol airport.’[117]

Her evidence included this exchange:

> ‘A. When we were in Cheltenham, because we were in a central position, we had a choice between Birmingham, Oxford or Bristol. We chose Bristol for personal reasons, because the family were travelling over from the Channel Islands, but we were given the choice.
>
> ‘Q. Was anything said to you about why you might prefer one place to other?
>
> ‘A. No, never.
>
> ‘Q. So a choice, but no guidance?
>
> ‘A. No, not at all. I think more choice for travelling. I think that was the reason. We were travelling from Cheltenham, but it certainly was not because one place was better than another. That was definitely never mentioned to us.’[118]

She was asked:

> ‘Q. Do you think you would have reacted well in the 1990s to have been told, “Well, it is Bristol we are sending you to”? Would you have asked, “Well, why there, why not —”
>
> ‘A. There would have been no reason to. As far as we were concerned if we were being sent to a specialised centre, there was no reason to doubt where we were going, or why we were going. All we wanted to do was to get our child to a place where they were going to try to help us. We did not ask those sort of questions.’[119]

118 A parent told the Inquiry that she was offered a choice of centres in theory, but not in practice. She said:

> ‘At Gloucester Royal I was told that no treatment could be carried out there and given the choice of going to the Bristol Royal Infirmary or the John Radcliffe Hospital. John Radcliffe, however, had no beds.’[120]

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[117] WIT 0022 0003 Justine Eastwood

[118] T95 p. 58 Justine Eastwood

[119] T95 p. 61–2 Justine Eastwood

[120] WIT 0520 0001. This parent was one of a number of parents who gave a witness statement to the Inquiry and gave only partial consent to publication of the statement, as they did not wish to be publicly identified

119 Another parent said:

> 'I was told that the Morriston Hospital always transferred its cardiac cases to the London Hospitals, but [the child's] condition was so grave that [the child] was rushed to the Bristol Children's Hospital … We were told that the BCH was a centre of excellence and we were happy with [the child] being taken there.'[121]

Referrals to Bristol – evidence of the actual pattern of referrals from the South West of England

120 Both the cardiologists and the surgeons at Bristol were aware that some paediatricians within the catchment area were not routinely referring all or some of their patients to Bristol.

121 Mr Wisheart told the Inquiry:

> 'Hospitals in the South Western RHA: Plymouth referred nearly all children elsewhere, Yeovil referred a proportion elsewhere. Hospitals in the Wessex RHA: Swindon referred a significant proportion elsewhere. I do not know why … '[122]

122 Dr Jordan said:

> 'Most of the following hospitals either did not routinely refer or only referred a minority of patients to Bristol: Plymouth Hospitals, Yeovil District Hospital, Cardiff Hospitals.'[123]

He explained the referral patterns from Plymouth and Yeovil thus:

> 'I was, of course, aware that paediatricians in Plymouth and one in Yeovil were referring most of their patients to Southampton. The original reasons for this were geographical in the case of Yeovil and historical in relation to both sites, coupled with the fact that the surgical waiting lists in Bristol were longer than elsewhere.'[124]

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[121] WIT 0353 0001. This parent was one of a number of parents who gave a witness statement to the Inquiry and gave only partial consent to publication of the statement, as they did not wish to be publicly identified

[122] WIT 0120 0118 Mr Wisheart

[123] WIT 0099 0035 Dr Jordan

[124] WIT 0099 0037 Dr Jordan

123 Dr Joffe said:

> 'I believe it was an accepted reality that most paediatricians would support the nearest tertiary or specialty unit within their region, if (a) there was one present at their teaching institution, where these units tended to be located, and (b) they were satisfied with the overall management, both cardiological and cardiac surgical that their patients had received from us in the past.'[125]

However, Dr Joffe told the Inquiry:

> 'I have no knowledge of whether clinicians within Bristol's catchment area refer children to centres other than the BRI, except for those in Plymouth who refer their patients to Southampton. This has been the situation from well before my arrival in Bristol in 1980, and continues today despite the transfer of all paediatric open-heart surgery to BCH, and the excellent results being achieved currently. I don't know why, since I have had no dealings with them.'[126]

124 Asked what, in their view, referring clinicians thought of the service at Bristol, Dr Joffe said:

> 'As far as I could judge, the view held … was generally positive and favourable. I cannot recall being confronted by any other clinician in the referring centres with adverse comments or concern about results.'[127]

Dr Jordan said:

> 'I cannot recall during my time as a consultant that any paediatricians in the regions expressed concerns about the service provided. I discussed on several occasions with some of the paediatricians in Plymouth, when *they* raised the issue, the possibility of sending more patients to Bristol. They certainly did not say that they considered the standard in Bristol was deficient. The advice which I gave was that I could not say that the standard of treatment they would receive in Bristol would be better than in other centres to which they were currently referring (notably Southampton) and that as Southampton had no waiting list and Bristol had considerable waiting lists I could see advantages in patients continuing to go to other centres.'[128]

Referrals from Plymouth

125 As noted above, the Bristol clinicians were aware that there were few referrals to Bristol from Plymouth. The Inquiry heard from six Plymouth paediatricians.[129] A number of factors influencing this practice emerged from their letters.

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[125] WIT 0097 0291 Dr Joffe

[126] WIT 0097 0292 Dr Joffe

[127] WIT 0097 0290 Dr Joffe

[128] WIT 0099 0035 Dr Jordan (emphasis in original)

[129] Dr H Baumer (REF 0001 0076 – 0077), Dr AJ Cronin (REF 0001 0078), Dr R Evans (REF 0001 0079 – 0080), Dr RWA Jones (REF 0001 0081 – 0082), Dr P Ward (REF 0001 0084) and Dr TGM Perham (REF 0001 0146 – 0148)

126 Dr Perham,[130] who was appointed at Derriford Hospital in 1972, explained:

> 'You should know historically why Plymouth has had a different service compared to other paediatric centres within the South West peninsula. … in 1972 the consultant paediatricians here … had regular visits from Dr Ronald Gibson, Consultant Cardiologist from the Royal Brompton Hospital, London. Children were referred to his hospital for investigation and paediatric surgery if necessary.'

Dr Perham explained how, on the retirement of Dr Gibson, Plymouth had contact with Dr Barry Keeton who had previously been a senior registrar in paediatric cardiology at the Royal Brompton and had moved to Southampton. Dr Perham explained that:

> 'The [Southampton] unit offered an extremely good clinical, caring service both from the paediatric cardiology medical point of view as well as the surgical point of view. Gradually this became formalised with the team from Southampton undertaking regular joint outpatient appointments with us and these now occur every two weeks. … We therefore had a contact with the Southampton team and very seldom would the children be referred elsewhere …'[131]

127 Professor Sutherland was a cardiologist at Southampton General Hospital from 1983 until 1987. He told the Inquiry that at some time in 1986–1987 Dr Perham contacted his colleague Dr Barry Keeton.

128 Professor Sutherland told the Inquiry:

> '[Dr Perham] expressed concern to Dr Keeton that the surgical results for complex congenital heart disease in the Bristol centre were worrying him and asked if it would be appropriate for the Southwest region to send complex cases to the surgeons in Southampton where the surgical results were documented and appeared substantially better. Dr Keeton discussed the problem with me and we decided to set up a clinical service for the Southwest region … This involved one of us performing a monthly clinic in Plymouth General Hospital and the surgical cases who were complex being subsequently referred to Southampton General Hospital. Dr [Perham] and his other paediatric colleagues wished to continue to support the Bristol centre and continued to send their non-complex cases for surgery there.
>
> 'During 1986 I was personally contacted by Prof. A Henderson … with regard to paediatric cardiology services in Wales. … Prof. Henderson expressed his concerns to me about referring children from Wales to Bristol in view of the poor surgical results in that department. He suggested that it would be appropriate that I offer a service to Cardiff similar to that Dr Keeton and I were offering to Plymouth.'[132]

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[130] Consultant paediatrician, Derriford Hospital, Plymouth, REF 0001 0146

[131] REF 0001 0146 – 0147

[132] REF 0001 0149; letter from Professor Sutherland

129 Dr Keeton responded:

> 'Patients were referred to me from Plymouth starting soon after I was appointed to Southampton in October 1978 as the first paediatric cardiologist in the Wessex Cardiothoracic Centre. I think that, initially, this happened when the Brompton were unable to accept emergency referrals but gradually more and more of the patients came to Southampton. My diary indicates that I visited Plymouth in 1979 and although I cannot be certain precisely when the regular Plymouth clinics performed by Dr George Sutherland and myself started I was certainly visiting to do clinics in 1984 and have been going regularly since then.'[133]

130 Dr Perham referred to a meeting in the early 1980s with the members of the Bristol Unit that he thought was the result of pressures exerted on the Bristol paediatric team by its management to increase paediatric numbers. He said:

> 'I believe the request was management driven but there seemed to be no way that the Bristol surgical unit could cope with increased numbers, particularly from the Plymouth district.' [134]

131 Similarly, Dr A Cronin[135] referred to a long-standing relationship between Plymouth and Southampton (although he also pointed out that the Bristol cardiologists, Dr Jordan and Dr Hayes, saw some children from Plymouth).

132 Dr R Evans[136] confirmed that when she was employed by Plymouth NHS Trust in 1991 she followed the 'established local practice' of referring children to Southampton.

133 Dr P Ward[137] also told the Inquiry that he followed the established Plymouth pattern of referring to Southampton.

134 Dr R Jones[138] thought highly of the Southampton service, and was 'aware of [its] good results'. He told the Inquiry that he thought Bristol was unlikely to be as good. The reason he gave for thinking this was that:

> 'Whilst I was aware that Mr Wisheart had a good reputation, backup surgical services when he was unavailable or on leave were not entirely satisfactory.'

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[133] REF 0001 0152; letter from Dr Keeton

[134] REF 0001 0147; letter from Dr Perham

[135] Consultant paediatrician, Scott Hospital, Plymouth, REF 0001 0078

[136] Consultant community paediatrician, Scott Hospital, Plymouth, REF 0001 0079 – 0080

[137] Consultant paediatrician, Derriford Hospital, Plymouth, REF 0001 0084

[138] Consultant paediatrician, Derriford Hospital, Plymouth, REF 0001 0082

135 Dr C Sainsbury[139] told the Inquiry:

> 'I did become aware that my colleagues in Plymouth chose to refer children to Southampton as their tertiary centre, rather than Bristol. I recall being surprised by this, because of the difficult nature of the journey from Plymouth to Southampton. I do recall discussing this with my colleagues, at South Devon Healthcare Trust … and I remember at the time we agreed the service that we were getting from Bristol seemed to be a good one and I did not see any reason to refer differently to the established practice for South Devon Healthcare.'

Referrals from Yeovil

136 The referral pattern from Yeovil to Southampton also appears to have had a historical explanation. The Inquiry heard from two Yeovil paediatricians.[140]

137 Dr M Webster[141] explained that he worked in Taunton and Yeovil from 1982 to 1991. He said:

> 'At the time of my appointment paediatric cardiological services to each hospital were long established. … The clinics in Taunton were attended by a visiting paediatric cardiologist from Bristol and those in Yeovil by visiting paediatric cardiologists from Southampton. My understanding was that the Yeovil clinics had originally taken place in Dorchester (for which Southampton was the natural referral centre) and although the clinics subsequently transferred to Yeovil, the same arrangements stayed in place.'

138 Dr T French[142] said:

> 'When I was a Yeovil-based doctor I referred all children from that area to Southampton as per existing arrangements.'

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[139] Consultant paediatrician, Torbay Hospital, Torquay, REF 0001 0066 – 0067

[140] Dr TJ French (REF 0001 0032 – 0033) and Dr M Webster (REF 0001 0034 – 0035)

[141] Consultant paediatrician, Taunton and Somerset Hospital, Taunton, REF 0001 0034

[142] Consultant paediatrician, Taunton and Somerset Hospital, Taunton, formerly of Yeovil District Hospital 1982–1991, REF 0001 0033

Referrals to Bristol from South Wales

The catchment area

139 Mr Peter Gregory, Director, NHS Wales, explained why referral patterns from Wales differed by area, and thus why it was essentially South Wales that fell within the Bristol catchment area:

> '… there are quite significantly different patterns of referral, for reasons which obviously spring from geography. The natural connection, socially and economically and in the NHS for North Wales is to the major conurbations in the north west of England and there has been traditionally a significant dependence on Liverpool for this service and Manchester and Liverpool for a variety of tertiary specialist services. Mid-Wales often drains down into Birmingham, although there are connections to the south; and South Wales, at this time, would be dependent … on the significant hospitals in the south of [England].'[143]

140 The South Glamorgan Health Authority's Approval in Principle Submission entitled '*Regional Cardiac Service for Wales*'[144] described the paediatric cardiology clinics available to children resident in Wales in June 1986:

> 'North Wales is served by cardiologists from Liverpool who carry out 22 clinics per year. Clinics are held in Wrexham, Rhyl and Bangor.
>
> 'Mid Wales receives a visit from a cardiologist from Cardiff who performs a clinic in Aberystwyth 4 times a year, seeing mainly adults, but small numbers of older children also.
>
> 'South Wales is served principally by one cardiologist from Cardiff who, in addition to holding weekly paediatric clinics in the University Hospital, performs clinics in Newport (12/year), East Glamorgan (3/year), Camarthen (5/year), Swansea (3/year) and Pontypridd (4/year). In addition, a cardiologist from London performs clinics in Bridgend 5 times per year, seeing patients referred from paediatricians in Bridgend, Swansea, Neath and Pontypridd.'[145]

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[143] T10 p. 9–10 Mr Gregory

[144] South Glamorgan Health Authority's Approval in Principle Submission, '*Regional Cardiac Service for Wales*', is discussed in detail in Chapter 7

[145] WO 0001 0148; South Glamorgan Health Authority's Approval in Principle Submission: '*Regional Cardiac Service for Wales*'

141 The document also identified the patterns of referral to cardiologists in June 1986:

> ‘Gwynedd, Clwyd, Northern Dyfed and Northern Powys: All neonatal and infant emergencies and almost all older children are referred to Liverpool. Small numbers of older children from Northern Dyfed are referred to Cardiff.
>
> ‘Southern Dyfed: Almost all children are referred to Cardiff.
>
> ‘West Glamorgan: Almost all neonatal and infant emergencies are referred directly to London, the majority going to the Hammersmith Hospital and the remainder equally divided between the Brompton Hospital, the National Heart Hospital and Great Ormond Street Hospital. Of the 4 paediatricians in West Glamorgan, 2 refer all their older children to a visiting cardiologist from the Hammersmith Hospital at her Bridgend clinic and 2 refer some older children direct to London but most to Cardiff.
>
> ‘Mid Glamorgan: Most neonatal and infant emergencies are referred directly to London; a small number go to Cardiff. Three of the five paediatricians refer their older children to the Hammersmith cardiologist at Bridgend. The other 2 refer to Cardiff.
>
> ‘South Glamorgan: Almost all neonatal and infant emergencies and older children are referred to Cardiff.
>
> ‘Gwent and Southern Powys: Most neonatal and infant emergencies are referred to Cardiff except when the paediatric cardiologist is unavailable, in which case they are referred to Bristol (very small numbers). Most older children also go to Cardiff apart from those living in the Chepstow area who are referred to Bristol.’[146]

Referrals for surgery were described thus:

> ‘All children requiring cardiac surgery seen by cardiologists in England or visiting from England are referred for surgery to their surgical colleagues in England. Of children requiring surgery referred to Cardiff, two thirds are referred to cardiac surgeons in Cardiff, the remaining third being shared between surgeons at the Brompton Hospital, Harefield Hospital, Great Ormond Street Hospital and the National Heart Hospital.’[147]

142 Professor Crompton told the Inquiry that in his view there had been little immediate impact on referral patterns after the designation of NICS as a SRS in 1984.[148]

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[146] WO 0001 0148 – 0149; South Glamorgan Health Authority’s Approval in Principle Submission: ‘*Regional Cardiac Service for Wales*’

[147] WO 0001 0149

[148] WIT 0070 0002 Professor Crompton

143 Mr Gregory told the Inquiry[149] that he was not aware that referral patterns changed at all between the 1981 Working Party Report[150] and the time when the Approval in Principle document was submitted.

Funding of referrals from Wales

144 Mrs Maclean of the Inquiry Panel asked Mr Angilley about the financing of Welsh referrals to Bristol:

> ‘Q. … To go back to the finance implications, when you were describing clearing the top-slicing procedure with the regions, could you just tell me how that worked out in Wales? Were there different procedures, given that this is an England and Wales thing?
>
> ‘A. I do not think that the money, from recollection — I would need to look at that and come back to you, if I may.’[151]

145 Subsequently, Mr Angilley wrote to the Inquiry in answer to Mrs Maclean’s question:

> ‘Towards the end of my oral evidence to the Inquiry, Mrs Maclean asked a question which I was unable to answer. Her question concerned the procedure by which the Supra Regional Services Advisory Group’s recommendations for top-sliced funding were cleared with Welsh interests. The answer is that the cost of these services were met entirely by the NHS in England, so it was not necessary to clear the funding proposals with the Welsh. I believe that at the inception of the Supra Regional Services, the Department of Health agreed with the Welsh Office that in view of the relatively small number of patients and the bureaucracy involved, it was not worth charging the Welsh NHS for its use of these services. However, the Welsh Office had a standing invitation to send an observer to meetings of the Advisory Group, which they normally did during my time as Secretary. Although their representative was not a voting member, he or she would be free to advise the Group on any issue affecting Wales.’[152]

146 Mr Steven Owen, Administrative Secretary to the SRSAG from January 1992 to February 1996, was asked in oral evidence whether or not the SRSAG took into account the existence (or non-existence) of facilities on the other side of domestic borders when deciding which centres to designate, and if so what were the cross-border funding arrangements. He said:

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[149] T10 p. 42 Mr Gregory

[150] The Working Party was set up in 1979 to report on cardiothoracic services in Wales. It reported in 1981. Its report is considered in detail in Chapter 7

[151] T11 p. 81 Mr Angilley

[152] WIT 0034 0005; letter from Mr Angilley to the Inquiry dated 6 May 1999

> ‘Because of the funding quirk – and I understand Mr Angilley has undertaken to provide a paper on this – essentially there was an understanding and agreement that patients from Wales could be treated in English units without any cross-funding matters being undertaken. That also operated for Scotland, but that is almost by the by. Scotland and Wales were entirely free to provide whatever healthcare facilities they chose for their own patients in whatever infrastructure and formation they decided was best for their patients.’[153]

147 Mrs Maclean questioned Mr Owen further. His evidence included this exchange:

> ‘Q. … Perhaps I might take the opportunity to pursue my enquiries about the impact of the SRS funding mechanism for Wales. I know that Mr Angilley is dealing with this and you may prefer to leave it to him, but to deal with my impatience, can you enlighten me as to the impact of SRS funding for the Welsh Office?
>
> ‘A. There was no impact at all. SRS funding was for the English units, but because of a quirk in the financing system, which will be the subject of a paper Mr Angilley is providing, it was allowed that Welsh residents could be treated in English units without a bill, if you like, going back to the patient’s district of residence in Wales.
>
> ‘Q. So this was a “freebie”, in effect?
>
> ‘A. In effect, yes, that is right.’[154]

Evidence of influences on patterns of referral from South Wales

148 A number of factors appear to have influenced referral patterns from the South Wales catchment area. One event was the establishment of the Paediatric Cardiac Unit in Cardiff in 1991. Before considering the impact of the establishment of this centre, the influences on referrals from South Wales prior to 1991 are considered.

Funding and resources pre-1991

149 In relation to the funding of referrals from Wales, Mr Nix told the Inquiry:

> ‘Bristol and Weston HA also provided paediatric cardiac surgery and cardiology services to South Wales. However, the level of service provision was increasing annually and the Welsh Office wanted to provide a service in Cardiff. In 1987/1988 there were discussions with the Welsh Office about providing Paediatric Cardiac Surgery which did result, because of delays in reaching agreement, in the sending of letters to each Health Authority, stating that services would be restricted if funding for children over 1 year old was not provided. This was because children over 1 year old were not within the Supra Regional remit and were therefore the responsibility of the Health Authorities, whereas, those under 1 year old were the responsibility of the Welsh Office/DHSS. The SWRHA was present at the majority of the meetings and

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[153] T12 p. 13 Mr Owen

[154] T12 p. 114 Mr Owen

> kept informed of discussions. The Welsh Office did, I recall, fund some additional workload as an interim measure with a view to setting up a service in Cardiff.'[155]

150 He stated:

> 'So as to protect the service to the South West, the HA asked the Welsh HAs for money to pay for the increased work for the over 1 year of age group. The Welsh Office was asked for additional money for patients under 1 year old, as this age group was the responsibility of the Welsh Office in a similar way to DoH being responsible for Supra Regional services for the under-1s for England. There were a number of meetings with the Welsh Office (Mr Gregory). …'[156]

151 Mr John Watson[157] told the Inquiry:

> ' … there was an issue in respect of the possible expansion of cardiac services in general, from which there developed serious concern about funding of referrals from South Wales … The history for this was that the paediatric cardiologists would conduct "outreach" clinics in South Wales and would refer cases to Bristol, leaving it to others to sort out the funding for this work. I became involved in referral issues in 1986 when it became apparent that the number of referrals from South Wales to Bristol exceeded the resources available (and by this I mean both finances and staff). … we entered into discussion with the Welsh Office to try to ensure that they were paying for the services that they were receiving. It was felt that we needed to reach agreement with the referring bodies before the situation got out of hand.'[158]

152 Mr Watson continued:

> 'Irrespective of any such processes performed by us as managers, the decision on whether or not to refer a case to Bristol would essentially rest with the clinicians. With this background we had to address a very real problem of lack of funding of the Welsh referrals, to a point where a decision had to be made, probably by the district management team, about whether or not more patients could be taken until the funding position was sorted out.'[159]

153 Mr Watson referred to discussions and correspondence, particularly that passing between himself and the Welsh Office in 1987 in relation to the funding for adult and paediatric cardiology referrals. He referred to a note of a meeting he had with Dr Baker,[160] Miss Stoneham[161] and Mr Nix in May 1987.[162] The note records:

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[155] WIT 0106 0006 – 0007 Mr Nix
[156] WIT 0106 0174 Mr Nix
[157] John Watson, General Manager, Central Unit, B&WDHA from 1986. Chief Executive, Avon FHSA, from March 1990 onwards
[158] WIT 0298 0012 – 0013 Mr Watson
[159] WIT 0298 0013 Mr Watson
[160] Formerly the District Medical Officer for B&WDHA from July 1984 to 1988, and subsequently a consultant in public health medicine for B&DHA from October 1991 onwards
[161] Manager of the Children's and Obstetric Sub Unit from February 1986
[162] UBHT 0062 0299; meeting on 6 May 1987

> 'It was reported by Mr Nix that we have funding for services to adults and children under the age of one year. It was also noted that the expansion to 670 cases per annum excludes the Welsh position, other than Gwent. Mr Nix and Miss Stoneham indicated that they were in the process of ascertaining the maximum number of patients who could be treated within the resources which would be available … It was agreed that it would be necessary to put some constraints upon the medical staff with regard to where referrals could be accepted from if the services were to be maintained within the funds available. Dr Baker agreed to write to the clinicians involved.'

154 Dr Baker wrote to Dr Joffe, Dr Jordan, Mr Wisheart and Mr Dhasmana on 8 May 1987. In the letter he referred to:

> '… considerable uncertainty and confusion over the nature of the cardiological and cardiac surgical response that those in Wales wish to receive. As you may be aware, several London hospitals as well as Southampton, have cardiologists who are active in holding clinics in South and Mid-Wales and referring patients to their own centres for cardiac surgery. Unless the Welsh Office and the constituent authorities decide where they wish to spend their resources and organise the referral patterns through the relevant cardiologist, then we cannot be confident about the volume of service which will be required from our units here in Bristol. If this is not agreed, then we cannot sensibly determine the implications for our services in terms of space and staffing nor can we make appropriate charges upon the Welsh Office or any other DHSS funding source to cover the costs of the service.
>
> '… Until we have formal arrangements with the Welsh Office and individual health authorities, I do not think that we should be undertaking any services to Welsh patients other than to neonates and infants from Gwent Health Authority. Even with Gwent HA we do not have full formal agreements, although I know that the DMO [District Medical Officer] from Gwent is anxious to establish such agreements. This can probably proceed and we can make sure that resources are covered appropriately including travelling time. I am aware that there have been some informal visits to West Glamorgan and Dyfed Health Authorities, but I must advise that until the matters which I have raised above are settled … these unresourced services should not continue.
>
> 'I have been careful to indicate in all my communications that we are most anxious to assist South Wales and the onus is upon them to get their house in order. Unfortunately, I learn that there are mounting political pressures to limit any out of Wales cardiological and cardiac surgical services.'[163]

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[163] UBHT 0092 0002 – 0003; letter from Dr Baker dated 8 May 1987

155 Mr Watson told the Inquiry:

> 'Whilst the assessment throughout 1986/1987/1988 of the disproportionate numbers of referrals to resources was going on, we still got new cases in. Throughout that time, from a management perspective, it remained the view that we could not manage the patients at that continuing rate … the situation at the BRI, with regard to resources and the Welsh issue, continued for some time. It was not until 1989 that funding deals were agreed with the Welsh Office.'[164]

156 In September 1987 Dr Baker wrote to Mr Watson.[165] The letter referred to a forthcoming meeting between the Welsh Office and health authorities in South Wales to discuss cardiac services. Dr Baker asked Mr Watson to assist in preparing an estimate of the service that Bristol could generate in the future. In the letter, Dr Baker wrote:

> 'I have received a request from Dr Skone of South Glamorgan Health Authority to undertake 50 coronary bypass procedures[166] for patients from their health authority. I am aware that our own services have been slowed by the absence of James Wisheart recently, but I realise also that we are trying to progress some cases from our waiting list through facilities in London. Can you advise me whether you wish to entertain any number of these adult cases from South Glamorgan. Regarding our waiting list initiative, I did write to Gerald Keen indicating that he maximises the flow of patients to London during James Wisheart's absence. He has replied indicating that he himself has a very short waiting list, that Mr Dhasmana has referred nine cases, and they await James Wisheart's return for cases to be progressed from his waiting list.'

157 On 2 November 1987 Dr Roylance wrote to Professor Gareth Crompton, Chief Medical Officer for Wales.[167] This letter was centrally concerned with paediatric cardiac referrals from Wales. Dr Roylance wrote:

> 'It seems that until now there has been a somewhat ill-defined and underfunded referral pattern from the Welsh District Health Authorities. Referrals from Gwent Health Authority are part of a recognised supra regional service for infants and neonates and this service is funded appropriately. There are referrals also for children above the age of one and these referrals are not funded. Clinicians in other health authorities in South Wales have been anxious to have the assistance of our cardiologists, Dr Jordan and Dr Joffe and a number of clinics have sprung up in West Glamorgan, East Dyfed and Pembrokeshire Health Authorities which are visited by these cardiologists. The referral pattern which is emerging from these authorities is unfunded presently. Officers of South Glamorgan Health Authority are considering the future pattern of their referrals and the extent to which they may

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[164] WIT 0298 0016 Mr Watson

[165] UBHT 0278 0302; letter dated 8 September 1987

[166] That is on adult patients

[167] UBHT 0062 0354 – 0355; letter dated 2 November 1987

> wish to use services in Bristol. Liaison and any further referral patterns from Mid-Glamorgan Health Authority are uncertain.
>
> 'It is apparent that the current volume of our services has outstripped the resources available for their operation and it has been necessary to redress this situation. It would appear that in 1985 our services were funded adequately and that it is since that year that unfunded growth in the services has taken place. It has been necessary therefore to recognise these facts and to discuss with individual health authorities in South Wales the pattern of referrals that has emerged since 1985, the intention to continue the pattern and the funding required to undertake the service. It is understood that for neonates and infants supra regional funding arrangements can be made between the Welsh Office and the DHSS. Referrals for children in other age groups is not covered by any formal arrangement as for cross boundary flow adjustment. It has been necessary therefore to consider some form of direct charging for services with individual health authorities.'

158 The letter to Professor Crompton enclosed copies of the letters sent to the chief administrative medical officers of DHAs in South Wales[168] on the same day. These letters set out the number of referrals Bristol would accept from each DHA, based on its 1985 figures. In these letters Dr Roylance wrote:

> 'As you are aware, we have been pursuing for some time with the Welsh Office the need to clarify arrangements for the referral from Wales to Bristol of children requiring cardiology or cardiac surgery services. We still seem to be some way from reaching a longer term agreement and are now encountering considerable difficulties because the number of referrals is outstripping the resources available.
>
> 'It is therefore our intention to restrict the number of referrals we can accept to the number of referrals accepted during 1985 when we believe the service was funded adequately, unless arrangements are made regarding funding with those authorities who wish to refer patients in excess of these numbers. Neonatal and infant cardiology and cardiac surgery services can be funded as supra regional services through the Welsh Office and the DHSS directly if future workloads are forecast … On advice from our cardiologists and cardiac surgeons, the rate of admissions and procedures for children (infants in parenthesis) per million total population are as follows: Admissions 150 (65), Catheterisations 75 (35), Closed operations 30 (20), Open operations 35 (12).'

159 Each letter went on to apply these rates to the particular district and to set out the actual number of referrals which would be accepted by Bristol.

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[168] Dr Reynolds, East Dyfed Health Authority (UBHT 0278 0287 – 0288), Dr Skone, South Glamorgan Health Authority (UBHT 0278 0291 – 0292), Dr Harrett, Gwent Health Authority (UBHT 0278 0283 – 0284), Dr R Doyle, Pembrokeshire Health Authority (UBHT 0278 0285 – 0286), Dr Hughes, Mid Glamorgan Health Authority (UBHT 0278 0293 – 0294), and Dr Littlepage, West Glamorgan Health Authority (UBHT 0278 0289 – 0290)

160 The letters concluded:

> 'I regret having to pursue this type of approach whilst being aware that this matter is under active discussion at the Welsh Office with professional staff in Wales. It is certainly not our intention to put undue pressure on those who have the difficult task of finding the longer term solutions to the problem. However, in common with many other health authorities, we are faced with ever increasing demands within a relatively static resource base. The inevitable consequences of allowing continued development of unfunded work from outside the region is to produce a deleterious effect on the services we can provide to the population in our own district.'

161 In December 1987 Mr Watson wrote to Mr Dhasmana, Mr Wisheart, Dr Joffe and Dr Jordan, enclosing a copy of a draft letter he intended sending to the Welsh Office regarding referrals.[169] In the letter he stated:

> 'Since we met and discussed this subject, various attempts have been made to make progress and I feel that this firmer action is needed. Hopefully, it will be possible to meet representatives from Wales early in the New Year and reach some agreement on funding.'

162 That month Dr Roylance wrote to Mr Owen, Director of the NHS in Wales:[170]

> 'As you are no doubt aware, on 2 November 1987 I wrote to Dr Crompton, Chief Medical Officer for Wales, regarding children's cardiology and cardiac surgery services for Wales. I understand that this matter has now been referred to yourself. Since that time we have not received a clear response from yourself and, unfortunately, the situation within this district is becoming increasingly difficult and it is therefore necessary to take some action on the matter. We have now decided that as from 1 February 1988 we are unable to receive any new patients aged over 1 year from Wales. I should emphasise that although no new cases in this category can be accepted until agreement on appropriate funding is reached, I would anticipate that in the case of children under the age of 1 year there should not be difficulty with reaching agreement via the DHSS for supra regional funding.'

163 In January 1988 Dr Baker wrote to Mr Watson,[171] enclosing correspondence from Mr Gregory[172] and Professor Crompton:[173]

> 'Our conclusion might be that the Welsh like writing letters and find it difficult to make decisions. … There seems to be some confusion about their future plans in so far as they talk of a new paediatric cardiac unit to be built in Cardiff with work expected to begin in 1988 whilst Dr [Professor] Crompton's letter indicates that

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[169] UBHT 0165 0019; letter dated 22 December 1987
[170] UBHT 0165 0020; letter dated 18 December 1987
[171] UBHT 0062 0384; letter dated 11 January 1988
[172] UBHT 0278 0268 – 0269; letter dated 23 December 1987
[173] UBHT 0278 0270 – 0271; letter dated 15 December 1987

> there is still some uncertainty as to the nature of this unit and where it will be located … In spite of the Welsh efforts to reassure us I am sure that you will feel that we are still dealing with under funded over referrals of Welsh cases to BCH/BRI and I would have thought there were grounds for proceeding with the letter we composed for John Roylance.'

164 Of this correspondence Mr Watson said:

> 'It can be seen here that Dr Ian Baker was recommending in January 1988 that we should stick to our guns in terms of limiting the referrals. The clinicians would have been generally unhappy about this as they were looking to expand the Department. There was discussion with the cardiologists who had direct input … naturally they were quite frustrated as they simply wanted to treat the patients.'[174]

165 Negotiations with the Welsh Office continued during 1988. It was during this period that paediatricians in West Glamorgan approached Dr Joffe to take over an 'outreach' clinic at Bridgend previously undertaken by Dr Hallidie-Smith. Dr Baker wrote to Dr Mason, SWRHA Regional Medical Officer:[175]

> 'The facility with which the Welsh Office and its health authorities serve their populations with English based cardiologists is amazing. John Watson however, the Unit General Manager responsible for cardiac services here feels that whatever is agreeable on the professional networks must have the agreement of the Managers concerned. His position as stated previously is one of wishing to curtail all services to South Wales until he is compensated appropriately for the services he renders. … matters are clearly getting worse rather than better.'

166 In July 1989 Mr Watson wrote to Mr Gregory.[176] The letter, headed 'Cardiac Services for Wales – Children Over 1 Year', confirmed that agreement had been reached for funding referrals for the year commencing 1 April 1989, with discussions for funding for the following year planned to take place in December 1989. The letter recorded:

> 'Based on advice from our cardiologists and surgeons, the expected total referrals is 75 cases. The basis of the charge will be the number of cases over 28.'

1991 onwards

167 The Paediatric Cardiac Unit at University Hospital Wales, Cardiff, admitted its first patients in June 1991.[177] Once the Cardiff unit was established, the Welsh Office sought to encourage referrals to it. Professor Crompton told the Inquiry:

> '… the most important factor from 1991 on in Cardiff was the huge commitment of time that the paediatric cardiologist, with support from the others in his team, made

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[174] WIT 0298 0016 Mr Watson
[175] UBHT 0278 0174; letter dated 18 October 1988
[176] UBHT 0103 0045; letter dated 20 July 1989
[177] WIT 0058 0008 Mr Gregory

> in the visiting and the revisiting, and the persistent seeking of trying to influence the District General Hospital paediatricians in Wales to give the Cardiff centre a chance to show what it could do, if I can put it like that. They were very assiduous in doing that.'[178]

168 Once the Cardiff unit was established, the Welsh Office ceased to fund centrally the referral of paediatric cardiac cases to Bristol. Mr R Williams, Assistant Director, Health Services Division, Welsh Office, outlined this change of policy in a letter to the general managers of East Dyfed, Gwent, Powys and Mid, South and West Glamorgan Health Authorities:

> 'Since the new paediatric cardiac unit at UHW will be centrally funded to provide a service throughout South and Mid Wales, it is proposed that central funds will cease to be available for the referral of new patients to Bristol and Weston Health Authority for paediatric cardiac services once the paediatric cardiac unit at UHW becomes operational. It would, therefore, fall to individual health authorities wishing to continue with current arrangements to contract with, and fund from their own resources, Bristol and Weston Health Authority in respect of any new patients referred to that Authority once the paediatric cardiac unit at UHW comes into operation.'[179]

169 Mr Gregory told the Inquiry:

> 'In February 1991, the Welsh Office wrote to the six relevant South and Mid Wales Health Authorities advising them of the arrangements which would apply to the central funding of paediatric cardiac services, and to seek advice in quantifying continuing reliance on Bristol in financial year 1991/92.'[180]

Referral to cardiologists

170 The Inquiry heard evidence that referrals to Bristol increased in the period to 1991, and that the establishment of the Cardiff unit in 1991 did not lead to all patients within its catchment area in South Wales thereafter being referred to it.

171 As with the referrals from the South West of England, the Inquiry heard evidence that the contact between referring paediatricians and cardiologists was a key influence on the pattern of referrals. Both during the period 1984 to 1991 and afterwards, relationships between paediatricians and cardiologists were a significant influence on referral patterns from South Wales.

172 Mr Gregory said: '… up to the present day, there are referrals out of Wales of children who, when the unit was fully operative, could, but for clinical preference, have been treated in Cardiff'.[181]

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[178] T21 p. 16–17 Professor Crompton

[179] UBHT 0194 0010; letter from Mr Williams dated 26 February 1991

[180] WIT 0058 0008 Mr Gregory

[181] T10 p. 50–1 Mr Gregory

173 Mr Gregory told the Inquiry that a change in referral patterns occurred in 1987, because:

> ‘a) The premature death towards the end of 1986 of Dr Leslie Davies, the well respected cardiologist who saw the vast majority of the young patients referred to the Cardiff centre in what was largely an adult cardiac practice, created a crisis in the local service in South Wales.
>
> ‘b) The specialties of cardiology and cardiac surgery in the UK by this time were noticeably understaffed to meet the demands of the population for treatment … The London Centres, in particular, found it less easy to accommodate the Welsh referrals within desirable timescales for treatment.’[182]

174 Professor Crompton explained how referring paediatricians in Wales responded:

> ‘Welsh paediatricians responded by arranging for additional visits by other cardiologists to their hospitals and we see Bristol and Southampton based clinicians visited South Wales on a regular basis. Whilst patients from the Royal Gwent Hospital, Newport and Nevill Hall Hospital at Abergavenny had traditionally referred to Bristol, we now see others, but not all in South Wales using the Bristol centre.’[183]

175 Mr Gregory was asked for his views as to why children from South Wales were referred to London hospitals. His evidence included this exchange:

> ‘Q. For what reasons do you understand children were referred to Brompton, the National Heart Hospital or Great Ormond Street?
>
> ‘A. Because those were the hospitals with which the referring paediatricians had established relations. The Inquiry will know that can be for a variety of reasons. As a consequence, there was an established pattern of referral. At that time, the pattern of referral, once established and once regarded as satisfactory, is likely to be retained. Indeed, the patterns of referrals to England throughout the period with which the Inquiry is concerned, indeed, up to the present day, are agnostic of the establishment of a specialist service if the clinician concerned believes it is in the best interests of the child they be referred elsewhere. Even when the Cardiff unit was up and fully functioning as a comprehensive unit, children were still referred to centres in England. So it comes back to an issue of the clinical preference of the referring clinician.

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[182] WIT 0070 0002 Professor Crompton

[183] WIT 0070 0002 Professor Crompton

> ‘Q. The clinical preference, the way you describe it, your understanding would be very much influenced by habit and personal relationships?
>
> ‘A. I think those are factors. I think in this case we are talking about London hospitals with significant reputations for providing specialist services of this kind, which at that stage were not available in a comparable specialist service in Wales. So the logic of that would be that clinicians, for the reasons you have described, but also for the reasons I have referred to, would be looking to England to provide the service.’[184]

Evidence of the actual pattern of referrals from South Wales

176 Dr Jordan confirmed that, in a number of places in Wales, Dr Hallidie-Smith had conducted clinics from the Hammersmith Hospital and that on her retirement Bristol took over a number of her clinics. He said: ‘I think particularly one that I dealt with in the East Glamorgan General Hospital’.[185] As to the clinics run by Dr Leslie Davies, he said that Bristol started to pick up some of his work ‘before Dr Davies’ death, because what there was of paediatric cardiac surgery at that time in Cardiff had stopped before then’.[186]

177 Dr Agarwal[187] told the Inquiry:

> ‘When I joined Swansea in 1976, the paediatric cardiac service was far from satisfactory. Children with cardiac problems were either referred to Cardiff or hospitals in London … The follow-up of these children locally was often lost. Initially I persuaded Professor Muir and later Dr LG Davies from Cardiff to hold joint cardiac clinics with us in Swansea but because of lack of neonatal cardiac surgery in Cardiff, the situation was still not satisfactory.’

Dr Agarwal went on to explain how, in 1982 or 1983 at the suggestion of a colleague, he transferred a premature infant to the BRHSC. He said:

> ‘Until this time, to my knowledge no paediatric cardiac patients had been sent to Bristol, however from this time onwards myself and my colleagues in Swansea started to send children … to Bristol cardiologists. … After the death of Dr LG Davies … I persuaded Dr Hyam Joffe … to hold regular clinics with us in Swansea starting some time in 1986.’[188]

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[184] T10 p. 14–15 Mr Gregory

[185] T79 p. 134 Dr Jordan

[186] T79 p. 134 Dr Jordan

[187] Consultant paediatrician, Singleton Hospital, Swansea

[188] REF 0001 0085; letter from Dr Agarwal

178 Dr Dewi Evans,[189] who was appointed at Swansea in 1980, did alter his referral pattern when the Cardiff unit became operational in 1991. He told the Inquiry:

> '… the services in Swansea were very ad hoc at that time [in 1980]. I arranged a link with the Hammersmith Hospital, with the late Dr Hallidie-Smith. As she came up to retirement I established links with Dr Hyam Joffe in Bristol. … about 1985 I transferred my allegiance to the cardiac team in Cardiff when it was formed in 1991.'

Dr Evans said that whilst Dr Agarwal continued to refer all his patients to Dr Joffe until his retirement, Dr Evans began to refer to Cardiff 'for reasons of expediency and practicality'.

179 Dr Palit of Haverfordwest[190] started to refer to Bristol when Dr Davies died. The reason for choosing Bristol was geographic. Dr Palit told the Inquiry that he 'started a joint clinic in paediatric cardiology with the late Dr LG Davies from Cardiff, who used to visit Dyfed periodically … he would then refer the patients further away for surgery … [The] decision to send our children to Bristol was very easy because there was no other centre nearby us, who could give us a regular service.' After the death of Dr Davies, Dr Palit approached Dr Jordan and then had 'no cause to refer children with heart problems elsewhere' until Dr Jordan retired.

180 However, Dr Palit's colleague, Dr G Vas Falcao,[191] told the Inquiry that 'During this period all paediatric cardiac problems from Pembrokeshire were referred to the paediatric cardiac unit at University Hospital of Wales'.

181 Dr I Hodges[192] explained that in Mid Glamorgan, children's cardiological services were, at the beginning of the period of the Inquiry's Terms of Reference, provided by Dr Hallidie-Smith. Subsequently, referrals were to Dr Jordan until his retirement, and then to Cardiff.

182 Dr Hodges' colleague, Dr J Morgan, said that when he started practice in 1981 'children with cardiac problems were referred to the Hammersmith Hospital in London. Dr K Hallidie-Smith came down to Wales three times a year.' Any child needing ultrasound had to go to London, and any surgery was carried out at Hammersmith or Great Ormond Street.

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[189] Consultant paediatrician, Singleton Hospital, Swansea, REF 0001 0087 – 0088

[190] Consultant paediatrician, Withybush General Hospital, Haverfordwest, REF 0001 0092 – 0093

[191] Consultant paediatrician, Withybush General Hospital, Haverfordwest, REF 0001 0094

[192] Consultant paediatrician, East Glamorgan General Hospital, Mid Glamorgan, REF 0001 0096 – 0097

183 Dr Morgan's evidence was that by 1989:

> '… there were difficulties with continuing this service and negotiations between Bristol and Mid Glamorgan Health Authority resulted in cardiac services both medical and surgical being transferred to Bristol. … The service that was then established from Bristol consisted of a very senior paediatric cardiologist, Dr Stephen Jordan who came to our hospital on a much more frequent basis. He was able to perform ultrasound cardiac scans as part of his clinic with us and this was very much appreciated by parents as they no longer had to go up to London for this investigation. … When Dr Jordan retired, a cardiac service was being developed in Cardiff and the care of our patients were transferred to this service …'[193]

184 Dr A Griffiths[194] of Abergavenny was appointed in 1969. He told the Inquiry:

> '… initially our cardiac patients were referred to the teaching centre at Cardiff. In those days there was no paediatric cardiologist on the staff but the children were referred to Dr Leslie Davies who was an adult cardiologist. From the surgical point of view however this service became gradually more unacceptable, children being left on the waiting list for very long periods of time and eventually Dr Davies retired. … therefore we contacted the Bristol team and their paediatric cardiologists would come out and run a combined cardiac clinic with us. … The service for children with cardiac problems improved dramatically.'

185 This was confirmed by Dr Griffiths' colleague Dr T Williams[195] who was appointed in 1986, and who told the Inquiry:

> '… in 1986 we had an inadequate service from Cardiff. We made contact with Bristol and have continued with their support since that time. Establishing the service led to a considerable improvement in the quality of care given to our local children…'[196]

186 Dr Edwards[197] said that from 1979 he referred to the Hammersmith and Dr Hallidie-Smith:

> 'When Dr Hallidie-Smith retired in mid 1980s there was still not a fully functioning cardiac unit at Cardiff. … We were also aware of the fact that peripheral clinics had been established from Bristol, mainly by Dr Jordan, in many hospitals in South Wales, with Consultant General Paediatricians being very pleased with the level of service that they were receiving, both from the local clinics and from Bristol itself.

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[193] REF 0001 0136 – 0137; letter from Dr Morgan

[194] Consultant paediatrician, Nevill Hall Hospital, Abergavenny, REF 0001 0128 – 0129

[195] Consultant paediatrician, Nevill Hall Hospital, Abergavenny, REF 0001 0133

[196] REF 0001 0133; letter from Dr Williams

[197] Consultant paediatrician, Princess of Wales Hospital, Bridgend, REF 0001 0108

> For these two reasons therefore … we decided to link in with Bristol and established a pattern whereby bi-monthly clinics were held locally…'

187 His colleague, Dr Trefor Jones,[198] provided the Inquiry with a copy of a report prepared by him and Dr Edwards and Dr A Goodwin in November 1996[199], confirming that they had referred to Dr Hallidie-Smith until her retirement, and thereafter to Dr Joffe, and then to Dr Martin.

188 Dr Ferguson[200] wrote:

> 'I don't recall referring any patients with heart problems to centres other than BRI again for the reason that the referrals were always invariably made through the visiting cardiologist, Dr Steve Jordan, who was based there.'[201]

189 Not all paediatricians who changed their referral pattern from Bristol to Cardiff as a result of the establishment of the unit in Cardiff or the later retirement of Dr Jordan were entirely happy to do so.

190 Dr Prosser[202] told the Inquiry:

> '… from the opening of the first Severn Bridge in 1966, with the support of Dr LG Davies, Cardiologist at the University Hospital Wales, we started referring neonates and other small infants to paediatric cardiology services in Bristol. This was done because of the proximity of the Unit to the Royal Gwent and that as far as we were able to ascertain the services there were equal to those of other centres in the UK. … Following the death of Dr Davies we decided to ask Dr S Jordan to take over our monthly paediatric cardiology clinic … and our association with Bristol was strengthened. … Even with the establishment of the Paediatric Cardiology Unit in Cardiff in 1990 or thereabouts I and my colleagues were reluctant to give up our association with Bristol and were more or less forced to do so by the financial constraints imposed on us by the Welsh Office.'

191 Dr Maguire[203] spoke of a change in the pattern in 1993:

> 'We changed our cardiac services from Bristol to UHW on the basis of a desire by Welsh Office to have the Welsh units using the newly developed paediatric cardiac services in Cardiff …'

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[198] Consultant paediatrician, Princess of Wales Hospital, Bridgend, REF 0001 0114 – 0115

[199] REF 0001 0116 – 0121; *'A Review of the Provision of Paediatric Cardiology at Bridgend',* dated November 1996

[200] Consultant paediatrician, Royal Gwent Hospital, Newport, REF 0001 0126 – 0127

[201] REF 0001 0126; letter from Dr Ferguson

[202] Consultant paediatrician, formerly at Royal Gwent Hospital, Newport, REF 0001 0131 – 0132

[203] Consultant paediatrician, Royal Gwent Hospital, Newport, REF 0001 0130

192 Dr Cawdrey[204] commented on the situation following the death of Dr Davies, who had previously carried out a clinic at the Royal Gwent Hospital. Dr Cawdrey wrote:

> 'Dr Steve Jordan started a regular clinic with us from that time. … Therefore, from this time, all children and babies with heart problems were seen by Dr Jordan and consequently most if not all of those requiring surgery received this in Bristol. In 1991, a full paediatric cardiology and cardiac surgery service was established in Cardiff. As we understood at the time the reasons for doing this were largely "political". It was felt that establishing such a service would enhance general cardiology training in Cardiff, but there was also considerable public pressure to establish a unit in Wales so that children in Wales would no longer need to travel "abroad" for their treatment! We in Newport saw no reason to change our arrangements immediately and continued to use Bristol until the spring of 1993, when Dr Jordan retired, and we thought it opportune and more convenient to switch to Cardiff for paediatric cardiology and paediatric cardiac surgery ...'

193 Dr Jordan commented on the letter:

> 'I think Dr Cawdrey at that time was Chairman or President of the Welsh Paediatric Association and they were the people who had – well, some of them had at least supported the idea of having a new unit in Cardiff. We discussed this. I think he admitted to a certain amount of embarrassment that he was still sending his patients to Bristol when in theory the body of which he was the Chairman or the President had apparently supported the establishment in Cardiff.'[205]

194 Dr J Matthes,[206] however, told the Inquiry that she had been a senior registrar in Cardiff and, on appointment as consultant in 1993, wished to transfer the list that she inherited to Cardiff. She said that Dr Joffe 'resisted this … I was told that the Bristol cardiologists felt that it was not in the patients' interests to transfer them to Cardiff as some of them had quite complex conditions. At no time was it ever intimated to me that there might be poorer results with the surgery at Bristol than at other centres.' Her patients continued to be treated in Bristol.

Concerns[207]

195 Some (five out of 27) referring paediatricians in Wales cited concerns about the standard of care at Bristol as a factor influencing their referral pattern.

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[204] Consultant paediatrician, Royal Gwent Hospital, Newport, REF 0001 0123

[205] T79 p. 133 Dr Jordan

[206] Clinical Director, Paediatrics, Singleton Hospital, Swansea, REF 0001 0090

[207] Concerns are set out in detail in Chapters 20–30. The extent to which any concerns of referring paediatricians may have influenced their referral patterns is set out here for completeness

196 Professor I Hughes[208] told the Inquiry:

> ‘I had formed an impression that the service for complex cardiac cases was less than satisfactory if only on the basis that the pattern of referral of any cases from Cardiff utilised centres other than Bristol … That transportation of cases to Southampton which would have travelled past Bristol is illustrative of the concern prevalent at that time regarding services in Bristol.’

197 Dr C Weaver[209] said:

> ‘My patients were mainly referred to GOS [Great Ormond Street Hospital] or to Southampton; personal acquaintance with a cardiologist in London was part of the reason for the referral pattern … I do have one recollection of a rather unsatisfactory post-operative arrangement when a baby needed emergency admission on my “intake”, who had recently undergone cardiac surgery in Bristol … Even after telephone discussion (I believe with Mr Wisheart) there seemed to be a certain lack of support and interest.’

Parents’ requests

198 Evidence from Welsh-based parents whose children were referred to Bristol reflected the same issues as mentioned earlier in the case of parents based in England.

199 Samantha Harris, whose daughter Kimberley was referred from the Princess of Wales Hospital, Bridgend, to Bristol, said:

> ‘The staff informed me that they had decided to transfer Kimberley to Bristol, in an ambulance, since there was a specialist heart unit there. I was not very pleased that this hospital had been selected, since it would have been much easier for me to go to London, where I have relatives. I also knew that hospitals such as Great Ormond Street had an excellent reputation, whereas I had never heard of the unit at Bristol before. … At no time was it explained to me that I had any choice in the matter …’[210]

200 Robert Briggs, whose daughter Laura was also referred from the Princess of Wales Hospital, Bridgend, to Bristol, said:

> ‘It was the Consultant’s decision to refer her to Bristol, and no alternative referrals were discussed with us, but we had no problems with that decision either at the time or at any subsequent time. We were simply told that it was the nearest hospital that dealt with children with severe heart problems.’[211]

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[208] Professor of Paediatrics, Cambridge, formerly Department of Child Health, Cardiff, REF 0001 0100 – 0101

[209] Consultant paediatrician, formerly at University Hospital of Wales, Cardiff, REF 0001 0106 – 0107

[210] WIT 0302 0004 Samantha Harris

[211] WIT 0136 0002 Robert Briggs

201 Carol Colclough, whose son Andrew was referred to Bristol from the Royal Gwent Hospital, Newport, said:

> 'Mr Ferguson [Dr Ferguson][212] recommended that Andrew be referred to Bristol for specialist attention and consideration for surgery. He recommended Bristol, and at that time there was no other specialist centre in South Wales. Later in 1991 a Specialist Unit was opened at the Heath Hospital in Cardiff but that option did not exist for us at the time and we were content enough to go to Bristol to get the necessary treatment. No other alternatives, such as London, were mentioned to us, but Mr Ferguson seemed very happy with Bristol, and we were content to go along with his recommendation.'[213]

202 Gail Booth, whose daughter Elisa was referred to Bristol from the Royal Gwent Hospital, Newport, said:

> '… they thought she may have a problem with her heart and that she would be transferred to Bristol. The staff told me that Bristol was one of the best heart hospitals in the whole country.'[214]

203 A parent explained that her child was referred from Neath General Hospital to Hammersmith. However, she said:

> 'When Dr Hallidie-Smith retired, [the child] was referred from Hammersmith Hospital to Bristol Children's Hospital. We were simply notified that this was what was to happen.'[215]

204 Some parents were given a choice, together with an opinion from the paediatrician as to the respective standards of the alternative centres. Caroline Jones, mother of Matthew, said that Dr Palit saw him at Withybush Hospital, Haverfordwest:

> 'He gave us the choice of sending Matthew either to Bristol or to Great Ormond Street Hospital in London. Dr Palit told us that the unit at Bristol had a good reputation and was on a par with Great Ormond Street. Because of this recommendation, and because Bristol is nearer, we chose Bristol.'[216]

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[212] Consultant paediatrician, Royal Gwent Hospital, Newport

[213] WIT 0176 0002 Carol Colclough

[214] WIT 0410 0001 Gail Booth

[215] WIT 0216 0003. This parent was one of a number of parents who gave a witness statement to the Inquiry and gave only partial consent to publication of the statement, as they did not wish to be publicly identified

[216] WIT 0238 0002 – 0003 Caroline Jones

Referrals to other centres by Bristol cardiologists and surgeons

Referral procedure and reasons for referral

205 The Inquiry heard evidence from the Bristol cardiologists and surgeons about the nature and extent of referrals to centres other than Bristol.

206 Dr Joffe explained the procedure once a child had been investigated by the Bristol cardiologists:

> 'If the cardiologist considers that surgery may be indicated, the results of investigative procedures are reviewed at a joint cardiology/cardiac surgical/radiological meeting.'[217]

He told the Inquiry:[218]

> 'It was, and still is, up to the paediatric cardiologists and cardiac surgeons together to determine the best course of action for each individual child.'

207 Dr Jordan told the Inquiry that he referred patients elsewhere:

> '... usually for one or more of the following main reasons:
>
> - 'There was a surgeon able to offer an operation that was not available in Bristol. This included, at different times, the Rastelli operation, arterial switch (Magdi Yacoub), Fontan operation (Brompton and GOS), autograft aortic valve replacement (Donald Ross) and heart or heart-lung transplantation (Harefield Hospital).
> - 'A surgeon or a team had shown a particular interest in the management of an unusual condition such as ventricular septal defect with prolapsing aortic valve cusp (Donald Ross and Jane Somerville at the National Heart Hospital).
> - 'Parents requested such a referral either because it was more convenient (e.g. they had relatives with whom they could stay in London) or had some other association, such as a relative or godparent who was a cardiac surgeon.
> - 'I or my colleagues were uncertain about the actual diagnosis, such as differentiating aorto-left ventricular tunnel from sinus of valsava aneurysm.

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[217] WIT 0097 0164 Dr Joffe

[218] WIT 0097 0292 Dr Joffe

- ‘I or my colleagues were uncertain as to the correct procedure and we wanted a “second opinion”.
- ‘Parents requested a “second opinion”, usually because they were uncertain as to the need for surgery or were unhappy with the risk that they had been given by the surgeon.
- ‘Parents where a previous child had been operated on in Bristol and had died, in which case I always offered to send the child elsewhere.
- ‘When surgery had previously been carried out by another surgeon and the patient had moved into the area (or we had taken over an area formerly served by another unit). Not all parents wished to be referred back to the original surgeon.’[219]

208 Asked on what basis a unit would be chosen for a referral, Dr Joffe said:

> ‘A variety of reasons, including a personal connection between someone who had trained, let us say, at the Brompton, knew the surgeon and knew he did an operation particularly well; the overall perception that cardiologists, as a group, would have of a particular unit’s performance on another condition. The relationship between one surgeon and another, because these cases would be referred either by the cardiologists or after our joint meetings, by a cardiac surgeon, with whoever he or she, in this case he, was referring that patient to. So it is a variety of reasons, but I think, as you will see at that time, it was mostly Great Ormond Street, sometimes the Brompton, but later on Birmingham.’[220]

209 Dr Jordan acknowledged the comparatively short waiting list at Southampton, but explained why he would not have referred patients from Bristol there. His evidence included this exchange:

> ‘Q. Southampton, if I have understood it correctly, had no or very short waiting lists compared to Bristol?
>
> ‘A. The information I was given by the paediatricians in Plymouth was if a patient was seen by one of their paediatric cardiologists in outpatients, requiring a catheter and presumably an operation, they will be admitted within about three weeks for the catheter and they will have their operation next week. That is what they described to me as being a typical situation. Whether, you know, it always quite worked like that, I cannot say, but that was the information given to me.

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[219] WIT 0099 0037 Dr Jordan

[220] T90 p. 52 Dr Joffe

> ‘Q. And that was about this sort of time, three years or thereabouts before your retirement?
>
> ‘A. Yes. We had this discussion on odd occasions, but, yes, I mean, there was certainly a discussion about 1989/90, something like that.
>
> ‘Q. So were the Bristol children who were facing the long waiting list at Bristol referred to Southampton where there were very short waiting lists?
>
> ‘A. … No, they were not.
>
> ‘Q. Would that not have been a more sensible way of proceeding?
>
> ‘A. It is like all of these things: it is sensible in that it deals with the immediate problem. What then happens when Southampton builds up a waiting list because they have been sent twice as many patients as they can cope with?
>
> ‘Q. What would be the bars, the disincentives for you and Dr Joffe in sending a patient to Southampton, say?
>
> ‘A. Can I say, I have absolutely no criticisms of the surgery in Southampton, so let us get that out of the way. That is not a bar. Firstly, it would almost inevitably mean a longer journey for the patients and their parents. Secondly, there would then be problems of communication between the surgeons there and the patients: where do they follow them up? If it was a patient who came from Haverfordwest in South Wales, they would not want to be sending one of their teams out to Haverfordwest just to see one or two patients. There were those sort of logistic problems, basically, that it seemed to us desirable to avoid, if they could be avoided. Having said that, I did refer patients not to Southampton but to other hospitals for specific reasons, and obviously we had to make the best that we could of those particular objections.’[221]

210 Mr Dhasmana and Mr Wisheart gave evidence to the Inquiry about the circumstances in which a child might be referred to another centre for surgery. They identified Great Ormond Street, Harefield, the National Heart Hospital, the Royal Brompton Hospital and Birmingham as centres for such referrals. Mr Dhasmana told the Inquiry that such decisions were made in conjunction with the cardiologists and others, usually in joint meetings held on Mondays at the BRHSC. Mr Wisheart acknowledged that there might have been referrals elsewhere by the cardiologists about which he had not been told.

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[221] T79 p. 89–91 Dr Jordan

211 Mr Dhasmana said that a record of these referrals would usually be kept at the BRHSC with the cardiologists, and provided a list[222] produced by Dr Joffe illustrating referrals to other centres between 1992 and 1994. Mr Dhasmana added: 'There were similar patterns of referrals before 1992.'

212 Mr Wisheart told the Inquiry:

> 'There were always a small number of referrals away from Bristol to other centres, such as Great Ormond Street, the Brompton, the National Heart Hospital or in recent years to Birmingham. In many instances the decision to refer elsewhere was a joint one between the surgeons and the cardiologists. It is impossible for me to say whether or how many were referred elsewhere by the cardiologists without consulting the surgeons.'[223]

He added:

> 'I would now find it very difficult to indicate the extent of these referrals, other than to say that apart from [the neonatal Arterial Switch], it was relatively uncommon.'[224]

213 Mr Dhasmana told the Inquiry[225] that the reasons for such referrals included:

- 'Patients for consideration for heart or heart and lung transplantation;
- 'surgical treatment not available at Bristol i.e. patients with hypoplastic left heart requiring Norwood Procedure and Neonatal Switches after October 1993;
- 'for second opinions, when the risk of surgery was considered very high or surgical options were not clearly defined;
- 'I recall an instance when parents asked me for referral to Mr Yacoub at Harefield for a second opinion, before returning to me for surgery on their child;
- 'there were instances when patients were transferred to other centres, for example when an urgent surgery could not be provided at Bristol, for the lack of a bed.'

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[222] WIT 0084 0064 – 0065 Mr Dhasmana

[223] WIT 0120 0119 Mr Wisheart

[224] WIT 0120 0120 Mr Wisheart

[225] WIT 0084 0062 Mr Dhasmana. See Chapter 3 for an explanation of these clinical terms

214 Mr Wisheart told the Inquiry[226] that reasons for such referrals would include:

- ‘At the beginning of the period, before Mr Dhasmana was appointed, an urgent patient who presented when I was on leave would have had to be sent elsewhere.
- ‘Patients with conditions whose rarity and/or complexity placed them outside our experience would have presented from time to time, and referral elsewhere would have been considered.
- ‘There were patients about whom it was difficult to be confident as to what was the appropriate advice and therefore from time to time we would have consulted with colleagues elsewhere, most commonly with Great Ormond Street. In the light of their advice, there were some occasions when we asked the surgeons at Great Ormond Street to undertake a surgical procedure they had recommended. On other occasions we undertook the surgical procedure in Bristol.
- ‘After we stopped the neonatal arterial switch programme, children with simple transposition who were suitable for an arterial switch operation in the neonatal period were sent elsewhere, mainly to Birmingham.’

215 Mr Watson commented on referrals from Bristol to other centres. He said that this:

> ‘… would occur where the unit would be unable to deal with the specific patient and a more specialist referral would be needed. This is a separate issue to the waiting list issue which was one of capacity and does not fall within the meaning of what is normally understood by “tertiary referral”.’[227]

216 In relation to the waiting lists, Mr Watson explained:

> ‘… there are often waiting list initiatives in hospitals because waiting lists are always of concern … The waiting list initiative was not in any way limited to paediatric cardiology but was across the board.’[228]

217 He referred in particular to an arrangement with the Royal Brompton Hospital. In October 1987 he wrote to Dr Roylance.[229] Of the letter he said:

> ‘… [It] advised of my concerns about not hitting our targets of 50 patients for onward transfer to the Brompton Hospital for cardiac surgery. There was a question over whether the patients were reluctant to go to London, and this was potentially more so with paediatrics as a local hospital would be favoured by the visiting family … The issue in October 1987 was that a deal had been struck with the

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[226] WIT 0120 0119 – 0120 Mr Wisheart

[227] WIT 0298 0017 Mr Watson

[228] WIT 0298 0014 Mr Watson

[229] HAA 0119 0051 – 0052; letter dated 6 October 1987

> Brompton to take a certain number of cases under the waiting list initiative and the BRI was not referring as agreed.'[230]

218 He wrote to Dr Roylance:

> 'I have discussed the situation covering the next few months with the three cardiac surgeons concerned. Dr [*sic*] Dhasmana informs me that he would expect to be able to send a further 15 patients, although he may be able to increase this number if he was more forceful in not giving referred patients a choice between London and Bristol. Mr Keen informs me that he has a waiting list of only about 6 weeks at the moment and would not envisage the need to refer patients to the Brompton. Mr Wisheart has contacted all of the patients on his waiting list informing them that they can receive treatment more quickly at the Brompton and so far hardly any have found this possibility acceptable. He does feel, however, that it may be possible to refer on new patients as they come onto the waiting list … it would appear that if the trend continues as at present, we will not meet the number of 50 which was originally proposed, mainly because of a considerable number of patients who would rather wait to have their operations in Bristol.'[231]

It should be noted that this letter refers not only to paediatric cardiac surgery but also to adult heart surgery.

219 Mr Watson told the Inquiry:

> 'In all such situations there is a continual balancing act by those who allocate budgets. One inevitably has to consider looking to constrain this service, for example by restricting the number of incoming cases (as was the case with the Welsh referral of paediatric cardiology cases). The only options are to either get more resources or to take on fewer cases.'[232]

Evidence of referrals from Bristol to other centres

Parents' request for a referral to another centre

220 As has been noted above, the Inquiry heard that some parents were not offered a choice of referral to another centre.

221 Amanda Boyland, whose son James was referred to Bristol from the Royal Gwent Hospital, Newport, said of her discussions with the Bristol team:

> 'We were not told that there were other centres where the operation could be carried out. We were not given the choice for the operation to be performed anywhere else. No comparison of success rates at Bristol with anywhere else was provided to us.'[233]

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[230] WIT 0298 0014 – 0015 Mr Watson

[231] HAA 0119 0051; letter of 6 October 1987

[232] WIT 0298 0015 Mr Watson

[233] WIT 0232 0008 Amanda Boyland

222 Helen Johnson, mother of Jessica, told the Inquiry that she lived in the Bristol/Bath area and took Jessica to the BRHSC herself due to concerns about her health. She said:

> 'I can remember asking someone when Jessica would go to Great Ormond Street Hospital, because I assumed that that was where she would have her operation. The reply was that she would not have to go because Mr Dhasmana was an excellent surgeon and he was in Bristol. They also said that Jessica was too ill to move, anyway.'[234]

223 Although clinicians told the Inquiry that a request by parents could be a reason for a referral to another centre, there is evidence from parents to suggest that such a request was sometimes discouraged by the clinicians caring for the child.

224 Nigel Dymond, father of Naomi, said:

> 'I specifically recall during one of our meetings with Dr Martin at the North Devon District Hospital [Barnstaple] that my wife asked him if it might be better to take Naomi to somewhere like Southampton or London as opposed to going to Bristol. The reason my wife asked this question was at that time she was the secretary and I was the treasurer of the North Devon branch of the Bristol & South West Children's Heart Circle. At that time there were about five children that went up to Bristol for heart operations and only one survived. We were therefore concerned to ensure that Naomi received the best treatment possible. Dr Martin told us that Bristol was equal to the other hospitals and was a centre of excellence. He told us that the figures for Bristol were comparable to anywhere else and that there was no advantage to going elsewhere.'[235]

225 Marie Hill, whose daughter Kate was referred to Bristol from the Princess Margaret Hospital, Swindon, said:

> 'I cannot comment on the medical correctness of what was done and what was not done, but the very operation that Bristol was against, Brompton did and with success … As I left Bristol on the removal of Kate to Brompton Dr Jordan said to me, "If you go to Brompton, don't you ever put your foot back in Bristol again"'.[236]

Dr Jordan was given the opportunity to respond to this statement by way of a written comment, but did not do so.

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[234] WIT 0259 0002 and 0006 Helen Johnson

[235] WIT 0310 0006 – 0007 Nigel Dymond

[236] WIT 0554 0005 Marie Hill

226 Colin and Gaynor Griffiths, parents of Zara, told the Inquiry of their attempts to have her treated at Great Ormond Street rather than Bristol. Prior to her first operation they discussed their options with a nurse who had previously worked there:

> 'He told us that GOS was one of the best centres in the world and that Marc de Leval was one of the best surgeons … When we came home Colin went straight to our GP and told him that we were not happy with Bristol. He said to him "If it was your child would you send her to Bristol or to Great Ormond Street". Dr Lupini said he would send her to Great Ormond Street so we decided to move her. While Colin was there Dr Lupini called Bristol. When he told the person on the phone that he wanted Zara transferred, they said no and he fell into an argument with them.'

Zara was transferred and had her operation at Great Ormond Street.[237]

227 Jennifer Manfield, whose son Brad was referred to Bristol from Southmead Hospital, Westbury on Trym, explained that she and her husband became increasingly concerned about Mr Dhasmana carrying out Brad's operation in April 1995, after seeing two BBC television reports critical of Bristol. They raised this with Mr Dhasmana shortly before the operation. She said:

> 'My husband and I saw Mr Dhasmana … and we talked to him about the television reports … and he was clearly unhappy about the media coverage. He said we could take Brad home now if we wanted, but he did not offer us the possibility of a referral to another hospital.'[238]

A second opinion

228 Parents confirmed that children were sometimes referred to other centres for a second opinion, whether at their request or at the instigation of the Bristol clinicians.

229 Cynthia Baker, whose daughter Sarah was referred to Bristol from Exeter, said:

> 'I remember Mr Wisheart took the precaution of seeking a second opinion and he contacted Great Ormond Street Hospital in London to ask whether they considered he was doing the right thing in considering a Fontan operation.'[239]

230 However, Susan Perry, whose son Martin was operated on at the BRI, told the Inquiry about Martin's post-operative care. She said:

> 'My husband was pretty uptight and he asked [Helen Vegoda[240]] where we could get a 2nd opinion about Martin's condition and treatment. She obviously told

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[237] WIT 0393 0003 – 0004 Colin and Gaynor Griffiths

[238] WIT 0007 0005 – 0007 Jennifer Manfield

[239] WIT 0524 0004 Cynthia Baker

[240] Counsellor in Paediatric Cardiology

> Mr Dhasmana about this request and he was quite aggressive with us. He told us that there was no one else as good as he and Mr Wisheart.'[241]

Previous death of another child

231 The Inquiry heard from Diana Hill, mother of Jessica and James. Jessica had died following surgery at the BRI. Of James' operation, Diana Hill said:

> 'I did not want the operation to be performed at Bristol, and I put this request through the GP, who had to contact Dr Martin … Dr Martin was reluctant to refer us elsewhere, and wrote to our GP stating that this course of action was not necessary. In the end, my husband wrote to our GP, making it clear that … we wished to be referred to another hospital. We also asked Hugh Ross, the Chief Executive of UBHT, to intervene. James was subsequently referred to a cardiologist at the Birmingham Children's Hospital.'[242]

Previous operation at another hospital

232 Robert Joyce, father of Thomas, explained that when his family lived in London, Thomas had been treated at Guy's Hospital. On their move to Exeter, Thomas was first treated at the Royal Devon and Exeter Hospital, and was then transferred to Bristol. He said:

> 'Mr Wisheart explained that Thomas required major surgery and said that he could have it in Bristol or be referred back to Guy's – whichever we chose.'[243]

233 William Hine, father of Thomas, explained that although Thomas was born in Bristol and was under the care of Dr Jordan, he had a number of cardiac catheterisations at Great Ormond Street in 1982 because, as Mr Hine was told, 'they were unable to carry out this procedure in Bristol'. Thomas then had surgery at Great Ormond Street in 1983. Mr Hine told the Inquiry of discussions before Thomas' second operation:

> 'Dr Jordan told me that the operation could now be carried out at the BRI and gave Philippa and me the choice of having the operation carried out there or back at Great Ormond Street. We assumed that the treatment Thomas would receive at the BRI would be exactly the same as at Great Ormond Street and did not realise that the risks would be any different at Bristol.'[244]

Waiting list

234 A number of parents told the Inquiry that they had considered paying for their child's operation to be carried out privately elsewhere.

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[241] WIT 0462 0005 Susan Perry

[242] WIT 0263 0015 Diana Hill

[243] WIT 0528 0002 Robert Joyce

[244] WIT 0333 0002 William Hine

235 Aubrey Lewis, whose daughter Kirsty was referred to Bristol from the Royal Gwent Hospital, Newport, spoke of having been told of a waiting list, but not of being offered the option of going elsewhere. He said:

> 'Mr Wisheart explained there was a waiting list of about 2 months, although he told us he could sort out the problem on the Monday if we were able to pay privately. … If we had been able to have the operation done privately, Mr Wisheart would have done it – there was no question of going elsewhere.'[245]

236 Mr Wisheart commented on this evidence:

> 'There is no record and I have no recollection of this part of the conversation. The possibility of private treatment occasionally arose in these conversations but *only* because the family raised the matter. I never did so. I never sought to recruit a private patient from my National Health Service practice: indeed I discouraged virtually everyone who raised this possibility … I believe that [Mr Lewis' remarks] show clearly that I was discouraging him from proceeding in this way.'[246]

237 Robert Langston, whose son Oliver was referred to Bristol from Bath, said that Mr Dhasmana had explained that if Oliver was to have an Arterial Switch operation it:

> '… would have to be performed before he was fourteen days old. Because of circumstances at the BRI, Mr Dhasmana said that he could not guarantee that Oliver would be operated upon within this time frame, and that he would have to beg for bed space, and time in the operating theatre. … When we saw Mr Dhasmana the next day, my father (who was present at the meeting) told him of his intention to arrange for the operation to be done privately. Mr Dhasmana stated that there was no way that he was going to let us take Oliver out of the BCH to have his operation performed elsewhere. The reason he gave for this was that Oliver needed the operation as soon as possible …'[247]

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[245] WIT 0185 0005 Aubrey Lewis

[246] WIT 0185 0013 Mr Wisheart (emphasis in original)

[247] WIT 0184 0006 – 0007 Robert Langston

Chapter 12 – Waiting Lists

National guidelines

1 The *'Patient's Charter: Implementation Guidance'*[1] introduced, with effect from 1 April 1992, three new patients' rights. Patients were:

- to receive detailed information on local health services including standards and maximum waiting times;
- to be guaranteed admission for treatment no later than two years from referral; and
- to have any complaints investigated and answered promptly.

2 Such rights were not legally enforceable rights. Prior to April 1992, patients needing or awaiting treatment did not, however, enjoy even these rights.

Waiting lists at Bristol

3 In the management of cases awaiting surgery, there are three categories of case for the purposes of understanding waiting lists: the emergency, the urgent and the elective. Mr James Wisheart, consultant cardiac surgeon, explained these three categories of patient:

> 'For some of the patients, the question of timing and the optimal timing varies. For an emergency case, the optimal timing is now. For an urgent case it will be within the next few days, a week or two. For those sort of patients, those requirements would be met, or at least, something very close to them.
>
> 'Then there are a group of patients who are not as urgent as that and who would generally be called elective, and amongst those there will be some for whom the timing is really not particularly critical and there will be others at the other end of the spectrum for whom it will not be urgent but it should probably be within — or at a particular time, plus or minus a few months.'[2]

4 This chapter sets out the evidence relating to waiting lists and waiting times for elective paediatric cardiac surgery.[3] Although the focus is on paediatric cardiac surgery, reference is also made from time to time to adult patients. This is because both Mr Wisheart and Mr Janardan Dhasmana, consultant cardiac surgeon, operated on

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[1] WIT 0159 0320 – 0328; *'Patient's Charter: Implementation Guidance'* HSG (92) 4

[2] T40 p. 98 Mr Wisheart

[3] It is recognised that an elective case could later become an urgent or emergency case

both adults and children and because open-heart surgery could only be carried out at the BRI,[4] such that both adults and children were operated on there. Thus, the interaction between the management of adult and paediatric cases becomes relevant. The process of designating patients as emergency, urgent or elective is described elsewhere.[5] By focusing on elective patients, it should not be assumed that patients in the other categories were seen without waiting. It is merely that they were not subject to the waiting process described here.

5 Mr A Jooman[6] prepared tables for the Inquiry describing the cardiothoracic waiting list for the period 1984 to 1995 at both the BRI and the BRHSC. However, these tables are of limited value in ascertaining waiting lists in respect of paediatric cardiac surgery because he said they cannot be categorised between adults and children.[7]

6 An understanding of waiting times at Bristol within the period 1984–1995 can, however, be gained from other documents submitted to the Inquiry. But that understanding is somewhat limited, as records showing the position in regard to paediatric cardiac surgery for the entire period with which the Inquiry is concerned were not available.

7 The Inquiry heard some evidence that waiting times were around 12 months in 1987. For example, on 4 June 1987, the Secretary of the South Gwent Community Health Council (CHC) wrote to Mr J Evans at the Association of Welsh CHCs regarding a delay in operating on patients awaiting paediatric cardiac surgery:

> ‘I thought I should let you know that I have recently had occasion to accompany two young parents from Gwent, whose 3½ year old child died the day following cardiac surgery in Bristol last December … The child had been referred to Bristol when a few months old and the parents had to take him to the Out-Patient clinic every 12 weeks initially. The frequency was then increased to every 6 weeks. The child was also seen by a paediatrician in Gwent every 12 weeks.
>
> ‘In November 1985 the parents were told that the time had arrived for surgery to be undertaken and that it was hoped to admit the child in January or February 1986. In spite of repeated requests by the parents and several letters from the Royal Gwent Paediatrician expressing concern at the boy’s condition, he was not reviewed in Bristol during this 10/11 month delay in admission. During the interview, Mr Wisheart said that the delay in admission was entirely due to the pressure of demand faced by the department and the inadequacy of resources to meet that demand. He said that it was impossible to determine whether the delay had had any serious adverse effect on the baby’s prospects …’[8]

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[4] Until October 1995

[5] See Chapter 13

[6] District Statistical Information Officer, B&WDHA

[7] UBHT 0349 0001; note from Mr Jooman

[8] HAA 0119 0035; letter dated 4 June 1987

8 Commenting on that letter Mr Wisheart said:

> 'I would have to make reservations about when the optimal time was and how long the optimal period might have been. I do not know who told the parents January or February 1986, but with that reservation, I would certainly agree that there were delays, significant delays, in surgery both for adults and children at that time and probably at all times during my consultant career. We were working constantly to try and change that by increasing the facility. You will have noticed that this was immediately prior to the significant expansion of the facility in 1987/88.'[9]

9 In March 1987 Mr Wisheart wrote to Dr Stephen Jordan and Dr Hyam Joffe, consultant cardiologists:

> 'I just want to let you know that at the present time my paediatric waiting list stands at 74 patients. This represents a good year's work but, of course, many patients will not have their operation for more than a year in view of the urgent cases who will inevitably present during that period.'[10]

10 On 2 April 1987 Mr Dhasmana wrote to Dr Joffe referring to Mr Wisheart's letter:

> '… I wish to add that I have got about 30 paediatric patients on my Waiting List for routine open-heart procedures. On my present schedule I cannot operate on more than one paediatric case per week, that means already a seven and a half months Waiting List has developed. Combining these with Mr Wisheart's, our Waiting List for paediatric cases at this Centre stands at more than 100 cases. Even with the expansion, I do not foresee the possibility of operating on more than three or maximum (rarely) four cases a week without affecting the adult cardiac surgery. As we are all well aware the plans for any future project take a long time to implement, it may be feasible to look into the prospect of open heart surgery at the Children's Hospital now rather than in the distant future.'[11]

11 In September 1987 Mr Dhasmana wrote to Dr Rees and Professor Vann Jones, consultant cardiologists at the BRI, saying:

> 'There are 55 CHILDREN (of whom 21 went on the waiting list before 1.1.87).'[12]

12 A table dated 7 March 1988 indicated that Mr Dhasmana had 29 children on his cardiac surgery list and Mr Wisheart had 57, making a total of 86.[13]

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[9] T40 p. 95 Mr Wisheart

[10] UBHT 0092 0006; letter dated 26 March 1987

[11] JPD 0001 0005; letter from Mr Dhasmana dated 2 April 1987

[12] UBHT 0154 0220; letter from Mr Dhasmana dated 25 September 1987 (emphasis in original)

[13] HAA 0120 0011; table dated 7 March 1988. Note that Mr Dhasmana commenced work in 1986 and his waiting list is, as a consequence, shorter than Mr Wisheart's, who began in 1975

13 In April 1988 Mr Dhasmana wrote to Miss Marion Stoneham:[14]

> 'The Waiting List … is still considerably high under my care. I hope that with the expansion … it would be possible to reduce some of the Waiting Lists.'[15]

14 The Inquiry also heard evidence that between 1988 and 1991 the 'usual' waiting time for elective paediatric cardiac surgery was between six and nine months.[16]

15 In 1990 the report of the B&WDHA, referring to waiting times generally for cardiac surgery at the BRI and the BRHSC, noted:

> 'Waiting lists of unacceptable length, up to 12 months (dependent on Consultant)'[17]

but did not distinguish between adult and paediatric patients.

16 This 12-month waiting period is referred to in a strategy document prepared by the SWRHA in May 1991. Although again, it does not distinguish between adults and children, it states in relation to waiting lists for cardiac services in general at the BRI and the BRHSC that:

> 'While urgent patients appear to be treated by giving them a date for operation, some wait for over a year which is not acceptable and will be remedied by the booking system. For those who are referred to London hospitals some long waits are known to the referring consultants.'[18]

Explaining the waiting list

17 In a letter to Mr Arthur Wilson, Regional Treasurer, SWRHA, dated 17 February 1992, Dr John Roylance, Chief Executive, UBHT 1991–1995, wrote:

> '… waiting time is the glaring problem, and of course is due to the historic and ongoing pressure which has been relentlessly placed on the Cardiac Unit in Bristol, in the context of the inadequate provision in the region as a whole.'[19]

Volume of cases

18 The Inquiry heard evidence concerning the increase in the numbers of paediatric cardiac operations during the period of the Inquiry's Terms of Reference.

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[14] Manager of B&WDHA's Children's and Obstetric Services

[15] UBHT 0190 0008; Mr Dhasmana wrote a memorandum to Mr Wisheart dated 28 February 1989, saying that he had 25 patients on his waiting list. See UBHT 0179 0141

[16] T84 p. 113 Mr Dhasmana; UBHT 0179 0138; letter from Mr Dhasmana to Dr Roylance dated 25 February 1991

[17] JDW 0001 0333; report *'Development of Cardiac Services'* dated 30 November 1990

[18] UBHT 0156 0209; *'Towards a Strategy for Cardiac Services in the South Western Regional Health Authority'* dated 29 May 1991

[19] UBHT 0038 0407; letter dated 17 February 1992

19 The 1987 *'Annual Report on Paediatric Cardiology and Cardiac Surgery'*[20] noted that:

> 'Total admissions have more than doubled, and infant admissions have more than trebled, since 1980. This is in keeping with the unit's growing regional role, and its designation as supra regional centre for infants since 1984. Although admissions from the SW Region appear to have stabilised in 1987, those from Wessex and especially South Wales continue to increase. This trend is even more striking in respect of infants.'[21]

20 Mr Wisheart said:

> 'Prior to 1980 and in the early 1980s, we had been undertaking a total of about probably on average between 60 and 70 operations for congenital abnormalities each year.
>
> 'By the end of the 1980s, we were doing about double that number, namely, 140 to 150.
>
> 'One might ask, well, how come that the total number increased when you have the same number of abnormalities occurring in the community, give or take a little bit? I think that at the time we thought some came from South Wales, and that was undoubtedly true but it was not the whole answer, so I do not know the whole answer to that question.'[22]

21 Mr Wisheart explained that the throughput at the BRI increased in the 1980s but that the increase 'was predominantly in the adult area at that time'.[23] He stated:

> 'Over the period as a whole, the constant pressure to increase adult work did of course impinge on me because I was constantly involved in efforts to increase the facility, but in terms of my operating, the number of adults I operated on obviously fluctuated from year to year, but broadly stayed the same over the whole period of time.
>
> 'In other words, the proportion of my time that was devoted to children was nearly protected.
>
> 'The sessions which Mr Dhasmana and I did devote to children amounted to three a week — I do not mean three half days; there were three operations a week of whatever length, at least, which were children, so that meant that we could achieve 150 a year, plus or minus, and in that sense, we were actually meeting in full the demand that we understood to exist for paediatric cardiac surgery each year.

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[20] UBHT 0055 0009; *'Annual Report on Paediatric Cardiology and Cardiac Surgery'*, 1987

[21] UBHT 0055 0011; *'Annual Report on Paediatric Cardiology and Cardiac Surgery'*, 1987

[22] T40 p. 111 Mr Wisheart

[23] T40 p. 120 Mr Wisheart

> ‘That could never be said for the adult work.’[24]

22 Mr Dhasmana explained that the pressure to obtain beds for adults and the pressure on operating theatres from adults had an effect upon the waiting list for children. It later became known that the children were waiting longer for operations than they would have been if the Unit had been solely a paediatric unit. He said:

> ‘We now know that is the case. At that time, I did not know that.’[25]

23 Mr Wisheart was asked whether the fact that he and Mr Dhasmana both carried out adult as well as paediatric cardiac surgery meant that, in effect, the paediatric work suffered in a way it would not have done had one dedicated paediatric surgeon been appointed. Mr Wisheart told the Inquiry that there were enough sessions to deal with the paediatric demand, but the waiting list remained. He said:

> ’I believe that, had there been one full-time paediatric surgeon rather than the two of us, and that that one surgeon had been working in the Infirmary as we were working, that he would have had a number of allocated operating sessions to use for his paediatric work in exactly the same way as Mr Dhasmana and I …
>
> ‘So I think that in that context … a full-time paediatric surgeon would have made a marginal difference.
>
> ‘If we consider an alternative context … that the full-time surgeon was able to operate in the Children‘s Hospital and had … full control of his operating and post-operative care resources, then I think that that would probably have made a substantial difference. …
>
> ‘I suppose the final point I would like to make is that there is a difficulty about having one single surgeon, even if he is full-time, and that is the obvious one, that it means he is on call all the time when he is present, but when he is away, then there is nobody in town to look after that work.’ [26] [27]

24 Mr Wisheart’s evidence included this exchange:

> ’Q. If there was enough time available and enough resources available to cope with the demand – to cope with the demand and no more – the only way of reducing the waiting list will be to have some form of waiting list or additional time spent on attacking the waiting list, presumably?

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[24] T40 p. 114–15 Mr Wisheart

[25] T84 p. 90 Mr Dhasmana

[26] T40 p. 114–15 Mr Wisheart

[27] The paper – *‘Options for Development of Audit and Paediatric Cardiac Services in UBHT’* of May 1994 – also noted that one of the benefits of relocating paediatric cardiac surgery to the BRHSC would be ‘impact on waiting times’. See UBHT 0088 0135

> ‘A. Or else the ability to be more flexible and to operate from time to time on children in sessions when one would have normally operated on adults. But, I mean, we are not just talking of access to an operating theatre. The ability to operate on a child requires a whole package. You need to have a paediatric cardiac anaesthetist. Most of the nurses in theatre would have been able to do the work with a child, but some were certainly better than others, and again, as the nurses will describe to you, they tried to have nurses with experience looking after children in intensive care.
>
> ‘So the whole package has to be provided and not just access to an operating theatre slot.’[28]

25 On 18 January 1987 Mr Dhasmana had written to Dr Robert Johnson, the Chairman of the Division of Anaesthesia, asking for an extra operating session at the BRHSC. He was then only operating on alternate Wednesday mornings:

> ’As you are well aware, we have been designated as a supra regional Specialty Centre … As a result, an increasing amount of work has been coming from all parts of the South West and also from South Wales. … Having been given only one half day list in a fortnight, my Waiting List to deal with these problems has progressively lengthened and in many of these cases I have been operating as an emergency in the evenings or during the weekend. Some of these would have been operated during the routine hours if I had an operating session allocated to me during the week.’[29]

26 Mr Wisheart was asked whether the letter meant that, if Mr Dhasmana did an extra session at the BRHSC, he would have done one less adult session at the BRI. Mr Wisheart said:

> ‘I do not think he would have, although I think you would need to ask him, because it would depend on the details of his programme at that time, but I think he is actually saying that he has the freedom to operate at whatever time he is proposing.
>
> ‘I would like to say, this is of course closed work we are talking about now, not open-heart work, and I mean, he only had one half-day alternate weeks, I think. …
>
> ‘Had he had more, then some of his other operating could have been accommodated on it, but of course, emergency work by its nature does not occur in proximity to your planned operating sessions.’[30]

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[28] T40 p. 116 Mr Wisheart

[29] JPD 0001 0002; letter dated 27 January 1987. Seven years later, the paper – *‘Options for Development of Adult and Paediatric Cardiac Services in UBHT’* of May 1994 – warned, ‘With the loss of designation as a supra regional centre, BRCH [*sic*] must compete for paediatric services with other centres which are known to have shorter waiting times’. See UBHT 0088 0140

[30] T40 p. 117–18 Mr Wisheart

27 Mr Wisheart commented on the suggestion in the letter that some operations which were described as ’emergency‘ could have been done during routine hours. Mr Wisheart said:

> ‘Some of it, but that certainly was a problem, because for each of us, in the Children’s Hospital there was a much higher proportion of work that was urgent or emergency than in the Infirmary, amongst children, and it was work that did have to be done within a day or two, frequently, and so it was not uncommon to operate in the evening or at the weekend. It had to be done. That was the need of the child. Certainly, if that could have been reduced, that would have been a very good thing.’[31]

Attempts to reduce the waiting list

28 There was clearly pressure within each Directorate within the BRI[32] to reduce waiting lists, especially towards the end of each financial year, particularly after the introduction of trust status.

29 Mr Wisheart described the attempts made to reduce the waiting lists in general as ‘a constant battle’.[33] He said:

> ‘When we were doing 100 [operations] a year it [the waiting list] was too long. When we were doing 1,000 a year, it was still too long. So although we were running faster and faster, we never actually caught up.’[34]

30 Mr Wisheart was asked what efforts were made to improve the waiting list situation at the BRI and the BRHSC. He told the Inquiry:

> ‘In the Children’s Hospital, first, a number of things happened. … perhaps the more important thing was that the number of closed-heart operations that we did peaked around this time and subsequently became less, and there were two reasons for this — at least two reasons. The first one was that the cardiologists developed the ability to carry out certain interventions as a non-surgical procedure, in other words, as part of the cardiac catheterisation, so that some procedures that we had done at surgical operations were carried out at the time of catheterisation, so that reduced the number of operations. The second thing is that the trend towards earlier total correction of intracardiac abnormalities meant that we did less palliative work in young children to tide them over. So for those two reasons amongst others, the actual number of closed procedures declined following this time.
>
> ‘So that is what happened at the Children’s Hospital.

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[31] T40 p. 118–19 Mr Wisheart

[32] The establishment of the Directorate system is dealt with in Chapter 8

[33] T40 p. 105 Mr Wisheart

[34] T40 p. 107 Mr Wisheart

> 'In the Infirmary, the total capacity of the Infirmary did continue to increase, as I think you have pointed out, but I would have to say that the increase in throughput was predominantly in the adult area at that time. We had, by 1989 or 1990, achieved this level of 150 operations per year. It is not my recollection that there was a significant increase beyond that.'[35]

31 Miss Deborah Evans[36] indicated that over the period 1991 to 1995 waiting times were the biggest single issue in contract negotiations between the B&DHA and the UBHT. She also indicated however, that:

> 'This was a much bigger issue for adult services than it was for children's services across the District as a whole. In children's cardiology and cardiac surgery services (excluding those services covered by the supra regional contract for which Bristol and District Health Authority did not have a responsibility)[37] waiting times were rarely if ever an issue.'[38]

32 At the Cardiac Surgery Board meeting held on 23 November 1993,[39] it was noted:

> '10.1 Waiting list initiative[40]
>
> 'James Wisheart asked if anyone wanted to discuss this.
>
> 'Janet Maher reported that planning was in progress and we were negotiating with Bath and Somerset.'[41]

33 Dr Christopher Monk, consultant anaesthetist and Clinical Director of Anaesthesia at the UBHT from January 1993,[42] wrote a letter to Mr Wisheart as Clinical Director dated 22 January 1993 on behalf of the Directorate of Anaesthesia, complaining about the introduction of waiting list initiatives at the end of the financial year. Dr Monk described how various waiting list initiatives were undertaken during the year, allowing sufficient notice for resources to be allocated to implement the initiatives, but at the end of the financial year:

> 'As in the previous two years, the end of the current financial year results in a number of requests by the Purchaser for new waiting list initiatives. The aim of these being to decrease the number of patients with prolonged waiting times. Unfortunately, these requests are made at short notice, to multiple Surgical Directorates and for a large number of cases of varying surgical complexity. …

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[35] T40 p. 118–19 Mr Wisheart

[36] Director of Contract Management, B&DHA, 1991–1995

[37] For example, paediatric cardiac surgery until 1994

[38] WIT 0159 0023 Ms Evans

[39] UBHT 0084 0163; minutes of the Cardiac Surgery Board meeting held on 23 November 1993

[40] The Waiting List Initiative was launched in 1987 and was aimed at reducing the number of people waiting over two years for treatment

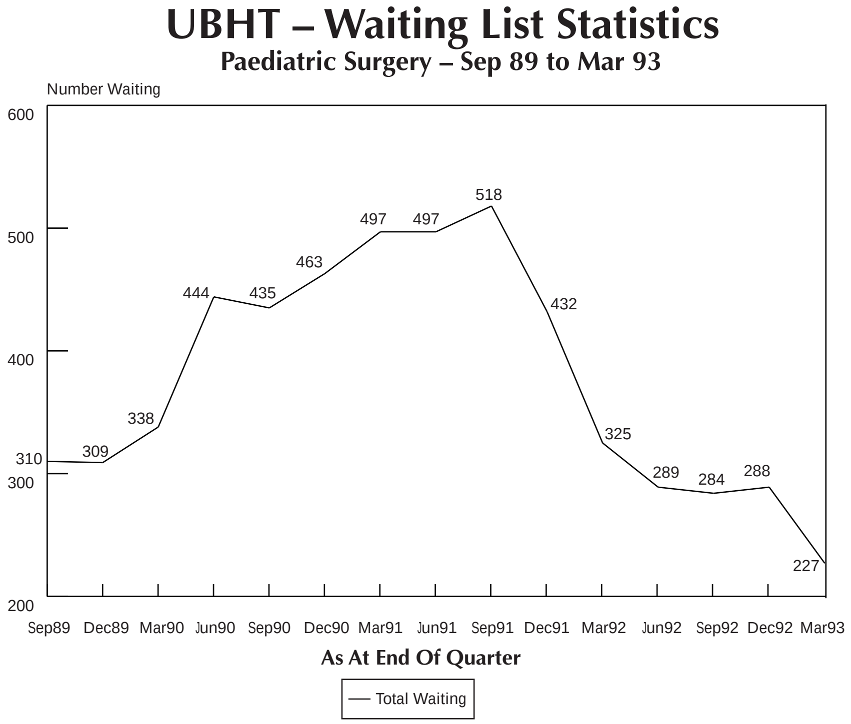
[41] UBHT 0084 0166 minutes of meeting held on 23 November 1993

[42] Presently the Associate Medical Director for Strategic Planning, UBHT

> '… considerable moral pressure is placed upon all clinical staff to avoid the failure of care for these patients … Yet by the simple expedient of planning more routine care for the Bristol and Weston patients then these waiting list initiative patients could have been treated as routine cases, with the highest standards of care during normal working hours.
>
> 'Should we, despite all our efforts, fail to respond to these initiatives, I do not feel it would be a failure of the Anaesthetic Directorate or the Surgical Directorate but that of a Purchasing policy which relies on last minute waiting list initiatives to provide medical care for the patients.' [43]

34 On 26 March 1993 Mr Jooman produced a report detailing waiting list statistics from September 1989 to March 1993. The graph in relation to paediatric cardiac surgery showed an overall trend of increase from 1989 to September 1991 and a dramatic reduction from September 1991 to March 1993.[44]

35 The first of these graphs shows the total numbers waiting, and the second shows the numbers waiting for more than one year.


UBHT – Waiting List Statistics

Paediatric Surgery – Sep 89 to Mar 93

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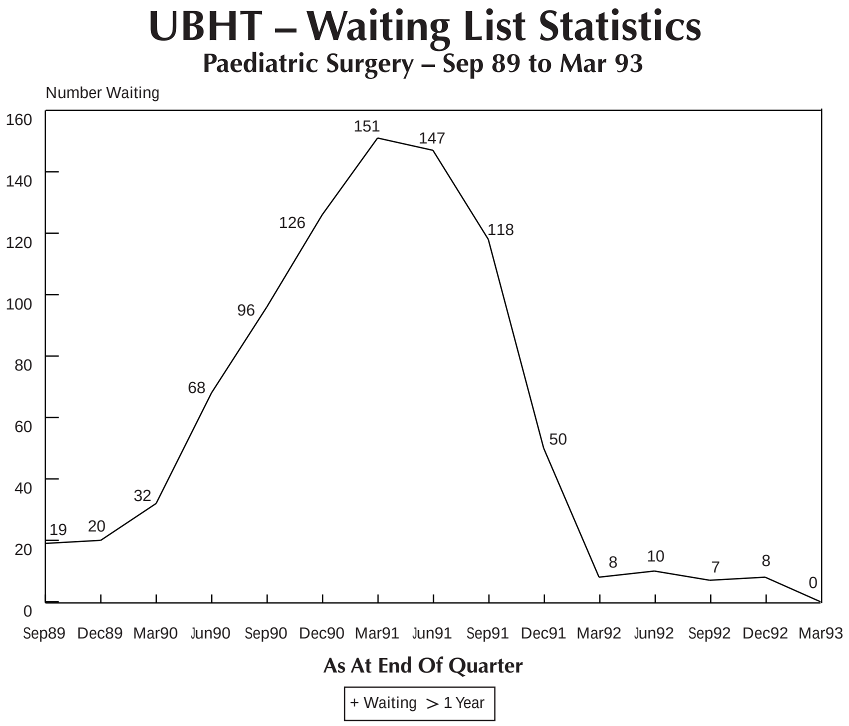
[43] UBHT 0247 0183 – 0184; letter dated 22 January 1993

[44] UBHT 0270 0187; report produced by Mr Jooman dated 26 March 1993



36 In December 1993 Miss Lesley Salmon, Associate General Manager for Cardiac Services, and Mr Dhasmana wrote a memorandum addressed to 'all cardiac surgery staff' regarding a waiting list initiative. It stated:

> 'We recognise and sympathise with the pressure this places on everyone and are grateful for the co-operation and willingness people have shown under the circumstances. No one is in much doubt, after three years of contracting, how important it is for us to meet the demand in the South West and to attract the work to UBHT. There will be further investment in cardiac surgery next year and we want purchasers to invest here! The intention is to avoid further waiting list initiatives if possible, and the key to this is to get our waiting times down overall. The Trust is actively planning to expand the service for this purpose in the coming year.'[45]

37 The Cardiac Surgery Management Board meeting on 29 March 1994 recorded that:

> 'Mr Dhasmana thanked everyone involved with the waiting list initiative for their help. A total of 39 patients had been treated on the scheme which was a great achievement.'[46]

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[45] UBHT 0179 0201; letter dated 3 December 1993

[46] UBHT 0132 0055; minutes of the Cardiac Surgery Management Board meeting on 29 March 1994

38 Many of the clinicians involved in the paediatric cardiac surgical service felt that it lacked resources, such as theatre time and space and beds, in comparison to the adult service.

39 Dr Bolsin, consultant anaesthetist, said that: '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 twelve adult cases.'[47]

40 Dr Martin's evidence to the Inquiry included this exchange:

> 'Q. … it was certainly your perception from what you have been telling us that the fact of doing the two together, adults and children, sometimes meant children were delayed for longer … than they would have [been] delayed had it been one service for children at one place?
>
> 'A. That might have been a factor. Equally it might just have been the actual allocation of paediatric beds within the adult department was inadequate for the throughput. By increasing the numbers on transferring, I think with the transfer from the Royal Infirmary to the Children's Hospital you would have gone up from essentially what were three beds being utilised to five or six and that would immediately have an impact on waiting.
>
> 'Q. You told the GMC, did you not, that the need for children having to compete with the adult list for paediatric time in the theatre made the delays ensue, or at least that was your general impression?
>
> 'A. As I have said, it is difficult for me to judge exactly whether it was pressure on theatre, pressure on beds on the intensive care unit, but I was aware that certainly some patients were waiting at the Children's Hospital longer than I would have hoped for.'[48]

41 Mr Dhasmana also took the view that running the paediatric and adult cardiac surgical services in the same unit led to conflicting demands. His evidence included the following:

> 'Q. So the pressure on beds from adults and the pressure on operating theatres from adults had, did it, an effect upon the waiting list for children?
>
> 'A. On both sides, yes, sir.
>
> 'Q. And that meant that children were waiting longer for operations than they would have been if the unit had been solely a paediatric unit?

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[47] WIT 0080 0002 Dr Bolsin

[48] T77 p. 29–30 Dr Martin

> ‘A. We now know that is the case.’[49]

42 The Chairman of the Inquiry sought to confirm this in the following exchange with Mr Wisheart:

> ‘Q. (The Chairman) … during all of the time that you were seeking to bring about the various developments, not least the appointment of another surgeon and the movement to another place, you were, were you not, chasing almost mutually incompatible goals, namely, making sure you had enough children treated through and looking at them, whilst at the same time meeting increasing adult waiting lists, always with the same, not only people, but physical resources, numbers of theatres. I imagine that is not atypical in the Health Service …
>
> ‘A. I think you are correct to say it is not atypical. I think it was very typical. I am not sure that I ever had any other experience as a junior doctor or senior doctor in the Health Service.’[50]

43 However, the Inquiry heard evidence that when it was necessary to cancel operations, it tended to be the adult rather than the paediatric cases that were further delayed.

44 Kay Armstrong, Cardiac Theatre Sister, gave evidence that: ‘When it was necessary to cancel elective surgery to fit in urgent cases it was adult, not paediatric cases which were cancelled on these occasions.’[51]

45 Sister Julia Thomas, Clinical Nurse Manager, Cardiac Unit, said:

> ‘There were occasions when the intensive care beds were occupied by seriously ill patients and other cases had to be cancelled. The adult cardiac cases were sometimes cancelled because beds were occupied by paediatric cardiac surgery cases, who sometimes tended to progress rather slowly and tended to take priority.’[52]

46 Alison Riddiford, Surgical Service Manager (General), told the Inquiry:

> ‘If there was an emergency operation, then it might be that an elective procedure was cancelled, although this would probably be an adult elective procedure.’[53]

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[49] T84 p. 90–1 Mr Dhasmana

[50] T94 p. 107 Mr Wisheart

[51] WIT 0132 0034 Ms Armstrong

[52] WIT 0213 0031 Julia Thomas

[53] WIT 0262 0022 Ms Riddiford

47 However, Mr Dhasmana recalled having to perform some of his surgery at night. His evidence to the Inquiry included this exchange:

> 'Q. So what restrained the unit from doing the operation was first of all waiting lists; secondly staffing, if I can say shortages …; and thirdly, do I get the sense that if you operate on more neonates, there is less room for non-neonates, given the pressures on bed space and operating theatres caused by the adults?
>
> 'A. Well, it is an emergency operation. You cannot wait for the next period to operate, so you have to — I mean, if you look in my record of closed cardiac surgery, it was working at night and various things, so almost I was doing open-heart surgery every night and then other surgery next day. So this was adding something new which I do not think we were geared up to, really.'[54]

The impact of financial incentives/penalties on waiting lists

48 At a meeting of the Cardiac Surgery Management Board on 18 July 1994, Miss Salmon reported that:

> 'Somerset were applying a financial penalty of 20% of the procedure price for any cardiac surgery patient who waited over six months for treatment. Professors Vann Jones and Angelini expressed their concern about this clause given the difficulties with managing a number of purchasing pressures.'[55]

49 Although the concern related to adult and child patients, it provides a context in which to understand the management, in terms of waiting times, for paediatric cases.

50 On 21 July 1994 Ms Linda Williamson, Contracts Manager for the B&DHA, wrote to Miss Salmon, complaining that part of a waiting list initiative had not been implemented:

> 'As you can see in the enclosed documentation, UBHT agreed to perform 20 cardiac operations between 1 April 1994 and 30 June 1994. Clearly these have not been done and in fact the specialty is under performing against contract.
>
> 'One option would be for us to claw back the £127,000.00.'[56]

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[54] T86 p. 65 Mr Dhasmana

[55] UBHT 0226 0085; minutes of the meeting of the Cardiac Surgery Management Board on 18 July 1994

[56] UBHT 0295 0615; letter dated 21 July 1994

51 At a meeting of the Cardiac Services Management Board on 26 September 1994, Miss Salmon:

> '… drew to the attention of the meeting that an offer of £127,000 had been made by BDHA to ensure a maximum waiting time for all their patients of 10 months, by April 1995.
>
> 'The Board agreed that she should put together a proposal for BDHA's approval. The Avon GP Fundholding Group had also approached cardiac surgery about purchasing extra activity, but this would be discussed with individual practices.
>
> 'Waiting time management was becoming increasingly difficult and complex with different waiting times being agreed with some purchasers. Financial penalties were also beginning to be imposed; £3,000 for any South and West patient waiting over 12 months and 20% of the procedure price for any Somerset patient waiting over 6 months.
>
> 'The South and West Region definition of a longer waiter would reduce to 10 months next April, adding to the pressure.'[57]

52 At the meeting of the Cardiac Services Management Board held on 28 November 1994, in relation to waiting list management it was reported that:

> 'The letter to BDHA detailing how the £127,000 non recurring waiting list resources would be used (circulated with the agenda) was discussed.
>
> 'Cardiology are over performing on the BDHA contact.
>
> 'RCF[58] will identify the names of patients and find out whether these can be counted and funded as part of the waiting list initiative.
>
> 'The additional 15 CABGs[59] and 2 valves required cannot be performed until Surgery is achieving contract for BDHA. RCF will explore arrangements for these to be subcontracted to the Glen Hospital.[60] The Board agreed that if subcontracting was to be necessary on a regular basis, a standing arrangement for one or two cases each week would be preferable to performing several cases at the end of the financial year.
>
> 'It was noted that weekend work was particularly unpopular.

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[57] UBHT 0227 0026; minutes of the meeting of the Cardiac Services Management Board on 26 September 1994

[58] Mrs Ferris, General Manager, Directorate of Cardiac Services, UBHT

[59] Coronary artery by-pass grafts

[60] The Glen BUPA Hospital, Durdham Down, Bristol

> ‘It was noted also that the additional Friday morning operating session was proving unpopular and difficult to implement. The issues of anaesthetic cover/funding and pressure on Theatre staffing need to be discussed. RCF to review with Mr Dhasmana and Mr [*sic*] Monk.’[61]

Effect of the waiting list on patients

53 Evidence on the possible effect on patients of the timing of surgery and delays in surgery generally is set out in Chapter 13.

54 As to any effect caused by there being a waiting list, Mr Wisheart said that, whereas some adult patients may have died while on a waiting list for cardiac surgery, he did not think that many paediatric patients, ‘if any’, died while on the waiting list.[62]

55 However, he said it must be accepted that some paediatric patients were detrimentally affected by being placed on a waiting list. He said that it:

> ‘… is really quite variable as to the effect of [being on a waiting list] would have on the child. The ones, of course, who wait are those who are in the elective group, and most of those who would wait longer are those for whom the timing is less critical, but I would be unable to say that that was the case entirely. In other words, I cannot say to you that there were not some children who would have suffered, for want of a better term, from the extra delay.’[63]

56 Mr Wisheart said that as at 1991 there was very limited knowledge available about the effect of keeping a given patient or patients in general on a waiting list in terms of morbidity or mortality:

> ‘I imagine there was some published information by that time, but I think there was quite a lot more in the years that followed this, in the early 1990s.’[64]

57 Mr Wisheart said it was possible to say that:

> ‘If we set aside those children who need urgent or emergency treatment and consider those who are not in immediate need of surgical treatment, the congenital abnormality which they suffer from will have an effect that secondary changes will develop in the heart and in the lungs, and possibly in other organs, but in most children, in all of them in the heart, in many in the lungs also, and in some, elsewhere.

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[61] UBHT 0227 0023; minutes of the meeting of the Cardiac Services Management Board on 28 November 1994

[62] T40 p. 101 Mr Wisheart

[63] T40 p. 98–9 Mr Wisheart

[64] T40 p. 102 Mr Wisheart

> ‘So that, if a child early in life has an abnormality of the heart but is relatively free of secondary effects, whereas N years later they may still be alive but in addition to the abnormality of the heart, they will have these secondary effects.
>
> ‘The importance of this is that whereas in the 1970s, say, and also in the early 1980s, people, surgeons and cardiologists, preferred to delay operations because they felt children would be operated on more safely when they were a little bit older, people came to realise and accept that, indeed, they should be operated on sooner in order to prevent the development of these secondary effects which, in essence, were complications — additional complications.
>
> ‘That, then, is the thinking underlying the trend towards earlier operating. …
>
> ‘So the effect of a child waiting, again, whether they are on a waiting list or not, is best understood within, I think, that set of ideas.
>
> ‘So, for some children, an extra wait will be of very little significance; for others it will be of some; for some it may be quite important, but whether or not they are on the waiting list is not the crucial factor; the crucial factor is that time is passing.’[65]

58 Mr Dhasmana said:

> ‘I think it was more obvious when you had a condition like VSD or AV canal, or similarly transposition, where the pulmonary or lungs are already subject to higher pressure. If you leave it longer, it could deteriorate. And of course, you know, I cannot prove it, but I had a feeling that the longer you leave it, post-operative recovery would be further prolonged.’[66]

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[65] T40 p. 103 Mr Wisheart

[66] T84 p. 91 Mr Dhasmana. See Chapter 3 for an explanation of these terms

Chapter 13 – Pre-operative Care

The transfer of children from referring hospitals

1 The detail of the way in which children came to be referred and transferred to Bristol from outreach clinics and generally is set out earlier in Chapter 10 and Chapter 11.

2 Dr Hyam Joffe and Dr Stephen Jordan, consultant cardiologists, explained that during the period of the Inquiry's Terms of Reference, children would be transferred from referring hospitals to the BRHSC where they were admitted and evaluated.[1]

3 Dr Jordan told the Inquiry:

> 'Occasionally, where it proved quite impossible to admit the infant to BRHSC a cardiologist would go (with an echo-machine if necessary), to an outlying hospital to see the infant and start the process of diagnosis and treatment.'[2]

4 However, the general procedure was that, prior to the transfer, the referring clinician would discuss the child's condition by telephone with one of the Bristol cardiologists who were available on a 24-hour basis[3] and would explain the practicalities of the transfer. Dr Jordan told the Inquiry:

> 'The usual procedure throughout this time was that the referring paediatrician and the cardiologist would discuss the patient's condition by phone and a decision would be made as to the best method of transfer. (In addition, any other treatment, such as the start of prostaglandin infusion or a dopamine infusion, could be considered.) In most cases transfer was with the infant being accompanied by one of the referring paediatric team, usually a senior registrar, and an experienced nurse. If the infant was already on a ventilator it could be that this team, plus one of the local anaesthetists, would bring the infant, but more usually the BRHSC would send a team, usually with a consultant anaesthetist and a senior nurse and a transport incubator with a ventilator would go from Bristol to collect the infant (sometimes described as a "scoop"). In addition, the neonatal unit at St Michael's Hospital across the road also had a "scoop" facility and in case of difficulty they would send their team for new born infants ...
>
> 'In most instances the transfer was by ambulance, which was reasonably quick as most of the referring hospitals were very close to the M5/M4 network. Patients from Truro more commonly came by air ambulance … to be met by an ambulance. The sophistication of this transfer service increased over the years concerned. In particular we gave increasing attention to stabilising the infant as far as possible

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[1] Although Dr Joffe explained: 'Prior to the opening of the BCH cardiac catheterisation laboratory in 1987, a few babies were initially examined by a paediatric cardiologist in the Bristol maternity units, i.e. Southmead or Bristol Maternity hospitals, and then transferred …' See WIT 0097 0295 Dr Joffe

[2] WIT 0099 0039 Dr Jordan

[3] WIT 0097 0295 Dr Joffe

> before transfer. Occasionally a cardiologist went with the "scoop" team, but this potentially left a period of several hours without cover in Bristol and the cardiologist probably had less to contribute than an anaesthetist.'[4] [5]

5 Dr John Laband, a junior doctor at the BRHSC from November 1994 to January 1995, confirmed in a letter to the Inquiry:

> 'We were the first contact with medical staff for parents of babies undergoing heart surgery, the patients first being admitted to the Children's Hospital before being transferred to the Bristol Royal Infirmary usually over the weekend.'[6]

Pre-operative management of care

Where children were managed pre-operatively

6 Dr Joffe explained:

> 'Children who were acutely ill were managed pre-operatively in the Children's Hospital … ill children who required open-heart surgery were transferred from the BCH to the BRI the previous evening or on the morning of the operation … those children who were not unduly ill, and were at home, were called off the waiting list for elective surgery. They were admitted directly to the BCH for closed-heart operations and to the BRI for open-heart operations, about three days before the date of surgery.'[7]

Under which specialty children were managed pre-operatively at the BRHSC

7 Mr Wisheart told the Inquiry that those children who were waiting for closed-heart operations at the BRHSC '… were admitted to and managed in the BRHSC by the cardiologists and the surgeons jointly'.[8]

8 Dr Joffe told the Inquiry that BRHSC patients for elective surgery '… were admitted under the paediatric cardiac surgeons'; and children who were acutely ill '… were managed pre-operatively in the Children's Hospital under the paediatric cardiology department. Those who required closed-heart surgery at BCH remained under the

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[4] WIT 0099 0039 Dr Jordan

[5] Dr Joffe explained: 'A specialised intensive care ambulance based at the paediatric intensive care unit … at BCH, and staffed by intensivists, only became available after 1995'. See WIT 0097 0295 – 0296 Dr Joffe

[6] INQ 0042 0004; letter from Dr Laband

[7] WIT 0097 0296 Dr Joffe

[8] WIT 0120 0126 Mr Wisheart

paediatric cardiologists until the day of the operation, although the cardiac surgeons liaised with us regarding treatment and the timing of surgery.'[9]

9 Dr Jordan told the Inquiry:

> 'Although sometime earlier it was traditional for all patients at the Children's Hospital to be admitted formally under a paediatrician, during the period in question the cardiac patients were admitted under the care of a cardiologist. The clerking and immediate care was by paediatric SHO [senior house officer], of which two or three had duties with one of the cardiologists. We also used the consultants and senior registrars in paediatrics to help with any non-cardiological problems.'[10]

10 Mr Wisheart told the Inquiry that emergency or urgent patients were generally admitted to and cared for pre-operatively at the Children's Hospital: '… their pre-operative management was by the cardiologists but became joint care once the referral to surgery had been made'.[11]

Under which specialty children were managed pre-operatively at the BRI

11 Mr Wisheart explained that elective patients were admitted to and cared for pre-operatively in the BRI under the joint care of cardiologists and surgeons: '… but there was a greater surgical contribution due to the fact that the paediatric cardiologists did most of their work at the BRHSC'.[12]

12 Julia Thomas, Clinical Nurse Manager of the Cardiac Unit,[13] told the Inquiry that on arrival at the BRI, if a child was very ill, he would either go straight to theatre or to the ICU, but otherwise would be admitted to the nursery for pre-operative care: '… once at the BRI, the children were under the care of the consultant paediatric cardiac surgeon, but care was also the responsibility of the multi-disciplinary team involving relevant medical specialties and nursing staff'.[14]

The management of pre-operative care at the BRHSC

13 In relation to the pre-operative care of children at the BRHSC, Dr Jordan explained that sick infants would be nursed in the paediatric ICU established in 1985:

> 'The unit was managed medically by a group consisting of the paediatric cardiologists, anaesthetists and Dr [Professor] Fleming from St Michael's Hospital, acting as a paediatric intensivist. The paediatric senior registrars ("SRs") and SHOs

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[9] WIT 0097 0296 Dr Joffe

[10] WIT 0099 0039 – 0040 Dr Jordan

[11] WIT 0120 0126 Mr Wisheart

[12] WIT 0120 0126 Mr Wisheart

[13] From 1988–1992, now a G grade Sister

[14] WIT 0213 0028 Julia Thomas

> also contributed. Latterly specific parts of paediatric SHO posts were devoted to the ITU but prior to that one or more SHOs at any one time combined work there with other duties. For the last few years, I believe that Dr Hughes, one of the anaesthetists, was in administrative charge.
>
> 'The main amount of regular attendance was at two fixed rounds each day, 8:30 and 17:30 (including Saturdays, Sundays and Bank Holidays) at which we made every effort to see that at least one cardiologist was present. There was usually a consultant and SR anaesthetists and the paediatric SR on call for that day. Dr Fleming also came regularly. In addition there were the SHOs with responsibility on the unit. The paediatric consultants did not usually come on these rounds but attended later, fitting in with their other duties, as did the paediatric surgeons. Obviously, if there was a cardiological problem at other times the cardiologist would be called and we were able almost always to ensure that the duty cardiologist was in the hospital or available from home.
>
> 'Although they operated at the BRHSC on a regular basis (every Monday morning and some Wednesdays, all day) and saw their patients on return to the ITU from theatre, the cardiac surgeons were less often available than the cardiologists. Initially some decisions such as when to remove chest drains were left to the surgeons, but increasingly were taken by cardiologists or other staff (there were no cardiac surgical junior staff at BRHSC) … We also, from an early stage, had echo-cardiography available and this was useful not only for diagnostic purposes but also to guide treatment for example by assessing left ventricular performance or pulmonary hypertension. This of course also applied to non-cardiac patients nursed on the unit to whose management the cardiologists also made a contribution.'[15]

14 Dr Jordan told the Inquiry about the equipment and staff available to the cardiologists to enable them to care for patients, including the management of pre-operative care:

> 'From 1987 onwards we had proper diagnostic equipment for angiography and echo-cardiography.'[16]

15 Dr Joffe told the Inquiry:

> 'In the early 1980s, children were catheterised in the BRI which, apart from having to transfer a child from BCH and back, was inappropriate for children. The angiography equipment was uniplane which meant that twice the number of contrast injections was required to obtain all the necessary views. The cardiac catheterisation suite which opened in the BCH in 1987 was "state of the art" at that stage, and functioned well until 1995.
>
> 'We struggled to acquire suitable echo-cardiography equipment during the early 1980s and it was only through the financial support of charitable organisations that

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[15] WIT 0099 0040 Dr Jordan

[16] WIT 0099 0043 Dr Jordan

> we were able to purchase a 2D echo-cardiography machine in about 1984, and a second in about 1989. The situation improved after Trust status, when we acquired our third machine, in lieu of the outmoded first apparatus. We were always short of cardiac technological staff and, throughout 1984 to 1995, we shared technicians with the adult cardiac catheterisation service at the BRI. It was only in this way that we could ensure that, for emergency catheterisation after hours, there would be someone on call who was familiar with the BCH equipment.
>
> 'The paediatric cardiologists performed all echo-cardiography procedures themselves until the late 1980s, when we were able to appoint our first echo-cardiographic technician with financial help from the paediatric oncology department for whom we provided a regular service. In the early 1980s, the paediatric cardiologists reported on all angiograms as part of the cardiac catheterisation reports. This was taken over by Dr Wilde, consultant cardiac radiologist in the mid-1980s and his overall advice and assistance was most welcome. By the early 1990s he became overwhelmed by the demands of adult cardiology and was no longer able to participate in the angiographic procedures himself, but still reported on the angiograms.'[17]

Further assessment of the clinical condition of children admitted for elective surgery following admission to the BRHSC

16 Dr Joffe told the Inquiry that children admitted to the BRHSC for elective closed-heart surgery:

> '… would be under the care of Mr Wisheart or Mr Dhasmana. However, these patients would be assessed by one or other of the consultant paediatric cardiologists during their twice daily ward round, which reviewed medical and pre- and post-operative surgical patients as a routine.'[18]

17 Mr Dhasmana said:

> 'These patients were admitted by the paediatric SHO attached to the cardiology team, and were also examined by the paediatric cardiologists during their ward round and, of course, I would be seeing patients and parents again before surgery … anaesthetists also saw patients as part of their pre-operative check-up.'[19]

18 Mr Wisheart explained:

> 'The pre-operative assessment is usually done to confirm the original diagnosis and the absence of any intercurrent illness in an elective patient. One was always conscious of the possibility of the development and evolution of sequelae of the congenital abnormality in elective patients. Between 1984–1995 this possibility

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[17] WIT 0097 0306 – 0307 Dr Joffe

[18] WIT 0097 0296 – 0297 Dr Joffe

[19] WIT 0084 0066 Mr Dhasmana

> was generally of decreasing significance which I believe is due to the fact that children were being operated on at an increasingly early age.'[20]

19 Mr Wisheart said that these patients admitted to the BRHSC:

> '… were reassessed both by the consultants and the junior doctors within paediatric cardiology and also by the consultant and the registrar in paediatric cardiac surgery. The child was assessed by the anaesthetists, but this would probably be for the first time.'[21]

The management of pre-operative care at the BRI

20 Children were generally admitted to Ward 5A at the BRI for elective surgery two days prior to their operation, having been transferred from the BRHSC. If the case was an emergency, children were admitted to the ward more quickly, or in some cases directly to theatre, depending on their condition and availability of ICU beds.[22]

21 The usual routine once on the ward was for the children to be clerked on admission by the SHO, who would examine the child and take a full medical history, request tests such as X-rays and bloods. The surgeon and the anaesthetist saw the child and parents pre-operatively, usually a day before surgery, when they would assess the clinical state of the child.[23]

22 Sister Julia Thomas told the Inquiry:

> 'The admitting nurse was responsible for welcoming the child and family to the unit. The pre-operative screening for infection was carried out by the nurse on admission. This included nose/throat swabs, urine samples and observations of temperature.'[24]

Observations of blood pressure and heart rate were taken and the child was measured and weighed.[25]

23 Julia Thomas said that the parents of the child were always involved in the pre-operative care and encouraged to stay with the child at all times before the operation. The child was prepared for theatre by the parents, who gave them two baths using anti-bacterial soap, and a hair wash.[26]

24 She continued in her evidence to say that pre-operative talks were given to the parents and to the child. A book was produced by the nursery staff for the parents to read, with

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[20] WIT 0120 0149 Mr Wisheart
[21] WIT 0120 0127 Mr Wisheart
[22] WIT 0114 0075 Fiona Thomas
[23] WIT 0114 0075 Fiona Thomas
[24] WIT 0213 0032 Julia Thomas
[25] WIT 0213 0033 Julia Thomas
[26] WIT 0213 0033 Julia Thomas

their child if appropriate, written in simple language with illustrative pictures.[27] The admission paperwork included a full discussion with the family about the child's likes, dislikes, fears, interests, etc.[28]

25 The parents were taken to see the ICU and the equipment was explained to them. They were encouraged to stay with their child at all times pre-operatively, and accompany them on their visits to other departments for electrocardiograms (ECGs) and X-rays, etc.[29] The family was always seen by a physiotherapist pre-operatively to explain treatment, and they were also seen by one of the nurse counsellors, Miss Helen Stratton or Mrs Helen Vegoda.[30]

26 An oral pre-medication was given to the child prior to surgery. The children painted their own operation gown with the play leader.[31] A nurse who knew the family accompanied the child to theatre. The parents were also able to accompany their child to theatre, although some consultant anaesthetists did not encourage the parents to go into the anaesthetic room.[32]

27 Mr Wisheart told the Inquiry:

> 'The nurses cared for the patients from the moment of their admission and made their own assessment in the period to surgery. If they found anything that they considered could be of importance to us they would always let the medical staff know. They had their own discussions with the parents and the families about the operation, about intensive care and other aspects of the patient's likely course.'[33]

28 Mr Wisheart went on:

> 'The physiotherapists play a very important role in the post-operative care of the patient. In order to do so they always saw the patients prior to surgery and made their own assessment at that time. They also undertook pre-operative physiotherapy and would have their own conversations with parents and families.'[34]

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[27] WIT 0213 0033 Julia Thomas
[28] WIT 0213 0033 Julia Thomas
[29] WIT 0213 0033 Julia Thomas
[30] WIT 0213 0033 Julia Thomas
[31] WIT 0213 0033 Julia Thomas
[32] WIT 0213 0033 Julia Thomas
[33] WIT 0120 0150 Mr Wisheart
[34] WIT 0120 0150 Mr Wisheart

Further assessment of the clinical condition of children admitted for elective surgery following admission to the BRI

29 In relation to children admitted for elective surgery to the BRI, Mr Wisheart confirmed that these patients would be reassessed following admission:

> '… the consultant surgeon had always seen the patients before and their status would be reassessed by the senior house officer, by the registrar and by the consultant. They were reassessed by the consultant paediatric cardiologist when he visited Ward 5. The anaesthetic registrar and the consultant would assess them; this would be for the first time and would not be a reassessment.'[35]

30 Mr Dhasmana explained:

> 'The pre-operative preparation included a clinical examination of the child as a whole and heart and lungs in particular. Blood tests included haematology, biochemistry, clotting study and for X-matching. The bacteriology tests included swabs taken from nose, throat or any other suspicious areas … ECG and chest X-rays were taken and patch tests for allergy to tapes and antiseptic solution were performed. A 2-D echo examination was repeated, if indicated. Suitability of the child for surgery was examined by at least three members of the medical team, admitting doctor, myself in all cases and a member of the anaesthetic team, during the pre-operative check-up and also by the nursing staff. Common causes for the postponement of routine operations were evidence of cold and other chest infections. Paediatric Cardiologists also used to see these patients. I would definitely ask for a Cardiologist's opinion if I felt that there was some change in the child's condition that required cardiological reassessment.'[36]

31 However, Dr Jordan and Dr Joffe told the Inquiry of the limitations on the cardiologists' involvement in pre-operative assessment or re-assessment at the BRI. Dr Joffe told the Inquiry:

> 'Because of their heavy workload with limited junior staff support … and the difficulties imposed by the split site … it was not possible for the consultant paediatric cardiologists to play much of a role in the immediate pre-operative assessment and post-operative care in the BRI.'[37]

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[35] WIT 0120 0127 Mr Wisheart

[36] WIT 0084 0066 Mr Dhasmana

[37] WIT 0097 0297 Dr Joffe

32 This was confirmed by Dr Jordan who told the Inquiry that reassessment following admission:

> '… was not always easy as far as the cardiologists were concerned as the children were admitted direct to Ward 5 at the BRI. Operation lists were produced at the end of the previous month but were subject to change according to the need to deal with emergencies and the availability of post-operative ITU beds in the BRI ward 5. I tried to see admissions of all patients the day before operation, but since there was no formal arrangement for this I often got to Ward 5 to find that the child had been sent off with his parents into town, having had his routine tests done. I was not encouraged to write anything in the notes to say that I had seen the patient. Clearly, if there was anything which I noted which suggested that the decision to operate should be reviewed, I would make every effort to contact the surgeon concerned. In practice this was unusual, but did occur on a few occasions. It should also be noted that the pre-op catheters … and echo results … would be at the Children's Hospital. It was possible for me or one of the radiologists (particularly Dr Wilde) to carry out a further echo-cardiogram if this was indicated. This became easier once the Heart Circle had provided money for an echo machine to be kept on the ward.'[38]

33 Dr Joffe stated:

> 'The majority of patients admitted to BRI for non-urgent open-heart surgery
> (a) would have been assessed fully, with echo-cardiography if necessary, either at BCH outpatients department or at a peripheral clinic, prior to the operation; and/or
> (b) would not have required further assessment of the cardiac status following comprehensive diagnostic investigations even a year before surgery, if the condition was known not to deteriorate in the medium term … an exception would be those patients without symptoms but with potentially progressive pulmonary vascular obstructive disease, who comprised a small minority of all open-heart operations. However, repeat clinical, radiological, electro-cardiographic and even echo-cardiographic examination in these cases would have been unlikely to establish whether a patient had changed from an operable to an inoperable state. I believe the only way to confirm the then current haemodynamic situation would have been to repeat the cardiac catheterisation study – or perform a lung biopsy. Even these investigations, of course, as is widely recognised in the field, are by no means infallible.'[39]

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[38] WIT 0099 0040 – 0041 Dr Jordan

[39] WIT 0097 0297 – 0298 Dr Joffe

34 Dr Jordan told the Inquiry:

> 'We did set out originally to look at the next weeks' operations in terms of reviewing the catheter and echo data at one of the combined (Monday or Wednesday) meetings with the surgeons, but since they did not manage to get to more than 50% of these at best, and there was often a backlog of recent investigations to discuss with them, this soon fell by the wayside.'[40]

Shortage of cardiologists with paediatric experience

35 In 1988 a joint working party of the British Cardiac Society (BCS) and the Royal College of Physicians of London (RCP) was set up as a result of what they called 'a perceived crisis in consultant staffing in paediatric cardiology in the United Kingdom' to look at the causes of the problems and make recommendations for the future. Their report[41] described the situation which confronted the profession in 1987 and 1988 as 'very worrying'.

36 Asked why it was that this particular crisis had arisen at that time, Dr Robert Swanton, President of the BCS, commented:

> 'I cannot tell you very much about it. I was aware there was a shortage of Senior Registrars in paediatric cardiology at that time. The paper goes on to point out that they will not be able to fill further consultant posts and suggests making proleptic appointments to allow continuing training in the consultant grade.
>
> 'Why that shortage of Senior Registrars occurred, I do not know. I think it was obviously manpower planning problems. We were dealing at that time with a very small specialty in its own right, anyway, and I think manpower planning obviously was a big problem at that stage.'[42]

37 Specifically concerning the situation in the South West, Dr Swanton said:

> 'I think part of the problem was the shortage of large hospitals in this part of the country. I mean, I do not know the area terribly well, but as it stands at the moment, in Cornwall there is one large unit in Truro and then, coming more in this direction, we have Plymouth. There are just those two units. Until recently, Plymouth did not have cardiac surgery and this city was the only centre for cardiac surgery in the whole of the South West of the country.
>
> 'The population is certainly big enough to justify it, but for some reason the development did not occur. Whether that was a local issue amongst the physicians, I just do not know, but it is still a problem, as I said earlier, in other parts of the country at the moment. There are big geographical holes in cardiac service

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[40] WIT 0099 0041 Dr Jordan

[41] BPCA 0001 0001 – 0004; *'British Heart Journal'* 1992; 68: 630–3

[42] T7 p. 7–8 Dr Swanton

> provision in the country. I do not want you to feel that the South West is alone by any means. There are huge black holes still.'[43]

38 The *'British Heart Journal'* published its fifth biennial survey, *'Staffing in cardiology in the United Kingdom 1988'*,[44] which stated that:

> 'The United Kingdom, with Ireland, has fewer cardiologists than all other European countries with reliable figures.'[45]

39 This shortage was reflected in Bristol, where the situation up to 1987 was that only two cardiologists, Dr Joffe and Dr Jordan, were carrying out the whole of the cardiological workload between them. The appointment of Dr Martin to consultant cardiologist at that time was proleptic. He was appointed to the position with six months of his training in paediatrics to complete before he could become a paediatric cardiologist.[46]

40 Mr Wisheart commented on the situation:

> 'Q. So we have difficulty in attracting a paediatric cardiologist in the 1980s — there may have been a shortage of them nationally, we have been told.
>
> 'A. I would not be able to say off-the-cuff when there were shortages, but I think they would be able to recognise that in a very small specialty, there can be problems of attracting trainees into it and having trainees ready for consultant posts at the irregular intervals when they become available. It is quite difficult. I think that was a problem for paediatric cardiology.'[47]

Further assessment by other specialties

41 Dr Stephen Pryn, consultant anaesthetist at the UBHT, told the Inquiry about the involvement of anaesthetists in pre-operative care:

> 'I always visited the patient on the afternoon or evening prior to surgery. I attempted to coincide my visit with the child's parents or guardians, although this was not always possible. I did not see it as my role, nor did I have the experience, to reassess the patient's cardiac condition with a view to determining whether the proposed operation was still indicated, nor whether this was the optimum time for the surgical intervention … during the visit I assessed the general medical fitness of the patient, reviewed the medication being taken, and assessed any specific anaesthetic problems. I developed an anaesthetic care plan in my mind and

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[43] T7 p. 52 Dr Swanton

[44] *'British Heart Journal'* 1989; 62: 482–7

[45] BCS 0001 0018; *'British Heart Journal'* 1989; 62: 482–7

[46] T84 p. 100–1 Mr Dhasmana

[47] T40 p. 82 Mr Wisheart

> explained to the parents the basics of my plan for pre-operative starvation, pre-medication, anaesthetic induction, invasive monitoring and intensive care.'[48]

42 Dr Pryn said:

> 'As an anaesthetist, I respected the experience and authority of the surgeons. If I saw a child pre-operatively and I thought that the child was not optimally fit for anaesthesia and surgery because, for example, of a chest infection, I would go and discuss the case with the consultant surgeon concerned. Having expressed concerns that I had, I appreciated that the surgeon had to balance the risks of delaying surgery with the risk of proceeding, and that the final decision had to be made by him.'[49]

43 Mr Eamonn Nicholson, clinical perfusionist, told the Inquiry:

> 'Perfusionists generally were not involved pre-operatively, save to visit the wards pre-operatively to review the patient's history from the records and to identify anything unusual which might affect the choice of equipment for perfusion … the pre-operative assessment and preparation did not involve perfusionists at the relevant time, but this has changed since Mr Pawade [consultant paediatric surgeon] came.'[50]

44 Mrs Mona Herborn, Sister in Cardiac Theatres at the BRI, explained that: 'Theatre staff had no input into pre-operative assessment of patients.'[51]

The decision to recommend surgery

45 The Inquiry heard that decisions about the type and timing of surgery and which surgeon was to operate were generally made following discussion in the joint cardiology/cardiac surgery meetings which were held twice weekly at the BRHSC catheterisation laboratory (Mondays at 8:00 am and Wednesday lunchtimes).

46 Mr Wisheart explained:

> 'These were essentially meetings between the cardiologists, the cardiac surgeons and the cardiac radiologist, but which frequently included the paediatric counsellor together with nurses and radiographers who worked in the catheterisation laboratory. From time to time an anaesthetist attended but this was not common. Where consultants were present, as far as possible, their juniors

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[48] WIT 0341 0016 Dr Pryn

[49] WIT 0341 0010 Dr Pryn

[50] WIT 0489 0053 Mr Nicholson

[51] WIT 0255 0031 Mrs Herborn

> would attend also … The paediatric cardiologist responsible for [the] child would indicate to which surgeon the referral was being made. He would then present the case, giving an account of the clinical history, the findings on examination …'[52]

47 Mr Wisheart said:

> 'In order to reach a decision there would then be a discussion which might primarily be between the referring cardiologist and the surgeon to whom the patient is referred but which would actively include all the others attending the meeting … the anaesthetists were not usually involved in this initial decision-making process and I think they would generally not regard it as being within their area of specialised expertise.'[53]

48 Mr Wisheart commented that the joint meetings:

> '… sought to make plans for the operation and also to foresee any additional features that would need to be taken into account during the procedure. This was recorded in the note of the meeting. If any additional features or developments came to light between the investigation and the operation, then the cardiologist would of course inform the surgeon.
>
> 'It was important that the anaesthetists, the nurses and the perfusionists should know what procedure was likely to be undertaken and what special features would be associated with any particular patient. I would expect our colleagues to be familiar with the patient's notes and all the expected details of the operation. If there were any special points affecting anaesthesia, perfusion or scrub nurses, then the surgeon would draw their attention to it prior to the operation. Having said that, it was relatively rare that such a discussion would be needed because all parties were used to working together and were familiar with each others' practice.
>
> 'Immediately prior to surgery, the patient was reviewed clinically, from the point of view of their present condition and the possibility of there being any intercurrent illness. The investigations were also reviewed. If such a review led to any new questions or any possible new interpretations of the data, then that would be discussed by the cardiologists, and/or cardiac radiologist and the paediatric cardiac surgeon as appropriate. The management of medication prior to surgery was agreed between us. There was not a meeting in the days or the week prior to surgery when all members of the team met together to discuss the details. However, the surgeon's team of registrar and SHO would discuss the details of all of these patients immediately prior to surgery.'[54]

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[52] WIT 0120 0128 Mr Wisheart. However, of the decision to refer to one surgeon or the other, Dr Jordan said that this '… was largely a function of which surgeon happened to be present, although there were some procedures, particularly the arterial switch, where it had been decided that only one surgeon (i.e. Mr Dhasmana) would carry out all operations.' See WIT 0099 0041 Dr Jordan

[53] WIT 0120 0129 – 0130 Mr Wisheart

[54] WIT 0120 0148 – 0149 Mr Wisheart

49 Mr Dhasmana stated:

> '… that it was the cardiologist's responsibility to refer their patients for the type of surgery and for the choice of a particular surgeon. However, it could have been influenced at the joint meeting …'[55]

50 Dr Jordan said that the decision whether or not to operate and when:

> '… was the final decision of the surgeon, but it was very unusual for there to be any disagreement on the treatment. More commonly discussions centred on whether other investigations were necessary and the exact timing of the operation. While we could together agree on the optimum timing the surgeon was the only one who controlled the waiting lists.'[56]

51 However, Mr Wisheart's view was that:

> '… to assign any "ultimate" responsibility to an individual is not appropriate to this process, which is based on discussion, debate and the agreement of a minimum of two people, before the referral can proceed. The answer to the question who carries ultimate responsibility therefore, cannot be one individual but must be at least two, namely the cardiologist and the surgeon, but it could be argued that it actually lies with the larger team.'[57]

52 If differences of opinion between the clinicians could not be resolved after discussion or it was agreed that further advice was required or that the patient should be referred to another centre, the cardiologist or the cardiac surgeon would make a referral.

53 In the case of urgent patients where decisions could not wait until the next Monday or Wednesday meeting, Mr Wisheart explained:

> 'The cardiologist will call the surgeon receiving paediatric cardiac emergencies on that day, and they would meet, possibly with the radiologist, see the patient and review the investigations. They would then decide what in their view was the appropriate course of action.'[58]

The decision on the timing of operations/the operating theatre list

54 The Inquiry heard that the joint meetings would discuss the category to which each patient should be assigned: elective, urgent or emergency.[59] The timing of surgery was then dependent on the theatre lists.

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[55] WIT 0084 0067 Mr Dhasmana

[56] WIT 0099 0041 Dr Jordan

[57] WIT 0120 0132 – 0133 Mr Wisheart

[58] WIT 0120 0130 – 0131 Mr Wisheart

[59] WIT 0120 0134 Mr Wisheart

55 Dr Jordan felt that the timing of the surgery was in the hands of the surgeons, although:

> 'The cardiologists did continue to see patients on the surgical waiting list and would remind the surgeons of patients who appeared to be waiting too long.'[60]

56 Dr Jordan told the Inquiry that the timing of operations:

> '… was entirely dependent on the waiting lists and the surgeon's assessment of urgency … in addition, it did also relate to the availability of paediatric trained nurses and the length of stay of children and infants already operated, some of whom stayed for over two weeks in ITU … certainly some patients, particularly those with AVSD [Atrio-Ventricular Septal Defect] and pulmonary hypertension in whom it was intended that operation should take place within one to two weeks, had to wait that number of months, or even longer.'[61]

57 Dr Jordan stated that the organisation and management of theatre lists was the responsibility of the surgeons at both the BRI and BRHSC.[62]

58 Dr Joffe agreed with Dr Jordan that the organisation and management of theatre lists was entirely in the hands of the surgeons.

59 Dr Joffe told the Inquiry that at the joint meetings:

> 'The paediatric cardiologists would … always give their perception of the urgency of the required intervention … The surgeons made the decisions about the timing of surgery.'[63]

60 Dr Joffe added:

> '… the patients are discussed in detail at joint meetings of cardiac surgeons and paediatric cardiologists and others and decisions are jointly come to in the vast majority of cases. Then the patient is either accepted or not, usually accepted, by one or other surgeon and then the patient's name goes on to a surgeon's list, not on the waiting list yet but an acceptance that the surgeon will see the family in outpatients and it is at that time, once the surgeon has had an opportunity to discuss the details of the risks with the families, that they effectively go on to the waiting list.
>
> 'So there would be a time period between the joint meeting which itself usually occurred within two to three weeks or so of the cardiac catheter study, if one is done or otherwise on the basis of the echo-cardiographic findings, the paediatric

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[60] WIT 0099 0042 Dr Jordan

[61] WIT 0099 0042 Dr Jordan

[62] WIT 0099 0042 Dr Jordan

[63] WIT 0097 0301 Dr Joffe

> cardiologists would put that patient into the list for discussion, so there is a short period of delay there inevitably in the system and then once the surgeon has accepted the patient after seeing the family, [the patient] goes on to their waiting list.'[64]

61 Mr Wisheart commented on the organisation and management of the theatre lists:

> 'Mr Dhasmana and I operated on children according to a consistent programme, and on days when cardiac anaesthetists were present … The operating plan for each month was made in the previous month; some gaps would be left so that emergencies could be accommodated … in selecting patients from the waiting lists for each month's operating programme I normally reviewed all the children on the waiting list. I would then select six or seven children for the operating programme. The selection would be based on the urgency which had been assigned to the patient and the length of time they had been waiting already. Any other features of note would be taken into account …'[65]

62 Mr Wisheart explained:

> 'If it is either urgent or emergency, then arrangements will be made at that point for the operation to be carried out.'[66]

Timing of emergency operations

63 In relation to emergency cases, Dr Joffe said:

> 'There were rarely problems with regard to the timing of an operation for patients requiring an emergency procedure … a theatre slot could always be arranged at the BRI for these patients, even if it meant cancelling a previously booked adult case. Quite often, these operations would be fitted in over the weekends.'[67]

64 Mr Dhasmana confirmed that emergency patients would be operated on:

> 'Whenever required, out of hours, in the night or over weekends.'[68]

Timing of urgent operations

65 Mr Wisheart provided a 'working definition' of the urgent category, namely:

> '… that the patient had to be operated on before they left hospital. Occasionally it would have included patients who were well enough to leave hospital, but nevertheless needed to be operated on within the next week or two.'[69]

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[64] T90 p. 81 Dr Joffe

[65] WIT 0120 0135 Mr Wisheart

[66] WIT 0120 0134 Mr Wisheart

[67] WIT 0097 299–300 Dr Joffe

[68] WIT 0084 0067 Mr Dhasmana

[69] WIT 0120 0137 Mr Wisheart

66 Mr Dhasmana told the Inquiry:

> ‘I would also tell parents, in the group of patients which were categorised as urgent/semi urgent, when to expect surgery. They could ring nearer the time to find out if the operation was on schedule or not. This would also serve as a reminder regarding the state of urgency … I would also tell parents to take the child to their doctor or referring clinician if there were any changes in the patient’s clinical condition. The GP and/or cardiologist would also remind me of the urgency. I used to leave a slot empty each week to accommodate an urgent case or any other patient, I had been informed of deteriorating while waiting for surgery.’[70]

Timing of elective operations

67 Mr Wisheart said:

> ‘If the operation is an elective one then a view is needed as to whether the operation should be in one month, three months, six months, one year or whenever. The arrangements will be made to see the family in the outpatients, and if the family accepts the advice which is offered to them, then the patient’s name is placed on the surgeon’s waiting list. The parents were informed in a broad way of when the operation was expected to take place. In practice, these estimates were not always accurate. The paediatric cardiologist continued to see the patient in his outpatient clinic … he would keep the surgeon informed of any new development or change in the patient’s condition that might influence the timing of surgery. The surgeon, when he made his monthly operating programme, determined the exact date of the proposed operation for each patient.’[71]

Delays in surgery

68 Dr Joffe said: ‘We were aware that there were constraints at times due to insufficient beds or nurses’[72] in carrying out operations at the BRI. However, he stated that emergency cases were normally dealt with within 24 hours.[73]

69 Dr Jordan said:

> ‘There were certainly continuing and important delays. For example, from about 1990 onwards we were trying to investigate all babies with Down syndrome [*sic*] and AVSD or large VSD [Ventricular Septal Defect] by three to four months in the expectation that they would then get their surgery within four to six weeks, but they often had to wait that number of months before an operation could actually take place. How much this affected the outcome, is a matter for speculation, but the general view for pulmonary hypertensive patients was that any delay would increase the risks.’[74]

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[70] WIT 0084 0067 Mr Dhasmana

[71] WIT 0120 0134 Mr Wisheart

[72] WIT 0097 0302 Dr Joffe

[73] WIT 0097 0301 Dr Joffe

[74] WIT 0099 0042 Dr Jordan

70 Dr Joffe commented on the delays in the urgent group of patients. He told the Inquiry that these were patients:

> '… for whom surgery was not so critical as to need an operation within about 24 hours, but who could deteriorate in the course of weeks or months. This group included patients who became increasingly cyanosed; and infants with large communicating defects and left to right shunts, causing high pulmonary blood flows and severe heart failure. Despite intensive treatment with appropriate medication, these babies remained breathless, could not feed adequately, and failed to thrive. They were often hospitalised at BCH for many weeks while awaiting surgery. Also in this group were infants with pulmonary hypertension, as occurs particularly with complete atrio-ventricular septal defects, typically in babies with Down's syndrome.'[75]

71 Dr Joffe continued:

> 'The concern about those who were deeply cyanosed or in persistent heart failure was that they might not be in optimal general condition for surgery. This could lead to difficulties at operation and in the immediate post-operative phase.'[76]

72 Of the urgent patients Mr Wisheart said:

> 'In many ways these patients offered us the greatest problem because they neither had the emergency status that clearly took priority over everybody else nor could they simply wait. We would normally seek to schedule them in the next gap in our operating programme (we did leave gaps for urgent and emergency cases). Of course the gaps were not usually available at the right time. In that event, either the urgent patient had to wait a little longer or else he had to replace a patient who was expecting surgery with all the disappointment for that family.'[77]

73 Mr Wisheart said:

> 'We did our best within the facilities available to us to ensure that children were operated on at the appropriate time. It should be remembered that for the many patients the "appropriate time" would have spanned quite a long period … we were not in the position where we had a facility with sufficient spare capacity to be able to deal with every child when he or she presented.'[78]

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[75] WIT 0097 0300 Dr Joffe

[76] WIT 0097 0302 Dr Joffe

[77] WIT 0120 0137 Mr Wisheart

[78] WIT 0120 0138 Mr Wisheart

74 Mr Wisheart explained:

> ‘It was my practice to give a broad indication when we would like to do the operation so that the parents and families can plan ahead … We tried to operate at the predicted time, but certainly did not always succeed.‘[79]

75 He explained that operations would have to be postponed if there was no ICU bed available, there was a shortage of nurses, and there was an emergency or, rarely, a shortage of blood for transfusion. Every effort would be made by members of the team to overcome these problems. If they could be overcome then the work would be done and the patient would be operated on. If they could not be overcome safely, then it would be dangerous and not in the patient’s best interests to proceed.[80]

76 Dr Joffe, commenting on delays in respect of non-urgent cases, said that such cases:

> ‘… would often be delayed beyond the anticipated date for surgery because of competition with the long adult waiting list. On the other hand, the long-term outcome for these patients would usually not be any different, even after delays of several months.’[81]

77 Dr Laband, a junior doctor at the BRHSC from November 1994 to January 1995, stated in a letter to the Inquiry:

> ‘It was a generally held view among the medical staff that these babies were held in the waiting list for far too long and were in a much weaker condition than they need have been.’[82]

78 Mr Wisheart said:

> ‘… patients having elective operations sometimes had to wait a considerable time for surgery, perhaps longer than predicted at the outset. For the great majority this was not of critical importance, but for some it may have been of significance.’[83]

79 Mr Dhasmana estimated that elective surgery patients could wait for eight to nine months before surgery and sometimes longer if they were moved in order to accommodate more urgent cases.[84]

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[79] WIT 0120 0139 Mr Wisheart
[80] WIT 0120 0140 Mr Wisheart
[81] WIT 0097 0300 Dr Joffe
[82] INQ 0042 0004; letter from Dr Laband
[83] WIT 0120 0142 Mr Wisheart
[84] WIT 0084 0067 Mr Dhasmana

80 Mr Dhasmana commented on whether operations were carried out at the appropriate time. He told the Inquiry:

> '… every clinician worries about the waiting list and the known fact that a patient may deteriorate over this period. Ideally there should not be a waiting list for any patient, but resources are limited and the clinician has to prioritise amongst his patients on the basis of clinical criterion … there were targets to be attained for the number of Coronary Arterial Surgery so there was unwritten competition between adults and paediatrics. Some of our colleagues, practising with adults only, used to get unhappy with the prospect of ITU beds getting "clogged" by paediatric patients. Mr Wisheart and myself used to make some adjustments to our operating programme so that not more than three major paediatric operations were carried out in one week … The availability of beds in ITU also played an important role in the scheduling of both adult and paediatric operations. Similarly, the availability of anaesthetists was a factor in my scheduling of paediatric operations. During the mid to late 80s Dr Masey and Dr Burton were the main anaesthetists dealing with infants and neonates. The situation improved in the 1990s with the appointment of Dr Underwood and Dr Pryn enabling us to operate on infants more frequently. Additionally, the availability of nurses capable of dealing with children was also a known factor … the situation could get worse if there was leave of absence due to sickness amongst this small core of nurses in the ITU or in the operating theatres.'[85]

81 Mr Dhasmana felt that the operations were at a time 'that was not ideal, but most probably appropriate in the circumstances, with limitations in the resources.'[86]

82 Mr Wisheart commented on the waiting lists:

> 'In the situation in which we found ourselves where most months we would have liked to operate on twice as many patients as we were able to do, it was unfortunately essential to establish priorities amongst patients who were ready for surgery.'[87]

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[85] WIT 0084 0067 – 0068 Mr Dhasmana

[86] WIT 0084 0068 Mr Dhasmana

[87] WIT 0120 0137 Mr Wisheart

83 Julia Thomas said:

> ‘There were occasions when the intensive care beds were occupied by seriously ill patients and other cases had to be cancelled … this situation was improved by the expansion of the intensive care beds to eight, and the provision of seven high dependency beds, in 1988. This allowed the less complicated of the adult cases to be “fast tracked” in the high dependency unit, thus leaving the ITU beds available for more seriously ill patients. Occasionally, nursing staff shortages, mainly due to sickness, caused the closure of an ITU bed. There were also occasions when theatre staff sickness caused cases to be cancelled. This also happened when theatre staff had been working during the night on emergency cases, as the first morning case was then postponed. This had a knock-on effect on the theatre list for the rest of the day.’[88]

84 Mrs Herborn explained the organisation and management of theatre lists:

> ‘A monthly meeting would take place between surgeons where the monthly theatre list would be made. This was passed to the theatre sister who would arrange the theatre staff duty roster around the theatre list. However, each list would invariably undergo a multitude of alterations. These may have been due to a shortage of beds in the ITU, a more urgent/emergency case being presented, or the fact that because an operation had overrun the previous day, there was no scrub nurse or anaesthetic assistant available to assist that morning’s operation. Daily theatre lists were compiled by the Senior House Officer in cardiac surgery and sent to us the afternoon before. These were more detailed than the monthly lists so that theatre staff were able to prepare the theatres according to the type of operation to be undertaken.’[89]

85 Mr Wisheart also explained that late referral for surgery, whether by a general practitioner, paediatrician or paediatric cardiologist, would be a reason for the operation taking place later than might have been desirable.[90]

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[88] WIT 0213 0031 Julia Thomas

[89] WIT 0255 0029 – 0030 Mrs Herborn

[90] WIT 0120 0142 Mr Wisheart

Chapter 14 – Care in the Operating Theatre and the ‘Learning Curve’

Introduction

1 This chapter is in two separate but connected parts, ‘Care in the operating theatre’ and ‘The “learning curve”’.

2 The first part deals with the full operating team in theatre and focuses on the roles of the various contributors to patient care in the operating environment.

3 The second part considers the ‘learning curve’ that surgeons have to manage in order to carry out new procedures and improve techniques and skills for the benefit of patients. It also specifically considers the Arterial Switch procedure.

Care in the operating theatre

The operating theatre team

4 Mr James Wisheart, consultant cardiac surgeon, explained:

> ‘… the team in the operating theatre is made up of:
>
> ‘(i) the anaesthetists, who normally include consultants, either senior registrars or registrars and the anaesthetic nurse;
>
> ‘(ii) the surgeon, together with his senior registrar or registrar and senior house officer;
>
> ‘(iii) the nurses who scrub to assist the surgeon and to be the “runner”[1] in the operating theatre (and the anaesthetic nurse);
>
> ‘(iv) the perfusionists who operate the cardio-pulmonary bypass equipment.’[2]

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[1] Or ‘circulating nurse’

[2] WIT 0120 0165 Mr Wisheart

5 Mr Janardan Dhasmana, consultant cardiac surgeon, identified the members of the operating theatre team as being the surgeons, anaesthetists, nurses, perfusionists, supporting laboratory staff and technicians.[3]

6 Mr Wisheart explained how a particular team would be brought together for an operation. He said that the patient was referred to a surgeon and placed on his waiting list and would then be scheduled for an operation on a day when it was known that a paediatric cardiac anaesthetist would be working:

> ‘When the nursing team sees the operating programme it plans the allocation of its members to particular operations, and a nurse who is experienced in the work for children will be allocated to this paediatric procedure.
>
> ‘Similarly an anaesthetic nurse who has experience with children will be allocated to assist the anaesthetist.
>
> ‘The perfusionists will similarly allocate one of their members to carry out this perfusion and one to assist them. The assistant may be either more junior or more senior than the person who is actually undertaking the perfusion.’[4]

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[3] WIT 0084 0070 Mr Dhasmana

[4] WIT 0120 0166 Mr Wisheart

7 Mr Wisheart explained the involvement of the various teams in the various phases of an operation in the form of a table:[5]

Phase of the Operation	Anaesthetic Team	Surgical Team	Nursing Team		Perfusionists
			Anaesthetic Nurse	Scrub Nurse	
1) In the Anaesthetic Room	+	Standby	+	Preparing	Preparing
2) Moving into Operating Theatre	+	Registrar present in Theatre, Consultant on standby	+	Preparation complete, ready to Begin	Preparing
3) Preparing for Cardio Pulmonary Bypass	+	Usually done by Registrar, sometimes the Consultant & Registrar	+	+	Standing by
4) On Cardio Pulmonary bypass	Consultant may take break for coffee, Registrar stays	+	+ or –	+	+
5) Coming off Cardio Pulmonary Bypass	Consultant returns +	+	+	+	+
6) Closing the chest	The Consultant and/or the Registrar	The Consultant and/or the Registrar	+ or –	+	Initially standing by then tidying up

Note: + indicates that the whole team is actively participating in this phase of the operation.
+ or – indicates this person or group in the team need be less fully committed during this phase of operation.
29/06/99

8 Mr Dhasmana commented on Mr Wisheart's table:

> 'I have nothing more to add, except for supporting his statement that every team was an integral part of the whole service and communication and co-ordination between different teams was essential in order to achieve successful outcomes.'[6]

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[5] WIT 0120 0168 Mr Wisheart. The table does not refer to the actual conduct of the surgery

[6] WIT 0084 0070 Mr Dhasmana

9 Mr Wisheart also set out those factors that he thought affected the performance of the team in the operating theatre. These included:

> 'Mundane issues such as the absolute necessity for punctuality, openness and honesty … Each individual member of the Team must have prepared for the operation and should anticipate the problems and needs that could arise.'[7]

10 Mr Wisheart commented on the hours of work. He said:

> 'The theatre nurses contracts provided for a stated number of hours per week. In cardiac surgery the nurses also provided on call cover at nights and weekends. If they worked extra hours attempts were made to "give back" those hours.
>
> 'Perfusionists worked in a similar way, but were paid for overtime hours.
>
> 'Junior doctors contractual arrangements evolved during the period 1984–1995. Initially there was no specified number of hours of work; later it was limited to 80 hours a week and still further on to 56 hours a week as a target. In cardiac surgery vigorous efforts were made to comply with these regulations but we did not always succeed.
>
> 'Consultants contracts do not specify any particular number of hours per week.[8]
>
> 'There were occasions when personnel were tired but I believe their performance in the operating theatre remained at a high level.'[9]

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[7] WIT 0120 0171 Mr Wisheart

[8] This may convey a misleading impression. The Inquiry has received advice that from 1984 until 1st April 1991, the National Health Service (Remuneration and Conditions of Service) Regulations 1974 provided for the remuneration and conditions of service of officers employed by a Health Authority or Special Health Authority. These 'officers' included doctors**.** Forty-four hours were contracted for (11 sessions of four hours' notional duration). With effect from 1st April 1991, the National Health Service (Remuneration and Conditions of Service) Regulations 1991 were made, which, amended only in respect of the definition of authority, to take account of changes made by the Health Authorities Act 1995, and in respect of the power of Authorities to determine remuneration where there was no recognised negotiating body, continue to the present.
Where a full-time consultant or Associate Specialist appointment is made, it may be held on one of two bases: whole time or 'maximum part-time'. Both are '… expected to devote substantially the whole of their professional time to their duties in the NHS'. A maximum part-time practitioner is paid ten-elevenths of the whole time salary, and has a minimum work commitment equivalent to ten notional half-days.
It appears to follow that a consultant contracts for 11 sessions per week, each session being of a notional four hours' duration.
'Employing authorities' (i.e. Trusts) may offer part-time appointments to be held by consultants and associate specialists.
A staff grade of hospital practitioner contracts for a minimum average work commitment of 10 sessions a week, each session being equivalent to four hours' work *plus* a liability to deputise for absent colleagues who are on annual and study leave, or for no more than two weeks where other forms of leave have been taken or a vacancy has been unfilled. In addition, the staff grade practitioner commits to undertake 'such exceptional irregular commitments outside normally rostered duties as are essential for continuity of patient care; and … exceptionally, duty in occasional emergencies and unforeseen circumstances.' Junior doctors (SR, R, SHO and HO grades) contract for 40 standard hours per week, plus 'such further hours … as are agreed with the employing authority' subject to certain controls. Those controls in the 1995 edition introduced a provision that 'as soon as practicable the maximum average contracted hours of duty for practitioners working on on-call rotas' should not exceed 83 per week, including handovers at the start and finish of duty periods. There are other provisions restraining the average contracted hours 'in hard-pressed posts', and preventing any period of continuous duty being longer than 32 hours during the week and 56 at weekends, and for a minimum period of time off every three weeks.

[9] WIT 0120 0173 Mr Wisheart

The role of the surgeons

11 Mr Wisheart told the Inquiry:

> 'In the operating theatre the surgeon is the lead figure and has the ability to determine the prevailing atmosphere.'[10]

12 Mr Wisheart stated:

> 'The anaesthetic team will consist normally of a consultant, a Senior Registrar or Registrar and a nurse. In addition to their own internal communications they need to maintain a good level of communication with the surgeons and with the perfusionists and finally with the laboratory. As the surgeons, perfusionists and anaesthetists know each other, these communications do not need to involve lengthy conversations …
>
> 'The surgeons need to maintain a good level of communication with the anaesthetist, with the scrub nurse and with the perfusionists. Again, because the parties know each other, many of these communications may be unspoken. This is particularly the case with an experienced and efficient scrub nurse, who anticipates the needs of the surgeon …
>
> '[The anaesthetic nurse's] work is chiefly with the anaesthetic doctors, but he or she will frequently have a role of keeping the Ward informed of the progress of the operation and from time to time will interact with the nurse who is the "runner"…
>
> '[The scrub nurse] relates most closely and importantly to the operating surgeon and his team, but she also interacts frequently and importantly with the nurse who is the "runner" who provides the scrub nurse with any instruments, disposables, implants or other equipment, which she may need. The scrub nurse has some interactions with the perfusion team with regard to the provision of disposables which the surgeon uses in establishing cardio pulmonary bypass.'[11]

13 Dr Stephen Pryn, consultant in anaesthesia and intensive care, said of Mr Wisheart and Mr Dhasmana in the following exchange:

> 'A. They were never in theatre scrubbed ready to go when we came in from the anaesthetic room. Quite often, especially with Mr Wisheart's cases, the child would be anaesthetised on the operating table, the case would be started by his Senior Registrar, and the Senior Registrar would then get ready to place the lines to go on to bypass and the operation would then stop, as the nurses madly phoned around to try and find where Mr Wisheart was and ask him to come down, and we would basically be twiddling our thumbs for quite a long time before we could progress.

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[10] WIT 0120 0170 Mr Wisheart

[11] WIT 0120 0169 – 0170 Mr Wisheart

> ‘Q. Quite a long time?
>
> ‘A. Maybe half an hour. That never happened with Mr Pawade.[12]
>
> ‘Q. What about Mr Dhasmana? Had that been a problem with him?
>
> ‘A. He was not present when we brought the cases into theatres, but he was often present at the start or shortly after the start of surgery, so not so much a problem waiting to go on bypass with him.’[13]

14 Mrs Kay Armstrong, Cardiac Theatre Sister at the BRI, stated in her written evidence to the Inquiry:

> ‘Weekly meetings also took place between theatre sister, manager, surgeon, anaesthetist and perfusionist to discuss day to day problems, including the punctuality of surgeons. This was a big issue because we would bring a patient into theatre, anaesthetised. They would then be prepared for surgery by the registrar ready for the consultant surgeon to put them on bypass. However, there would sometimes be a long wait before the Consultant arrived which I felt was dangerous. Mr Wisheart was the main offender. Mr Dhasmana would usually come when he was asked.’[14]

She later continued:

> ‘We were often kept waiting for a surgeon to appear in theatre despite several attempts to inform him that the registrar had the patient ready to go on bypass.’[15]

15 Mr Wisheart commented in his written reply:

> ‘There is a practical problem in that the time taken to anaesthetise and place the patient on by-pass was extremely variable, and could range from a little over one hour up to three hours. I was always in the hospital at or immediately after 0800, but did not feel that I could simply spend the time waiting in the theatre suite. Therefore I sought to do something useful waiting to be called when needed.’[16]

He also stated:

> ‘In order to be in theatre when needed I expected to be called a sufficient time ahead to enable me to get to theatre, change and scrub. This did not always happen and I do recall asking to be called earlier on quite a number of occasions …

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[12] Consultant paediatric surgeon from 1995
[13] T72 p. 113 Dr Pryn
[14] WIT 0132 0009 Mrs Armstong
[15] WIT 0132 0014 Mrs Armstrong
[16] WIT 0132 0067 Mr Wisheart

‘If this was perceived to be a major issue, it was not drawn to my attention at the time in those terms by either the nursing or anaesthetic staff.’[17]

16 This issue was further explored with Mrs Armstrong in the following exchange:

‘A. The variability in time should have nothing to do with it. The point is that we would never send for the surgeons until we were ready for them to come. When we sent, it was how quickly they responded to us sending for them.

‘Q. But the variability, the length of time it took to put the patient on bypass is completely irrelevant because the surgeon would always be there before the patient began to go on bypass?

‘A. Yes, but not before – when I say “put the patient on bypass”, there is a good half an hour’s surgery that takes place before that.

‘Q. I do not think we are at odds.

‘A. (To the Panel): You understand, yes? So someone else opens the patient up. Someone else may well put the “purse strings” in. When we are at the point when the heparin is being given and we are putting the “purse strings” into the patient, then we would call for Mr Wisheart or Mr Dhasmana to come to theatre to put the patient on bypass.

‘Mr Dhasmana would always come straightaway, but Mr Wisheart would take some time to come and we would often need to call him two, maybe three times.

‘Q. Who would call the surgeon?

‘A. Whoever was the circulating nurse on that day.

‘Q. How much warning would a surgeon reasonably need, do you think, to be told and able to get to the theatre and change and get himself ready?

‘A. I would think they would need 10 to 15 minutes.

‘Q. So do you understand Mr Wisheart’s comment …?

‘A. No. I do not feel that the time taken in the anaesthetic room is relevant because we would not send for him until we were ready for him.

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[17] WIT 0132 0067 – 0068 Mr Wisheart

> ‘Q. He does say ... that if this was perceived to be a major issue, nobody told him that it was a major issue?
>
> ‘A. It was brought up frequently at the meetings. We used to have meetings where there was myself or Sister Herborn, the theatre manager. There would be the chief perfusionist and Mr Wisheart and punctuality was often on the agenda.
>
> ‘Q. So he is wrong about that?
>
> ‘A. I believe him to be wrong about that.’[18]

17 Mr Dhasmana commented in writing on Mrs Armstrong’s statement that he ‘would usually come when he was asked’:

> ‘I feel that this is a vague statement and may impart unfairly on me. In cases of complex and other major paediatric operations and in all emergency operations, I would always be waiting for the patient to arrive in the theatre from the anaesthetic room ... However, during many routine adult operations, some paediatrics like ASD and isolated VSD and [a] few other paediatric operations in older children the senior or experienced Registrar would start the case and I would then be called in when it was ready to go on bypass. I would like to add that this is a common practice in adult cardiac surgery amongst cardiac units in the UK.’[19]

18 Mrs Armstrong commented further in the following exchange:

> ‘A. He [Mr Dhasmana] was always present in theatre if we had an emergency such as a dissection or something like a TAVPD … Our instructions were to bleep him when the patient was brought into theatre. Those were always our instructions. We would bleep him. He would respond to his bleep, and then he would come to theatre. That process would probably take between 15 and 20 minutes.
>
> ‘Q. Just a little longer than the time-frame you mentioned a moment ago?[20]
>
> ‘A. That is correct. I did say that Mr Dhasmana would usually come when asked.
>
> ‘Q. You say Mr Wisheart was the chief offender?
>
> ‘A. That is correct.’[21]

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[18] T59 p. 62–4 Mrs Armstrong

[19] WIT 0132 0024 Mr Dhasmana; see Chapter 3 for an explanation of clinical terms

[20] ‘10 to 15 minutes’; T59 p. 63 Mrs Armstrong

[21] T59 p. 64–5 Mrs Armstrong; see Chapter 3 for an explanation of clinical terms

19 Mr Wisheart told the Inquiry subsequently that there were occasions when a surgeon was late arriving in theatre.[22] He explained his approach:

> 'So I, in general, sought to use the time some other way and asked the theatre to inform me in good time so I could stop what I was doing, change, scrub and join the operation.
>
> 'The problem that seemed to arise is that when they informed me they really wanted me in 10 minutes rather than in 20, if I may put it that way. I am not saying I was never at fault myself in any other way, but that was a common issue and it arises directly out of this sort of background; how long does it take to get going, and one never knew.'[23]

20 Mr Wisheart was asked by Counsel to the Inquiry in the following exchange:

> 'Q. ... if it is the case that it was a late call by the theatre to you when you were quite appropriately doing something else, can you help with why the comment should be directed more at you than at him [Mr Dhasmana] because one would have thought that it ought to have been equal?
>
> 'A. I cannot comment. I mean I cannot contribute anything to that, I am sorry.'[24]

21 Dr Sally Masey, consultant anaesthetist, told the Inquiry about the organisation of the theatre in the following exchange:

> 'Q. In the theatre there was a change, was there not, in 1994 in the organisation of the theatre in that surgical assistants were appointed?
>
> 'A. Two part-time surgical assistants were appointed, but I do not know the date.
>
> 'Q. Why was that change made?
>
> 'A. I do not know the reason why the change was made.
>
> 'Q. What was the professed reason for it?
>
> 'A. I cannot recollect professed reasons — reasons given for it, but I can think of reasons why this move was made.

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[22] T93 p. 125–6 Mr Wisheart

[23] T93 p. 126 Mr Wisheart

[24] T93 p. 127 Mr Wisheart

> ‘Q. What would they be?
>
> ‘A. The reason would be that the surgical assistants would be able to perform operative tasks that at that time were being performed by surgical Senior House Officers. This would free up those SHOs for other duties, if these duties could be performed by surgeons’ assistants.
>
> ‘Q. What was your attitude to this change …?
>
> ‘A. I felt it was a positive move.’[25]

The role of the theatre nurses

22 The theatre staff were made up of Registered General Nurses (RGNs), State Enrolled Nurses (SENs) or Operation Department Practitioners (ODPs). In 1994 it was decided to have separate teams of anaesthetic and scrub nurses so that the anaesthetists were working with the same staff to provide continuity.[26] Prior to this the staff were multi-skilled and worked on the scrub side and also in the anaesthetic room.[27]

Performance of the team: a surgeon’s perspective

23 Mr Dhasmana discussed teamwork in the operating theatre and the way in which operations at Bristol were conducted as compared with those he had witnessed in Birmingham when he went to observe the consultant paediatric cardiac surgeon, Mr Brawn, in the following exchange:

> ‘Q. What was it about his team that was better than your team?
>
> ‘A. Well, he had a dedicated paediatric cardiac surgical assistant in a way. My assistant, even though he could be a Senior Registrar, may not be a dedicated paediatric cardiac surgical assistant, may not have seen that many paediatric cardiac surgical cases and I have no other option but to take his assistance at that time to help me.
>
> ‘So in a way he would not automatically move in the same way or anticipate my move as it was being done in Birmingham. Similarly, nurses in Birmingham, they had almost everything ready on the table. They knew when he was going to require a suture, it was almost as if he is not looking, he is just doing that, he is getting it.
>
> ‘I used to really say in theatre that “we are not running a relay service here” because that is what I was noticing. Most of the time I am saying “4 O” then somebody else is in 4 O then somebody is getting from there and obviously by that time I would look at what is happening and this is all distracting.

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[25] T74 p. 33 Dr Masey

[26] WIT 0132 0006; Mrs Armstrong stated that she enrolled on the anaesthetic course in 1993 in preparation for this split

[27] WIT 0132 0006 Mrs Armstrong

‘That was one of the problems, that sometimes some of the nurses in theatre were very uncomfortable with me because I did not like that type of — it is not service to me, I thought it is service to the patient, and that was lacking and I think it was lacking because these nurses were on the same day dealing with an elderly gentleman, another person where probably such things do not matter that much at the time, but here it did.

‘Q. Again you are picking up I think on two or three factors there: one is that the consequence of having a “relay” operation, one person turning to another to another to another, is a further delay in the time it would take you to complete your operation?

‘A. That is correct, sir.

‘Q. Secondly, it indicates that if you needed something very quickly you might have to wait for it and that is not a good thing?

‘A. That is correct, sir.

‘Q. Thirdly, it indicates, does it, that you reacted to the nurses, telling them off for running a relay operation for the reasons you have explained, which I think you have told us sometimes affected the atmosphere in the theatre?

‘A. I am aware of that.

‘Q. If you have an atmosphere in an operating theatre I suppose that the whole team does not function quite so well; it is inevitable, is it not?

‘A. By “atmosphere” I do not really mean it should be pleasant with music going and all these things. I feel it should be professional and I felt it is not professional that, you know, things are not there. I mean the list is already out, you know what we are going to do. In a way it should be professionally ready for you and that is where my in a way criticism was.

‘As far as the pleasantness is concerned, I was very pleasant outside operating time, but during the operating time, I did not want chit-chat, I wanted things done and that somehow was not popular with many nurses.

‘Q. So for the reasons you have given, you could be cross and irritable in the operating theatre, could you?

‘A. I never realised that I could be, but yes, it would be seen that way.

> ‘Q. If you were telling nurses off for a relay operation as you have described it, your need to do that would be a distraction, would it, of you from focusing upon the particular job that you had to do with the patient?
>
> ‘A. I think when one uses the word “telling off”, it sounds harsher than what it really was. I do not think I was “telling off” because when you are telling off that means you had stopped doing things, what you were really doing. I was not stopped from doing anything really, I was just in a way hurrying up, if you like. It could be seen that way, or it could be interpreted, but I did not realise I was telling anybody off.
>
> ‘Q. But you said you found it distracting?
>
> ‘A. To me, yes, because I am operating here, looking at this, and then I ask for a suture and it is not there. So it is not there. I look this way and you have got magnification on all those things, all focused. Then you go back on there, it takes a little time, a millisecond, but you have gone out from there. To me, especially when you are doing a very minute vessel, I think it is a little bit — you know.
>
> ‘But I did have actually a few nurses who were very good and mostly they used to work with me and I had no problem with that.’[28]

24 Mrs Armstrong commented in the following exchange:

> ‘Q. Did you ever have the impression that excessive work was taking its toll on the surgeons?
>
> ‘A. I think occasionally, particularly with Mr Dhasmana, I would know when he was tired because his temper would deteriorate.’[29]

25 The nursing establishment in the operating theatre for each case comprised three nurses: an anaesthetic nurse-assistant, a scrub nurse and a circulating nurse. In addition there was an allocated Sister-in-charge, although the Sister ordinarily filled one of these roles and was rarely supernumerary.[30] Each member of the team had their own specific tasks to perform in assisting the medical staff, although each was also aware of what the other members of the team were doing so that they were able to cover for each other.[31]

26 Mrs Mona Herborn, a cardiac theatre sister at the BRI, explained each of the three nursing roles as follows in her written evidence to the Inquiry:

> ‘As a scrub nurse one stands next to the main surgeon performing the operation, to anticipate what equipment the surgeon will need at the various stages in the

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[28] T85 p. 12–15 Mr Dhasmana

[29] T59 p. 31 Mrs Armstrong

[30] WIT 0132 0041 Mrs Armstrong

[31] WIT 0132 0042 Mrs Armstrong

procedure, and hands it to him. As scrub nurse one needs to have a thorough knowledge of the operation being performed and be able to anticipate what equipment will be required. There is no time limit on the training to become a scrub nurse, which is carried out on the job and under the close supervision of an experienced scrub nurse.

'As an anaesthetic assistant one prepares the anaesthetics room which involves checking all equipment, laying out the required drugs and monitoring equipment. When ready, one calls for the patient, checks the patient's identity etc. The patient has usually been given a pre-med on the ward. An anaesthetic assistant's main role is concerned with the general safe keeping of the patient on the operating table.

'Once the operation starts the anaesthetic assistant has time to return to the anaesthetic room and tidy up, to get ready for the next patient. The patient is left in the care of the anaesthetist who stays with the patient at all times. The anaesthetic assistant is at the call of the anaesthetist if he needs any further equipment, for example syringe pumps or drugs. If there are any problems with the equipment during the operation it is the anaesthetics assistant who sorts it out or calls the necessary help to sort it out. At the end of the operation the anaesthetic assistant informs the ICU that the patient is about to arrive and ensures that the patient's notes, blood form, blood bags and all things that have come with the patient or been acquired during the operation go to the ICU with them ...

'As a "runner" one has to know all the aspects of what is going on and is usually interchangeable with the scrub nurse in terms of skills and experience. The runner's role is to give the scrub nurse anything extra required that is not on the trolley, for example more sutures. The circulating nurse has to be quick on her feet.'[32]

Management of the theatre nurses

27 Mrs Armstrong[33] was Staff Nurse in the cardiac theatre at the BRI from October 1984, being promoted to Sister in 1986. The Cardiac Theatre Sisters[34] managed the day-to-day running of the theatres and were responsible to the Theatre Nursing Officer, who in turn was responsible to the Director of Nursing Services.[35]

28 In 1984, the Director of Nursing Services was Miss Janet Gerrish and the Theatre Nursing Officer was Miss L MacKenzie. Mrs Armstrong explained that in the following years leading up to 1995 the management structure changed frequently and often with little warning, and that the cardiac theatre had six different managers over this period.[36] After Miss Gerrish left in October 1991, Mrs Armstrong said that the nursing

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[32] WIT 0255 0001 – 0002 Mrs Herborn

[33] Cardiac Theatre Sister at the BRHSC October 1984–1988

[34] There were three G grade Cardiac Theatre Sisters

[35] WIT 0132 0003 Mrs Armstrong

[36] Mrs Armstrong listed these managers in order as Alison Whiting, Gill Kelly, Lesley Salmon, Julia Thomas, Fiona Thomas and Rachel Ferris

staff felt that there was no one at management level specifically designated to take account of and be responsible for nurses' interests. Miss Gerrish's role was subsumed into a general management post and the post of Director of Nursing Services came to an end.[37]

29 She explained further in her oral evidence:

> 'When Julia Thomas first took over the cardiac unit as Nurse Manager, she actually did not have theatre under her at that point, so for some time, we had Lesley Salmon. First we had Gill Kelly and then Lesley Salmon, then Julia was made responsible for us as well. So in that time I had to answer to all of those people.'[38]

She continued:

> 'On a daily basis, we would be answerable to the Nurse Manager. If there were any issues which we were not happy with or she was not happy with, that would be dealt with by the General Manager.'[39]

30 In 1991, Lesley Salmon as Associate General Manager for Cardiac Surgery delegated the job of managing the cardiac theatres to one of the ICU Sisters. Mrs Armstrong stated that it was very difficult to run theatres at that time and to be managed by someone who did not understand how theatres worked. She gave the example that they were being asked to work shift patterns that were unworkable.[40] This had an effect on the staffing levels and on recruitment to theatres.[41]

31 Mrs Armstrong said that as a Sister it was essentially her responsibility to run the cardiac theatres. This included staffing, both recruitment and training; daily organisation of the running of the theatre lists; maintenance and ordering of equipment and stores; health and safety, by, for example, providing a safe environment for the patients and everyone working in theatres.[42]

32 The budget was managed by the Nursing Manager and was not the responsibility of the Theatre Sisters.[43]

33 After the Directorate of Cardiac Services was set up in 1993, the structure of line-management became Clinical Director to Cardiac Services Manager to Cardiac Theatre Manager. The Cardiac Theatre Sisters still had no control over their theatre budget or staffing numbers.[44]

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[37] WIT 0132 0004 Mrs Armstrong
[38] T59 p. 5 Mrs Armstrong
[39] T59 p. 5 Mrs Armstrong
[40] The shift patterns would involve theatre continuing past the scheduled finishing time of 5.00 pm often until 7.00 or 8.00 pm
[41] WIT 0132 0004 Mrs Armstrong
[42] WIT 0132 0005 Mrs Armstrong
[43] WIT 0132 0005 Mrs Armstrong
[44] WIT 0132 0009 Mrs Armstrong

34 The co-ordination of the staff team was the responsibility of the Sister in charge for that day. On rare occasions, if there was no Sister on duty, this responsibility fell to the most senior member of staff on duty, who would liaise with the Theatre Manager if there were any issues with which they felt unable to deal.[45]

35 Mrs Armstrong stated that the nature of work in the theatre makes it essential to work well as a team. She said that this was often made difficult, however, by poor communication from members of the surgical staff. She gave as an example that:

> '… it was a regular occurrence to be told at the start of the day that we would be cancelling a case due to the lack of an ICU bed yet carry on and operate on that patient later in the day. This would cause confusion particularly if staff had been relocated to other duties'.[46]

The role of the perfusionists

36 Mr Edward Caddy was the Chief Clinical Perfusionist at the BRI until his retirement in June 1994. He told the Inquiry that he began working at the BRI as a Theatre Technician in 1964/65:

> 'I started by making various pieces of equipment including oxygenators for theatre as none of the equipment used in open heart surgery was made in the UK, everything was imported from the United States and Europe. My engineering training came in useful for this.'[47]

37 Mr Caddy explained the role of the perfusionist:

> 'A perfusionist sets up and is responsible for the heart/lung machine in its complete assembly of sterile parts, together with its management during open heart surgery.
>
> 'Pre-operatively, the perfusionist will need to know the weight of the patient, this is especially critical in babies. The weight will determine the flow rates of the heart/lung machine thereby the size of the oxygenator to be selected for that operation. The perfusionist will also need to know the blood chemistry of the patient, so that the machine can be primed correctly … It is then the perfusionist's job to maintain circulation to the rest of the body and to keep the patient's body at a temperature decided by the surgeon.'[48]

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[45] WIT 0132 0011 Mrs Armstrong

[46] WIT 0132 0014 Mrs Armstrong

[47] WIT 0143 0001 Mr Caddy

[48] WIT 0143 0003 Mr Caddy

> ‘Once the surgeon has completed his repair work, he will de-air the heart, which is a very important procedure. I remember that James Wisheart was very good at this. I would say he was meticulous.
>
> ‘The surgeon will then ask the perfusionist to rewarm the body to normal temperature, when the heart may restart on its own. Otherwise, the DC defibrillator[49] will be used to start the heart.’[50]

38 Mr Caddy told the Inquiry:

> ‘Throughout the period 1984–1995, my team would generally consist of 3 or 4 senior perfusionists and 1 student. In theatre, I would be working with the assistance of one of the perfusionists from my team; there would also be 2 anaesthetists (consultant and senior registrar) and 2 surgeons (consultant and senior registrar) present, together with a scrub nurse and nurse runner(s).’[51]

39 Of the perfusionists, Mr Wisheart said:

> ‘Perfusionists have as their chief role the operation of cardio pulmonary bypass (the heart lung machine). This is the equipment without which open heart surgery cannot be performed. It maintains life for the time necessary to do whatever surgical procedure is being done within the heart … It maintains life by doing the work of the lungs … adding oxygen to the blood and also by doing the work of the heart … by pumping the blood around the body. The delivery of oxygenated blood to all the organs of the body is essential to maintain life. Thus [it] will be seen that the role of the perfusionist is of vital importance.’[52]

40 Mr Wisheart also explained the role of the perfusionists as members of the team:

> ‘The perfusionists relate chiefly to the anaesthetists and the surgeons who both need to be aware of how the procedure of cardio pulmonary bypass is progressing. The perfusionist in turn needs to be aware of how the surgery is progressing so that he can take the appropriate steps in operating his equipment. He also needs to know if the anaesthetist is going to perform any manoeuvres, which might affect with [*sic*] the performance of cardio pulmonary bypass by influencing the vascular control of the circulation. The perfusionist will need frequent information from the laboratory. Finally the perfusionist will interact with the scrub nurse to a limited degree, in terms of the provision of disposables for cardio pulmonary bypass and possibly some of the implantable material which the surgeon will wish to use.’[53]

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[49] A device used to apply an electrical shock via paddles to the chest wall

[50] WIT 0143 0004 Mr Caddy

[51] WIT 0143 0005 Mr Caddy

[52] WIT 0120 0163 – 0164 Mr Wisheart

[53] WIT 0120 0170 Mr Wisheart

41 Of Mr Wisheart, Mr Caddy said:

> 'I had known Mr Wisheart since he came to Bristol in 1976. We had a very good professional working relationship. I saw Mr Wisheart frequently in theatre … I always felt that he was courteous and reasonable. For example, if I persuaded him that operating lists should be rearranged to accommodate absence of perfusion staff during a holiday period so as to avoid over-burdening the remaining staff, then he would … rearrange the lists.'[54]

42 Mr Eamonn Nicholson, who started work at the BRI as a clinical perfusionist in 1988, told the Inquiry:

> 'The Perfusion Department remained very separate from the other theatre staff. The perfusionists had their own coffee-room, separate from other theatre staff …'[55]

43 Mr Nicholson said:

> 'I joined Mr D Caddy and Mr L Lawrence, his deputy, in 1988. There were 4 other perfusionists in the team then, apart from myself. Mr Lawrence and 1 other are still with the Department … Since 1988, the number in the team has grown due to the increased workload. Two theatres require 3 perfusionists on duty.'[56]

44 As to the way in which the various specialties worked together, Mr Nicholson said:

> '… I have no knowledge, on the extent of collaboration between the nurses and clinicians. The nursing staff appeared to work well with the cardiac surgeons, but in my view they had limited power in the overall running of the operating list. There was sometimes conflict over the length of the time some operations took and the consequence it had, of keeping staff working late. If the first operation took much longer than expected, a decision had to be made whether to cancel the second, which caused conflict between nursing staff and the cardiac surgeons.
>
> 'The working relationship between the perfusionists, surgeons and anaesthetists was similar to what I had been used to at Guy's. There is and has to be a cohesion between all three with good communication. My impression was that there was, and still is, good inter professional communication. The nursing staff (scrub team) does not really have a great deal of input with the duties of the perfusionists and anaesthetists, but is more concerned with assisting the surgeon. Having said this there was, and still is, good communication between the scrub nurse and perfusionist concerning the types of cannulae, connections, and other perfusion related equipment, which might be needed.'[57]

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[54] WIT 0143 0019 Mr Caddy

[55] WIT 0489 0002 Mr Nicholson

[56] WIT 0489 0004 Mr Nicholson

[57] WIT 0489 0006 – 0007 Mr Nicholson

The role of the anaesthetists

45 Dr Duncan Macrae also referred to the collaboration necessary in the operating theatre between the anaesthetists, the perfusionists and the surgeon:

> ‘I think it [perfusion] is a shared responsibility between the perfusion technician, who is usually a scientist who has been trained to look after the circuitry and to understand the physiology of the heart-lung machine; but also it is a shared responsibility between that technician, the surgeon who is doing the plumbing side of things, putting the pipes in the appropriate blood vessels, and the anaesthetist who has overall responsibility for the physiology of the rest of the body whilst the heart is being looked at and operated on by the surgeons.
>
> ‘So all three team members have a role to play in the overall conduct of perfusion. I think the most important thing about perfusion is that there is a proper structure and protocol in place, which all of those three elements will bind to. You asked me specifically about the role of the anaesthetist, and I think that that, in particular, is to help the perfusionist to interpret the blood gas levels, particularly the levels of oxygen and so on, in the blood during the bypass and the level of acid that builds up, and help him to manage that; to help the perfusionist to control blood pressure so it is not too low and not too high, because we know that in both of those situations that if there is a lot of blood coming back because the perfusion is not good, the surgeon may not be able to do the operation as quickly and as efficiently as possible. So there is that aspect of making the surgeon’s job easier and also protecting the patient.
>
> ‘So it is very much a team effort. If the surgeon has not put the pipes in or has put in a tube that is too small, the bypass may not be adequate. The perfusionist will say, “I cannot get enough flow”. The anaesthetist will say that the oxygen levels are low or the acid levels are high.
>
> ‘So all three must interact. It is not possible, for that category, to say really perfusion equals perfusionist; perfusion equals all three of those elements.’[58]

46 Dr Michael Scallan, consultant anaesthetist, commented further on the anaesthetist’s role in the following exchange:

> ‘Q. What is the responsibility of the anaesthetist if acidosis has occurred?
>
> ‘A. There are two things. One is to try and prevent its development and that is to try and maintain an adequate perfusion, the need for circulatory arrest, the need for low flow may prevent that at a particular time. The other thing is to correct the acidosis when it develops, to give appropriate medication to reverse the acidosis.’[59]

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[58] T71 p. 95–7 Dr Macrae

[59] T75 p. 75–6 Dr Scallan

47 Dr Scallan went on:

> 'A lot of the work of perfusionists is dedicated to [the anaesthetist], but he will work with the anaesthetist and will discuss difficulties such as acidosis and what to do about it. The ultimate responsibility must be with the anaesthetist and with the surgeon.'[60]

48 Dr Scallan said that whether the perfusionist would make changes himself, for example, in order to correct acidosis, or wait for a prompt from the anaesthetist, would largely depend on the local arrangement.[61] Dr Underwood[62] commented that:

> 'In our department the perfusionists are fairly autonomous, although I agree with Dr Scallan they obviously work along with the anaesthetists in maintaining the perfusion of the patient during the operation.
>
> 'They also receive a lot of instruction from the surgeon who must have certain conditions in order to complete the operation, so that my perception is not that the perfusionist works for the anaesthetist in any sense, but would indeed work with the anaesthetist in many aspects.'[63]

49 Dr Peter Hutton was appointed as a Clinical Lecturer in the Department of Anaesthesia at the University of Bristol in 1982. This post carried honorary Senior Registrar status. He recalled that:

> '… junior anaesthetists were well supervised by consultant anaesthetists. Towards the end of my training there were some non-bypass cases … which I did alone but all paediatric bypass cases had a consultant present throughout or at least in the next theatre. All those cases which I did undertake "solo" were first discussed with a consultant who was always present in the hospital during the procedure.
>
> 'I cannot ever remember having any difficulty contacting consultants when they were on call or getting them in when appropriate.'[64]

50 Counsel to the Inquiry elicited the following information about the function of an anaesthetist from Dr Masey in the following exchange:

> 'A. In the anaesthetic room, when the child was brought into the anaesthetic room the child would be accompanied by a ward nurse and quite often by one or other or both parents. In the anaesthetic room would be a consultant anaesthetist, quite often a trainee anaesthetist and an anaesthetic assistant.

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[60] T75 p. 78 Dr Scallan

[61] T75 p. 78 Dr Scallan

[62] Dr Susan Underwood, consultant anaesthetist at the BRI since 1991

[63] T75 p. 79 Dr Underwood

[64] INQ 0042 0002; letter to the Inquiry

> ‘Q. Okay. The patient would be anaesthetised?
>
> ‘A. The patient would be anaesthetised.
>
> ‘Q. And then taken to theatre?
>
> ‘A. The patient would be taken into the operating theatre.
>
> ‘Q. Which would be next door?
>
> ‘A. Which is next door.’[65]

51 Dr Underwood commented in her oral evidence about the absence of the anaesthetist from the theatre during a period for which the patient is on bypass. She said:

> ‘This is not ideal and in the climate of the time, meant a choice on the part of the anaesthetist between those patients upstairs [in the ITU] and downstairs [in the theatre]. On occasion, the ward round did not get done because the patient in theatre needed the anaesthetist, but it was more common, as I wrote in my statement,[66] to do the ward round at that time.’[67]

52 Dr Scallan was asked whether, in his experience, the choice was a common one for an anaesthetist, to have to choose between doing a ward round or seeing a patient who required attention in the ICU, and remaining in theatre during bypass. He replied:

> ‘Yes, this dilemma did certainly arise. I have certainly experienced it myself. During the course of cardio pulmonary bypass it is undoubtedly a period when the demands on the anaesthetist are less, because a lot of the responsibility is dedicated to the perfusionist, and the anaesthetist does not leave the patient unattended; if the senior is not there, a junior anaesthetist would be present.’[68]

53 On this matter Dr Pryn said:

> ‘I found it difficult and very stressful to look after sick patients on CICU[69] when I was at the same time anaesthetising for cardiac operations. Often I would have to leave my patient in theatre with a trainee anaesthetist while I went to CICU to assess patients. If I was the on call anaesthetist on a Monday, I would wait until my patient in theatre was safely established on cardiopulmonary bypass before visiting CICU for a complete ward round.’[70]

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[65] T74 p. 35–6 Dr Masey

[66] WIT 0318 0007 Dr Underwood

[67] T75 p. 79–80 Dr Underwood

[68] T75 p. 80 Dr Scallan

[69] Cardiac intensive care unit

[70] WIT 0341 0030 Dr Pryn

The role of the cardiologists

54 The cardiologists also had a role, albeit limited, in surgery at the BRI and were sometimes called to theatre. As in the case of pre- and post-operative care (dealt with in Chapter 13 and Chapter 15 their involvement was affected by the split site: the fact that they were based at the BRHSC, whilst open-heart surgery was performed at the BRI.

55 Of the involvement of the cardiologists in theatre, Dr Underwood told the Inquiry that it was her impression that on occasion the surgeons were surprised by some of the anatomy that they found once surgery had begun. Her evidence included this exchange:

> ‘Q. On occasion? How often can you remember that happening?
>
> ‘A. I would put it in the “from time to time” rather than “regularly”.
>
> ‘Q. When that happened, was it ever a response to call for the cardiologist to come over and have a look?
>
> ‘A. That was rarer; partly the physical problem of coming from one hospital to another, but certainly, cardiologists did come to theatre on occasion.’[71]

The ‘learning curve’

Introduction

56 The focus of this part of the chapter is the approach adopted by the surgical team, and particularly the surgeons, to new procedures, and how surgeons became competent at a procedure. Reference will be made to what in evidence to the Inquiry was described as the ‘learning curve’, the adverse effects of this and how this might be overcome.

57 By way of illustration, we will focus on the Arterial Switch programme[72] in Bristol, as this was a new procedure introduced within the period of the Inquiry’s Terms of Reference.

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[71] T75 p. 81–2 Dr Underwood

[72] See Chapter 3 for an explanation of this term

New procedures

58 Referring to new procedures Mr Wisheart, in his written evidence to the Inquiry, stated:

> 'There is a constant stream of new or modified procedures being described in the literature and at the national and international surgical meetings. The great majority of these are simply an incremental change (a change of detail) and only a very small minority represent a major (or radical) change in technique, instrumentation or the methods of managing operations.'[73]

59 Mr Wisheart went on:

> 'The vast majority of new techniques or modifications of techniques can be understood and carried out from knowledge acquired from journals, meetings or discussions.'[74]

60 Mr Wisheart stated that 'a major or radical change' occurred when:

> '… an innovation is described which is radically different from anything that has gone before.'[75]

He cited keyhole surgery as an example of a major change.

61 Mr Wisheart suggested a third category:

> 'There are new procedures which cannot really be described as representing an incremental change nor are they quite as radical as the ones I have described under the heading Major; they could be classified as Intermediate. The Fontan operation and its evolving modifications could be included under this heading.'[76]

62 Dr Brian Williams, consultant anaesthetist, stated:

> 'When a new procedure was introduced the recognised process was to learn by reading about it, watching it be performed and then putting it into practice either with or without supervision depending on the complexity. Simulation was not available at the time. Ethical approval from the local research and ethics committee would be required to institute research of a new technique previously untried.'[77]

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[73] WIT 0120 0313 Mr Wisheart

[74] WIT 0120 0313 – 0314 Mr Wisheart

[75] WIT 0120 0314 – 0315 Mr Wisheart

[76] WIT 0120 0315 – 0316 Mr Wisheart; and see Chapter 3 for an explanation of this term

[77] WIT 0352 0019 Dr Williams

The approach to a new procedure

63 In the course of his evidence, Dr Howard Swanton, President of the British Cardiac Society, was asked:

> 'Q. There is obviously a difference between the development of a new technique where previously there was no technique at all, where the surgeon or the cardiologist would say, "Until the development of this technique, there was nothing we could do, but now we can try this", on the one hand, and on the other hand, the development of a new technique where there is an existing technique, where it is thought that the new technique might provide better and longer life, but at least initially with a higher mortality.
>
> 'At the moment, as I understand it, there is no formal structure in which debate would take place as to when and in what respects the new technique would be developed in that second example; is that right?
>
> 'A. Well, not quite right. Every hospital has its ethical committee with lay members on the Board, certainly, if you were planning, for instance, to try a new drug or a new drug trial on the medical side, you would submit the protocol to the ethical committee.
>
> 'Q. So the surgeon who wanted to do a new operation would submit the proposal to the committee?
>
> 'A. That would be appropriate, yes.'[78]

64 It was put to Dr Michael Godman, President of the British Paediatric Cardiac Association (BPCA), that often a new procedure 'may burst onto the world' and that following publication there was 'perhaps naturally a temptation, in the rest of the world, to wish to follow suit?'[79]

65 Dr Godman agreed that there was, and added:

> 'I listened earlier this morning to some of the evidence that was produced on the ethics of the Arterial Switch procedure in the early 1980s and late 1970s, and I think many of the arguments and points raised in that ethical debate obviously hold true for any new technique that is introduced.'[80]

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[78] T7 p. 50–1 Dr Swanton

[79] T7 p. 108–9 Dr Godman

[80] T7 p. 109 Dr Godman

66 Dr Godman was questioned about the approach urged by the BPCA:

> 'Q. When you are talking about the learning curve here, you are talking about somebody visiting from one centre to another centre?
>
> 'A. Yes.
>
> 'Q. That has funding implications?
>
> 'A. Yes, it does.
>
> 'Q. So the position of the BPCA would be that this is necessary in the protection of the patient, and necessary to divert a surgeon from his operating list in Birmingham so that he can go to – again, purely hypothetical – Newcastle? …
>
> 'A. Or Edinburgh.
>
> 'Q. And work there for a week, two weeks, hands-on, before he comes back to Birmingham?
>
> 'A. No, in practice it would not be a week or two weeks. We are talking about individual procedures. We are talking about small numbers in congenital heart surgery, so if we are talking about a particularly complex lesion a visiting surgeon was asked to come to help with or introduce, that might be a series of visits, four, five or six in the course of a year, rather than coming and spending a week or two weeks. It is more probable it would be a visit for a day.
>
> 'Q. If it is to be a learning curve, that has to be done before the surgeon actually operates himself for the first time?
>
> 'A. Yes.
>
> 'Q. That would mean your four or five visits would have to be sufficiently narrowly spaced so that —
>
> 'A. Ideally yes.'[81]

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[81] T7 p. 111–12 Dr Godman

67 He added:

> 'I know a number of centres where increasingly, for example, there are two paediatric cardiac surgeons in the centre, they are working together, particularly on more complicated cases, so they are not working in isolation, you have two assisting each other with the procedure. If one is a relatively new appointment, his senior colleague may at least help him in a significant number of cases, for example, in his first six or nine months in a post.'[82]

68 He also illustrated his views by describing the steps that had been taken in respect of the 'progressive' introduction in the last two and a half/three years in the UK of:

> '… a new device, an occlusion device to close a hole in the partition between the two upper chambers of the heart, the Atrial Septal Defect. The practice there has been that a centre has to do a minimum of six procedures with an experienced investigator or clinician who has done the procedure in a substantial number of cases. He needs to be present for 6 procedures.'[83]

69 Mr Wisheart stated:

> 'In terms of what was written in contracts or professional guidance no appraisal or training was required by a paediatric cardiac surgeon before embarking on a new operative procedure. I believe that most surgeons would acquaint themselves fully with the requirements, and details of any new procedure and be in a position to perform it competently.'[84]

70 Mr Dhasmana stated:

> 'There was no professional guidance or contractual obligations at that time available for clinicians to follow any particular regimen or protocol when embarking on a new procedure. Decisions were made in regard to a clinicians training, confidence and skill. The support and advice of fellow clinicians was very important in deciding to do so, and in achieving a team spirit, essential for the success of any programme.'[85]

71 Mr Wisheart stated:

> 'The practice has become widespread of inviting experts to visit one's own centre in connection with starting a new and complex operation. At the beginning of this period [the period of the Inquiry's Terms of Reference], however, it was not at all common, but it probably grew slowly during the period up to 1995.'[86]

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[82] T7 p. 111 Dr Godman

[83] T7 p. 110 Dr Godman

[84] WIT 0120 0313 Mr Wisheart

[85] WIT 0084 0111 Mr Dhasmana

[86] WIT 0120 0316 Mr Wisheart

72 Mr Wisheart explained the effects of introducing a new procedure:

> ‘If any member of the Team introduces a new procedure or technique, that may alter what is expected from other members of the Team. For example, if the surgeon is doing something different, then he may expect the nurse to supply him with different instrumentation or equipment. Similarly, if the anaesthetists change their management of anaesthesia, it may well interact with what the perfusionist is doing in his management of the circulation on bypass.’[87]

73 He went on:

> ‘If the surgeon is going to undertake a radically new procedure in paediatric cardiac surgery, he would need to explain it to the nurse, the anaesthetist, and the perfusionist. To the nurse he would want to explain what will be done, and in what order, so that the nurse can have the appropriate instruments and equipment available. To the anaesthetists he will wish to explain the plan of the operation so that they can place the patient in the appropriate position, can provide for all appropriate monitoring needs and can tailor what they do to the plan and needs of the operation. Similarly the perfusionist will want to know how the operation is likely to proceed, what temperature the patient will need to be at, whether there will be periods of low flow or circulatory arrest and so forth.’[88]

74 Professor Angelini, Professor of Cardiac Surgery, University of Bristol, stated:

> ‘Every time a new procedure has been introduced I have been in lengthy discussions with the medical as well as the nursing and perfusion personnel, with a specific purpose to try to plan ahead what we wanted to do.’[89]

75 Dr Underwood stated:

> ‘For a brand new procedure the members of the cardiac surgery team would need to be trained. However, variations on operations already performed or operations performed on patients at a different age or size may not seem to be sufficiently new to warrant further training.’[90]

76 Dr Williams referred to the anaesthetists’:

> ‘… responsibility for ensuring that those who assist them, that is, operating department assistants, nurses and trainee anaesthetists were appropriately trained for the task delegated to them.’[91]

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[87] WIT 0120 0321 Mr Wisheart

[88] WIT 0120 0322 Mr Wisheart

[89] WIT 0073 0008 Professor Angelini

[90] WIT 0318 0008 Dr Underwood

[91] WIT 0352 0021 Dr Williams

77 Ms Barbara Sherriff, Assistant General Manager at the BRHSC since 1992, stated:

> 'If a surgeon introduced new surgical procedures and other members of staff needed to be aware of any implications, then the medical staff trained those who needed to know … For a procedure with clinical implications which was not purely a nursing matter … then liaison took place between medical staff and ward staff.'[92]

78 The way in which managers were involved was addressed by Kathleen Orchard, General Manager of the Directorate of Surgery from 1991 to 1993, now a Senior Manager, Avon Health Authority, in her witness statement:

> 'Clinicians would ask their theatre managers for any new equipment and the first I would hear of it was when managers were concerned about costs or staff. This was something I would have to address, as it would affect the budget … Sometimes the ward manager or the theatre sister would come to me and say that Dr X wanted a new procedure, particularly if it would require extra resources. If this was the case, the Clinical Director and I would meet with the clinician and find out what the implications of this new procedure were.'[93]

79 Kathryn Hale, a senior nurse at the BRHSC from 1983 to 1989, stated:

> '… the paediatric cardiologists (and indeed the paediatric cardiac surgeons) were excellent at appraising staff of the need to introduce new clinical procedures. They, along with the clinical manager, developed the written procedures. Unit meetings, open to all grades of staff, were fora at which staff would have the opportunity to discuss new procedures and their possible implications on practice. Nursing staff were involved in preparing documentation to support new care interventions.'[94]

Defining the 'learning curve'

80 Mr Julian Dussek, President of the Society of Cardiothoracic Surgeons, in his paper for the Society entitled *'Avoiding the Learning Curve'*, wrote:

> 'The inference to be drawn from the phrase "learning curve" in the context of cardio-thoracic surgery is that there is an expected and acceptable excess of patients who will die or be harmed in the early experience of a learner but who would have fared better if they were operated upon by a surgeon who is on the plateau of experience.'[95]

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[92] WIT 0234 0034 – 0035 Ms Sherriff

[93] WIT 0170 0032 – 0033 Mrs Orchard

[94] WIT 0180 0042 – 0043 Ms Hale

[95] SCS 0003 0002; paper dated 13 September 1998

81 Mr Wisheart stated:

> ‘A “Learning Curve” is learning from experience about a new procedure, particularly in the initial phase, but also continuing beyond that.’[96]

82 He went on:

> ‘It is probably not inevitable, and in principle it is possible that a learning curve might not happen, but I believe that it will usually be present and measurable. My own experience indicates that the learning curve is a real phenomenon. Regardless of whether it is inevitable or not, the imperative is always to minimise the learning curve.’[97]

83 Mr Dhasmana stated in his written evidence to the Inquiry:

> ‘The learning curve in a clinical setting is very difficult to define and defend. In any technical field there are bound to be “failures”, which improve with increased experience. In complex and technically demanding operations like Arterial Switch, failure usually means loss of life, which is totally unacceptable to any surgeon. Unfortunately it occurs. Though it is unacceptable, its inevitability is well recognised … there is no clear-cut definition of an acceptable length of time period for the completion of this learning curve, although there is some indication that the period could be less in “High Volume” centres.’[98]

84 Dr Underwood commented:

> ‘I believe that it is inevitable that anyone undertaking a new procedure will experience a “learning curve” during which results may fall below those of someone more experienced in the technique.
>
> ‘It seems inevitable that learning curves must exist if new forms of treatment are ever to get started and advance medicine for patients. It is the minimising of the learning curve which is important in maintaining acceptable levels of performance.’[99]

85 Professor Angelini stated:

> ‘I accept that for every new procedure there is a *learning curve* during which the results may fall below standard. I think it is, however, important that any new surgical procedure is carried out with the support and with full discussion with all the rest of the surgical team members, and the complications which are bound to occur are equally openly discussed.’[100]

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[96] WIT 0120 0336 Mr Wisheart

[97] WIT 0120 0336 Mr Wisheart

[98] WIT 0084 0115 Mr Dhasmana

[99] WIT 0318 0009 Dr Underwood

[100] WIT 0073 0008 Professor Angelini

86 Mr Jaroslav Stark, consultant paediatric cardiothoracic surgeon and a member of the Inquiry's Expert Group, described 'the learning curve' as an experimental period in the development of a procedure:

> '… all the new operations you may in summary call "experiments" because you can not experiment on animals because you do not have the animal model, and even if you had the animal model we are not … allowed to try the operations on animals … So to some extent "experimenting" sounds a harsh word, but I think it was.'[101]

87 Professor Sir Kenneth Calman, Chief Medical Officer for England 1991 to 1998, commented:

> 'If it is an entirely new procedure you are going to pioneer yourself, you are likely to have done some of that in some kind of experimental way beforehand to ensure the outcome is likely to be what you think it will be …'[102]

88 Dr Robin Martin, consultant cardiologist, told the Inquiry:

> '… any time you make a treatment strategy there is a risk of a learning curve, a change in outcome for that group … What you are dealing with here still is a relatively small group of patients compared with [the] rest of our throughput … You see fluctuations in different groups at any one time. That makes it I think always difficult for us to analyse exactly what is happening with individual [small] groups of patients.'[103]

Managing the 'learning curve'[104]

89 Dr Underwood stated in her written evidence to the Inquiry:

> 'I believe it may be possible to shorten a learning curve by good theoretical knowledge of the new procedure, observing others with experience, training alongside others and then working with decreasing supervision by the experienced operator, in the same way that a trainee learns new skills.'[105]

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[101] T50 p. 12 Mr Stark

[102] T66 p. 64 Professor Sir Kenneth Calman

[103] T76 p. 143–4 Dr Martin

[104] Mr Barry Jackson, President of the Royal College of Surgeons of England, told the Inquiry that the Royal Colleges have since sought to respond to the issue of the 'learning curve' through a system called SERNIP, the Safety and Efficacy Register, New Interventional Procedures, introduced in 1996. Mr Jackson explained how SERNIP functioned: 'New techniques should be referred to this new body, SERNIP, for a careful assessment as to whether or not this was a technique that could be recommended to Trusts and purchasers for widespread implementation, or whether it needed further refinement, proper controlled trial assessment, or whether it was found wanting.' See T28 p. 104–5

[105] WIT 0318 0009 Dr Underwood

90 Mr Wisheart, in his written evidence to the Inquiry, suggested that the following steps could be taken:

- ‘Private preparation which includes reading, attending meetings, courses etc.
- ‘Visiting centres of “excellence” and observing there.
- ‘Visiting centres of “excellence” and having an opportunity to assist the experienced surgeon at an operation.
- ‘Attending workshops dedicated to promoting technical proficiency in specific procedures.
- ‘Inviting experts to operate or assist the surgeon in his own centre.’[106]

91 He went on:

> ‘… it will always be a different experience when a surgeon does an operation for himself for the first time.’[107]

92 Professor Angelini explained, in his written evidence to the Inquiry, how he approached a new procedure:

> ‘Any time I have embarked on a new surgical procedure, and this has happened on several occasions since 1992, I usually have gone to visit centres where those procedures were carried out, and subsequently have invited the expert(s) to Bristol to help me with the surgery. This has often been with regard to both surgical and anaesthetic expertise.’[108]

93 Professor Sir Kenneth Calman told the Inquiry of his experience:

> ‘I was involved surgically, for about eight years, mainly on transplantation and vascular surgery. During that process, the senior consultant I worked with took a year out to go and work in the United States on liver transplantation. He would not have done a liver transplant on his own in this country without a year’s experience with one of the most outstanding liver transplant surgeons in the world. That would be the way he would deal with an entirely new procedure: he would normally go somewhere where they are doing it and learn how it is done, come back with the skills and expertise and build up a team.’[109]

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[106] WIT 0120 0341 Mr Wisheart

[107] WIT 0120 0341 Mr Wisheart

[108] WIT 0073 0008 Professor Angelini

[109] T66 p. 63–4 Professor Sir Kenneth Calman

94 Sir Barry Jackson discussed the extent to which there were formal requirements to be followed, in the following exchange:

> ‘Q. … what would be the expectations as to the practical steps that had to be taken before a person could be confident or reasonably confident that actually they would not be harming their patient if they embarked on something relatively new?
>
> ‘A. There was nothing laid down about this. It was not formalised. It was up to an individual surgeon to take what steps they considered necessary to enable them to carry out that operation with a clear conscience.
>
> ‘Q. So perhaps there might be a range of steps available to them. The obvious one would be to review the literature to make sure they were familiar at least in theory with the steps that needed to be taken in performing this new technique. That presumably is something that everybody would have been aiming to do during the period with which we are concerned?
>
> ‘A. Yes, well, without either reading the literature, reading the technique in an article … or seeing a video, and videos were widely used at this time, or having seen the operation in somebody else’s operating theatre when visiting another surgeon, I do not think any surgeon would embark on a new operation without one or other of those steps being taken before they put, as we say in the trade, knife to skin.
>
> ‘Q. If the first level would be reviewing the literature, the second might be viewing a video; the third step that one might perhaps take would be to visit another centre and watch a colleague perform the procedure.
>
> ‘How common would that have been as a method of informing oneself across the …
>
> ‘A. I think it would have been less common than reading and watching videos, but I cannot quantify it.’[110]

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[110] T28 p. 112–14 Sir Barry Jackson

95 In his paper '*Avoiding the Learning Curve'*, Mr Dussek recommended:

> 'Surgeons should not be performing operations until they are competent to do so at an accepted general level of risk.
>
> 'Every surgeon should feel confident that he has the necessary education and experience to perform a new operation skilfully and that this skill should extend where necessary to the peri-operative management.
>
> 'Funding must be available for surgeons to attend the necessary training courses …
>
> 'The best way of learning a new procedure is to be taught by an established expert. Therefore facilities must exist whereby visiting consultants can be given honorary contracts with the minimum of fuss. The arrangements for recognised experts from overseas need to be simplified so that they can come at short notice. Possibly the GMC should keep a computerised register of consultants who would be recognised to train in other hospitals.
>
> 'Consultants must relinquish a historical reluctance to ask other consultants to help. With the emergence of the new "Calman trainees"[111] with possibly less surgical experience than their predecessors this is going to be of increasing importance.'[112]

Retraining

96 Mr Wisheart stated in his written evidence to the Inquiry:

> 'The concept of "Re-training as routine" was not established during the period [of the Inquiry's Terms of Reference]. The routine was the continuous learning which was needed to maintain one's knowledge and skill and keep abreast of new thinking, understanding and development. This was done through the reading of journals, the attendance at meetings and courses and regular dialogue and interchange with colleagues both junior and senior. In the latter part of the period this would have become finalised under the label of Continuing Medical Education.'[113]

97 He told the Inquiry that "retraining" carried connotations which were punitive in nature, although there is more acceptance now of the idea of undertaking retraining. Mr Wisheart went on to say that 'It was the philosophy of the team to consider together areas where there was room for improvement … Mr Dhasmana, on his own initiative, sought re-training in the neo-natal switch operation in 1992–1993.'[114]

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[111] *'Hospital Doctors – Training for the Future, The Report of the Working Group on Specialist Medical Training'*, DoH 1993

[112] SCS 0003 0005 Mr Dussek

[113] WIT 0120 0327 Mr Wisheart

[114] WIT 0120 0328 Mr Wisheart

98 Professor Marc de Leval, consultant paediatric cardiac surgeon, Great Ormond Street, commented:

> 'I have never found the definition of retraining. I have used the word in my paper on the "Cluster of Failures", and I still do not know what it means. Obviously retraining may indicate training to understand or try to pick up some technical details of a procedure or the management of the perfusion, the bypass, so I think that if you are facing failures, by definition you do not know exactly where the figure arises from. I think as surgeons we have a tendency, at least most of us, to incriminate the skill or the actual technical performance of the procedure, which I think is very shortsighted. We all make the mistake. So I think when you have a problem, you are in the dark and it is very difficult to decide whether it is appropriate, not knowing exactly what the cause of the failure was, and, for example in my own experience, I decided to retrain by doing the same, going to see Bill Brawn and having him to help me to do one or two Switches, and I believed, when I started to do the Switches myself, that I had learned some technical tricks.
>
> 'Five years later, I had realised that the way I do the Switches is the way I did them before my "Cluster of Failures", not the way I learned it, and I am convinced that my retraining has given me back the confidence that I had lost and I think this is the most important point, to reach a state of mental readiness which is such that you cannot proceed with confidence and you have to regain it.'[115]

The Arterial Switch procedure

The 'learning curve' and the Arterial Switch procedure

99 Mr Wisheart stated:

> 'I believe that the reality of the learning curve may be illustrated by the evolution of surgery for transposition of the Great Arteries in this country … in the late 80s and the very early 90s it was generally understood and accepted that when a unit introduced the Arterial Switch operation for neonates there would initially be a period of disappointing results.'[116]

100 Professor de Leval told the Inquiry:

> 'In the early 1980s we were balancing the early and the late risks, and one of the questions was, what kind of lower [*sic*] risk can you afford, assuming that the long-term results will be better? I do not think that question has been answered. The acute problem was the decision to deal with the learning curve. When we started the Switch operation, those who had started before us started with a mortality of — I mean, the person I am quoting is Jan Quaegebeur, who has become a master of the Switch, who started with a mortality of 25 per cent.

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[115] T60 p. 50 Professor de Leval

[116] WIT 0120 0337 – 0338 Mr Wisheart

> '… which, within a few years, came down to below 10 [per cent] and now, in his results, is probably about 2 or 3 per cent.'[117]

101 Mr Dhasmana told the Inquiry that his technique was derived:

> 'Mainly from Great Ormond Street but that was the same technique as you would be seeing in the books and by that time books had started really printing it out in the same way and also almost all publications at that time would come with techniques how to really do … this was also a similar technique with Mr [now Professor] Yacoub, published in 1980. A similar technique was by Dr Jatene from Brazil in 1977/1978. So technique was there, I just took it on. It is not a new technique, I did not use any new technique.'[118]

102 Mr Dhasmana was asked about referring a patient elsewhere for a Switch operation rather than operating himself, in the following exchange:

> 'Q. If you had thought about it, you might have seen perhaps that because of the consequences of the learning curve … that someone who had experience in the operations might well succeed in a difficult condition in the case of a patient who in your hands at the start might not survive the operation because of the underlying problems that the child suffered from and because of the lack of experience of the Unit; did you think of that and express that at all?
>
> 'A. Again we had that problem. We are talking in 1999 about the problem as was being seen in 1986 to 1988. I have already mentioned … when you start as a consultant paediatric cardiac surgeon, a lot of operations you are doing for the first time.
>
> 'So you could really take that analogy to all those operations when you are starting, you know right in the beginning. You know if somebody else could have operated on, I wish that was possible and I wished nobody … has to operate on somebody for the first time but unfortunately that was the practice at that time and I was just keeping up with the practice.
>
> 'Q. Does it follow that, if you had thought about it, you might have said to yourself, "There is Mr Sethia in Birmingham (or whoever) by 1988; that there are experienced surgeons elsewhere in the country dealing with this sort of operation; that if I take the first ten cases that come to me and if they are operated on by him or by somebody else then more of those children will live than if I carry out the operation myself". If you had thought about that, one of the consequences nowadays might be to transfer the child to another centre so that the operation can take place for the benefit of the child in that other centre, might it not?

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[117] T50 p. 10 Professor de Leval

[118] T84 p. 64 Mr Dhasmana

> ‘A. That is the case in the 1990s, yes, but that was not the case in 1988.
>
> ‘Q. It is a consequence of what you are saying that a deliberate decision was taken within the unit by the unit as a whole to carry out or begin a series of operations which would lead to the death of children in Bristol who would not necessarily die elsewhere; that is the consequence of the decision that was taken, is it not?
>
> ‘A. Whenever you are put on any complex case anywhere there is always that possibility that the child could survive elsewhere, how do you know whether he is going to survive here or there unless you have got very clear guidelines? Unfortunately at that time there were no clear guidelines so almost every surgeon was really doing the best available practice at that time and this is the reason you have a whole team to decide on.’[119]

103 Mr Dhasmana told the Inquiry that when he commenced the Arterial Switch programme at Bristol he anticipated that:

> ‘… mortality would be higher than what you could achieve a few years later.’[120]

The Arterial Switch programme at Bristol

104 The Arterial Switch programme for non-neonates was introduced at Bristol by Mr Dhasmana in 1988. He stated:

> ‘By 1988 this was a well-established procedure for the treatment of Transposition of the Great Arteries in the USA, Australia and a few centres in Europe. I was aware that a few centres in the UK, like GOS [Great Ormond Street], Harefield and Brompton, were using this technique in older children with TGA and VSD.’[121]

105 After discussion with colleagues in Bristol, Mr Dhasmana stated that he decided to start the Arterial Switch procedure given that:

- ‘I was familiar with the operation as I had assisted and looked quite a few [*sic*] of these patients operated on at the GOS, London during my term as Senior Registrar during 1982–1983.
- ‘I had kept myself well informed with developments in this field, having attended various courses, reviews of cine-films and read available published literature, giving details of techniques and various types of coronary arterial abnormality in this condition.
- ‘I considered myself experienced enough to deal with major operation[s] in this condition.

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[119] T84 p. 58–60 Mr Dhasmana

[120] T84 p. 51 Mr Dhasmana

[121] WIT 0084 0110 Mr Dhasmana. See Chapter 3 for an explanation of these clinical terms

- 'I was already using micro-vascular surgical techniques in dealing with coronary artery anastomosis in adult patients.
- 'and, most importantly, I believed that anatomical repair by Arterial Switch was the right treatment for this condition in the long run, even though the conventional operation by Sennings repair carried lower mortality this procedure was only a physiological repair with uncertain long-term prognosis.'[122]

106 Mr Dhasmana went on:

> 'Though there was a gap of about 5 years since the last operation, I had kept up to date on developments by attending courses and reading the literature available from various publications I was receiving. I believed that I followed the usual practice prevalent at that time, when embarking on a new procedure. I discussed the plan amongst colleagues … and appeared to have their support. Dr Martin joined the cardiology team during the early part of this programme, in 1988, and provided necessary advice and help, as he had been closely involved with the Arterial Switch programme at the Harefield hospital. He also gave me a copy of a section of Dr Quaegebeur's thesis on the subject, which proved very helpful.'[123]

107 Mr Dhasmana stated that Dr Sally Masey:

> '… was the only anaesthetist capable of helping me with this programme … I believe she had experience of Arterial Switch operations during the period of her training at Brompton…'[124]

108 Mr Wisheart stated:

> 'The early results of the non neonatal switch operation were disappointing in that they were less good than the results at centres where the procedure was established at that time.'[125]

109 In January 1992, Mr Dhasmana started the Arterial Switch programme for neonates:

> '… there were still no guidelines, or procedures for developing new operations, or for making major changes. However, more information from various publications and courses were becoming available on the subject i.e. Arterial Switches.'[126]

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[122] WIT 0084 0110 Mr Dhasmana

[123] WIT 0084 0110 Mr Dhasmana

[124] WIT 0084 0111 Mr Dhasmana

[125] WIT 0120 0352 Mr Wisheart

[126] WIT 0084 0112 Mr Dhasmana

110 Mr Dhasmana stated that it was decided to proceed with the neonatal programme after a review of the 14 Switch operations carried out before mid-January 1992:

> 'It was felt that technical competence had been achieved and that anaesthetists, cardiologists, perfusionists and nurse teams had gained enough experience. Therefore all members of the team agreed, that the procedure had proved successful in the group of older switches … Therefore, after consideration of all the issues, in the same way as in 1988, i.e. discussion with cardiologists and anaesthetists, it was agreed to develop this operative procedure with the neonate group.'[127]

111 In the neonatal Switch programme in the period up to September 1992 all five children died.[128]

112 Mr Wisheart stated:

> 'Evaluation of the disappointing results for this operation was made difficult because in addition to the expectation of the learning curve, the situation was confused further by the occurrence of a number of significant additional risk factors in either four or five of the nine neonatal switch patients who died …
>
> 'There were a significant number of patients with additional abnormalities in this small series so that the real cause of death remains a matter of debate.'[129]

113 Dr Martin was asked:

> 'Q. Was there at this stage anything in the way of what you would see as a learning curve taking place at Bristol?
>
> 'A. Certainly we looked at the first few cases and looked to see if there were any lessons there. Now whether that constitutes the learning curve or not I think it is very difficult to say. I think if you look, you know, just looking at the individual cases there were, the first case there was an unsuspected Coarctation of the Aorta[130] which we felt was a contributing factor.
>
> 'The second case, there were problems with thrombosis and infection and we were concerned there may be other factors that were important, if you like, other than the surgical expertise of doing the operation.

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[127] WIT 0084 0112 Mr Dhasmana

[128] UBHT 0054 0081 'Neonatal Switches'

[129] WIT 0120 0352 Mr Wisheart; Mr Wisheart is referring to the series, not just the period up to September 1992

[130] See Chapter 3 for an explanation of this term

> 'So I think we looked at these cases individually. If we found what we thought was a reasonable reason for that patient's death then, if you like, that colours your view as to whether it is appropriate to carry on later.
>
> 'Q. I think the question I asked was whether you thought there was something of a learning curve or not. Did you?
>
> 'A. I think we thought that possibly was part of our learning curve, yes.'[131]

Mr Dhasmana's visits to Mr Brawn in Birmingham

114 Mr Dhasmana stated that he halted the programme and sought help from outside Bristol:

> 'As I could not get any advice locally, I talked to my fellow surgical and cardiological colleagues during a BPCA [British Paediatric Cardiac Association] meeting held at Birmingham in November 1992. A cardiologist from the GOS Hospital, London, told me of problems Mr de Leval had experienced with neonatal switches on his most recent 7 or 8 patients, and that Mr Brawn had helped him to rectify the problem. I was therefore advised to seek Mr Brawn's help in this matter. I met Mr Brawn, at the same meeting, and he was very receptive, advising me to visit him in Birmingham when he was operating on the next neonatal switch. I did invite him to Bristol and help me with the operation, to which he politely declined.'[132]

115 Asked why he chose Mr Brawn, Mr Dhasmana told the Inquiry:

> 'It was not Birmingham I went to initially, it was the BPCA meeting at Birmingham in November 1992, which I was attending as a member. There I met a lot of my other colleagues, both cardiologists and paediatric surgeons and I discussed my problem with them, and one of the paediatric cardiologists from the Great Ormond Street Hospital then told me that they had a similar problem at Great Ormond Street Hospital and Mr Brawn was able to help really and "It would be a good thing if you talked to Mr Brawn". It so happened Mr Brawn was also attending the meeting, so I talked to Mr Brawn and also Mr Sethia. So it was following that meeting that I decided to go to Birmingham.'[133]

116 Dr Masey, who accompanied Mr Dhasmana, said that the reason for the visit was that:

> 'A programme to perform neonatal Switch procedures had started in 1992 and the results had been uniformly poor, so it was felt that some form of retraining was required in order to see whether we could proceed with this particular procedure.'[134]

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[131] T76 p. 140–1 Dr Martin

[132] WIT 0084 0112 Mr Dhasmana

[133] T85 p. 3 Mr Dhasmana

[134] T74 p. 87 Dr Masey

117 Mr Dhasmana and Dr Masey visited Birmingham in December 1992 in order to observe Mr Brawn at work. The operation was recorded on video and Mr Dhasmana kept a copy. Mr Dhasmana stated:

> 'I was particularly impressed with the organisation. As a result of this I arranged for theatre nurses and other perfusionists to visit and learn the workings of the Birmingham set-up … I believe that the whole team received further training as a result of these visits.'[135]

118 Dr Masey described Mr Dhasmana:

> 'He came back on the train and he was extremely enthusiastic about what he had seen and what he had been able to talk through with Mr Brawn, and felt very encouraged by what he had seen in relation to how he felt he would go forward with the neonatal Switches that he was going to be operating on.'[136]

119 On his return, Mr Dhasmana stated that he:

> '… discussed proposed changes in the technique, set-up, pre- and post-operative management, with anaesthetists, cardiologists and nurses. They agreed to make the changes and to re-start the neonatal Switch programme … On the table I made various changes in technique, for example reductions in cross clamp and by pass time, as observed during Mr Brawn's neonatal operation, and from studying the video recording … Nurses were involved with operations. These changes resulted in an observable improvement, with the next two patients surviving the operation. Although the third patient died the fourth survived resulting in optimism in the Unit.'[137]

120 The neonatal programme was recommenced. Six operations were carried out. Patients one, two and four survived. After the death of the sixth patient, Mr Dhasmana halted the programme and again visited Mr Brawn in Birmingham.

121 Mr Dhasmana told the Inquiry:

> 'I lost two patients in succession and both of these patients had normal coronary arteries, so in a way, that raised doubt again in my mind that here I was, I did two successful operations, the third did not make it, but it was a highly abnormal coronary artery and probably could be explained in any centre. But the next one survived so I am still happy, I have got, you know, out of four, three survivals. And the next two did not, although of course, with one of them we did have evidence of myocardial infarction, but nevertheless, these two did not and they had a normal coronary artery.

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[135] WIT 0084 0112 – 0113 Mr Dhasmana
[136] T74 p. 92 Dr Masey
[137] WIT 0084 0113 Mr Dhasmana

> '… during this period, between 1992 and this time, July 1993, I had operated on about 7 or 8 older Switches and they all survived. So that is why, really, I was very concerned that something is probably a little different in neonates which I have not still been able to transfer. That is what was quite worrying me.
>
> 'I told Dr Joffe that, "I am very sorry, it appears that I will not do any more neonatal switches" … He said, "Well, it so happens that I was going to get in touch with you". I said "What for?" He said "I have got another patient admitted with a similar problem".
>
> 'Then I narrated again what happened during the day in theatre and he I think tried to probably comfort me, saying "Let us just wait for the post mortem examination and then we can really …". I said, "Well, I am not taking that next case on …".
>
> '… He said "Well, what should we do?" I said "I tell you. We talk to Birmingham". He said "Well, why do you not do that?" So the next day, I ring Birmingham, I ask for Mr Brawn. It so happened he was nearby … he said "No problem, you know, bring the patient and I will operate here, and I tell you, I have got another patient here, so you will see two patients operated on the same day".'[138]

122 Mr Dhasmana recalled:

> 'I re-visited Birmingham in July 1993 accompanied by Dr Underwood and a patient from Bristol that Mr Brawn had agreed to operate on. We had further discussion on the problem being experienced in the Unit. We returned to Bristol, re-assured and prepared to re-start the programme. The next neonatal patient survived followed by a further fatality and the programme was ended.'[139]

123 Dr Underwood accompanied Mr Dhasmana to Birmingham. Dr Masey on her return from Birmingham in 1992, had instituted changes in practice. Dr Underwood told the Inquiry:

> '… when I went in the middle of 1993, it was to observe them doing the same thing which Dr Masey had described to me, and I do not remember adding anything different or extra after that particular visit.'[140]

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[138] T85 p. 48–9 Mr Dhasmana

[139] WIT 0084 0113 Mr Dhasmana

[140] T75 p. 99 Dr Underwood

124 When asked by Counsel to the Inquiry what he expected to discover from a second visit to Birmingham, Mr Dhasmana replied:

> 'What I noticed over these cases is that somehow, from outside and even when I have gone back in, the coronary artery looked in the right place. There was no obvious kink from outside. So I started asking myself whether what I called at that time the "lie", the way they are lying over the heart, have I got the angulation right, and maybe, technically anastomosis fine, and when you are looking at the post mortem, it looks fine, no problem, but the heart did not work. One of the things with anastomosis I think is the coronary artery, which I think is very important.'[141]

125 Professor de Leval commented as to whether Mr Dhasmana's visits to Birmingham constituted retraining:

> 'Whether this is what Mr Dhasmana was looking for, I am not sure. I think that the word "retraining" here might not be appropriate because he had never achieved good results in the Switches, so it was a question of training rather than retraining, which is slightly different, I believe.'[142]

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[141] T85 p. 50–1 Mr Dhasmana

[142] T60 p. 51 Professor de Leval

Chapter 15 – Post-operative Care

The management of post-operative care

1 After paediatric cardiac surgery at the BRI, the practice was that the consultant anaesthetist[1] accompanied the child back from theatre to the Intensive Care Unit (ICU, also referred to in evidence as ITU) with the theatre nurse. He or she connected the child to the ventilator and ensured that the necessary drugs were being delivered correctly, and gave instructions to the nurse regarding these matters. The consultant surgeon usually arrived 10–15 minutes later[2] to discuss the way forward with the anaesthetist, and to make any changes to the continuing care if appropriate.[3]

2 The child was received by the senior ward nurse in charge and the ICU nurse who was to look after the patient, who would be given relevant information about the operation performed, any problems encountered, the present condition, and treatment to be given.[4]

3 Julia Thomas stressed that:

> 'The children always had one nurse per shift, per 24 hours, to care for them. This was always a senior staff nurse or above and *NEVER* a nurse in training.'[5]

If the patient was very ill, then two nurses per shift were required. This was usually where the child required renal support in addition to ventilation and cardiac support.

4 Mr Roger Baird, consultant general surgeon, described the distance between the cardiac wards and the operating theatre:

> 'Q. Am I right in thinking that the operating theatre was two floors below the ITU used for cardiac services?
>
> 'A. At that time it was. Today they are on the same floor.
>
> 'Q. But then?
>
> 'A. Then they were two floors apart.
>
> 'Q. And access from one to the other by means of a lift?
>
> 'A. Yes.

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[1] Together with a senior registrar anaesthetist, a Senior House Officer (SHO) surgical team member and a surgical registrar

[2] Unless the child was very ill, in which case they arrived with the child

[3] WIT 0114 0087 Fiona Thomas. Fiona Thomas worked as a nurse on Ward 5 from 1986, became a G grade Sister from 1988, and became Clinical Nurse Manager of Cardiac Surgery from 1992

[4] WIT 0213 0040 Julia Thomas. Julia Thomas was Sister in charge of cardiac surgery, ICU from 1982 to 1988, and Clinical Nurse Manager of the Cardiac Unit from 1988 to 1992. She is now a G grade Sister

[5] WIT 0213 0040 Julia Thomas (witness's emphasis)

> ‘Q. A small lift?
>
> ‘A. Yes.
>
> ‘Q. And once one got up to the floor where the Intensive Care Unit was, a distance to be pushed along a corridor before one got to the ICU?
>
> ‘A. Yes.’[6]

5 Dr Susan Underwood, consultant anaesthetist, spoke of the journey from theatre to ICU. She was asked if this compromised the health or safety of patients:

> ‘A. No, I do not think so specifically. I think because we knew that the journey was long and potentially hazardous, we would not embark on it until the patient was quite stable, so that in moving a sick patient from the operating table to the cot or the bed, there may be some instability in a very sick patient, but then you would not move out of the theatre until you had overcome that period and then you would move to the Intensive Care Unit. There was never any pressure to press on with the next patient if the patient was not fit to make the journey, because everybody understood that you must not set out on the journey unless it was going to be made as safe as possible.
>
> ‘Q. Did you move directly from theatre to the ITU or was there a room immediately outside theatre where you would stabilise the patient after surgery?
>
> ‘A. No, you would stabilise in the theatre and then move up to the Intensive Care as one journey.’[7]

6 Dr Sally Masey, consultant anaesthetist, explained the nature of the surgical and anaesthetic presence in the ICU during the period 1984–1995. Her evidence included this exchange:

> ‘A. During that period there was a resident Senior House Officer in surgery and also a more senior surgeon, Registrar or Senior Registrar level, who was not necessarily resident but would sleep in the hospital if there was considered a reason to be so.
>
> ‘Q. You say “not necessarily resident”. You mean not ordinarily resident; not a full-time resident Registrar?
>
> ‘A. He was not expected to be resident. It was not in the contract to be resident.

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[6] T29 p. 103 Mr Baird. See Chapter 9 for a diagram showing the departmental relationship at the BRI

[7] T75 p. 15 Dr Underwood

> ‘Q. So the usual position would be that the resident Senior House Officer in surgery would be the permanent presence in Intensive Care?
>
> ‘A. During the whole 24 hours. During the working day there was also an anaesthetist of Registrar or Senior Registrar level who was designated to be on the Intensive Care Unit.
>
> ‘Q. And at night what was the position for anaesthesia?
>
> ‘A. At night that Registrar or Senior Registrar was not resident.
>
> ‘Q. So what was the anaesthetic cover in Intensive Care at night?
>
> ‘A. The anaesthetic cover was from home both for the trainee anaesthetist and the consultant anaesthetist.
>
> ‘Q. And so you would have, I imagine, some provision in your contract that you must live within X miles of the hospital, something of that sort?
>
> ‘A. I believe my contract states a mileage, although I think some contracts now or in certain parts of the country state a time within which one should be able to get into the hospital rather than a mileage.’[8]

7 In their report in 1995 Dr Stewart Hunter and Professor Marc de Leval[9] commented that:

> ‘The overall post-operative management at the Royal Infirmary appears to be less organised with multiple decision making processes between the surgical Senior Registrar and the SHO who do rounds at 8.00 am, the anaesthetists who see the patients at 9.00 am and the intensivists who work three days a week.’

8 Mr Wisheart commented on this criticism. He told the Inquiry:

> ‘I have to say that I was shocked when I read this, and I did not recognise the Intensive Care Unit that I worked in, and have done for many years. I recognise that everybody did not always, at the first word, agree with everybody else, but nearly always, after proper discussion, agreement would be reached. I actually refrained from any comment – well, pretty well any comment – to anybody on this, until very recently, when I read in the transcripts of these proceedings that this remark was based on the evidence of one person only to Mr de Leval and Dr Hunter. That is the evidence of Fiona Thomas. In fact – I am not really wishing to criticise Mr de Leval or Dr Hunter, because they had a very limited time to carry out their inquiry, but they did state quite clearly that they did not take evidence on this point from

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[8] T74 p. 42–3 Dr Masey

[9] PAR1 0008 0118; *‘Visit of Cardiac Services Directorate of the United Bristol Healthcare NHS Trust 10 February 1995’*. The visit and the report are dealt with in detail in Chapter 30

> anybody else. All I knew was that they had not taken evidence from me on this point, but I did not know who else. So I would simply draw your attention to that. I think that, therefore, this conclusion is not based on canvassing a broad spectrum of opinion.'[10]

9 Mr Wisheart confirmed, however, that during the period of the Inquiry's Terms of Reference there was no 'common ward round'[11] carried out by the surgeons and the anaesthetists together. He told the Inquiry that the surgical senior registrar and SHO would do their rounds at 8 am, before theatre, in addition to which:

> 'There would always be a Senior House Officer who was present 24 hours a day, and there would normally be a Surgical Registrar who is not in theatre and who would be available for discussion. And of course, all the consultants are not in theatre at the same time, so some of those would also be available for discussion. I would normally see the case when I came in and that might be 8, 8.30 or 9, depending on whether I had a meeting, so I would normally pick up anything that they had left for me or endorse what they had done or whatever somewhere between 8 and 9 o'clock.'[12]

10 Mr Wisheart confirmed that the anaesthetists would do their ward round at 10.30 or 11, at which time a surgical member of staff:

> '… would be present on the ward but he might or might not be physically with the anaesthetist doing their ward round; he might well have other things that he felt he had to do. By the same token, the anaesthetic registrar was present in intensive care at 8 o'clock when the surgical team were doing their ward round and would be available for discussion with the surgeons, so that the opportunity to liaise was certainly present.'[13]

11 Mr Wisheart was asked whether it was easy to co-ordinate the care in the ICU. He explained that there was:

> '… a cardiac surgical Senior Registrar, or Registrar, who are available at all times to intensive care. … the cardiac SHO … was just the person who was there, and indeed, one of his functions stated explicitly in the "red book"[14] that has been referred to was to ensure that if somebody came at one time and somebody else came at another time, they would be aware of each other's suggestion and advice in the event that it was not written down. So he was very much a co-ordinator, a person who did things that people more experienced than himself advised him to do, or he helped the more experienced person to do it. Then, of course, the

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[10] T93 p. 79 Mr Wisheart

[11] T40 p. 145 Mr Wisheart

[12] T40 p. 144 Mr Wisheart

[13] T40 p. 144–5 Mr Wisheart

[14] UBHT 0152 0008 – 0098; *'Bristol Royal Infirmary Cardiac Surgical Unit – A Notebook for Members of the Team.'* This was last updated in 1988, and was described by Dr Pryn at WIT 0341 0007 as '... a set of guidelines for the management of patients, both adult and children, undergoing cardiac surgery'

> consultants involved were actually frequently in intensive care, as operations, outpatients, whatever commitments, permitted. They would be in and out. They were keeping a careful eye and offering their advice, because things change and evolve and it is necessary to do so. So I would regard this as an incomplete picture. I would not claim it was ideal, and the basic reason it was not ideal is that not all of the members of the team were totally committed to either cardiac surgery or paediatric cardiac surgery. Some members of the team had commitments elsewhere, and that was quite a major difficulty, and one of the things we had been seeking to overcome.'[15]

12 Mr Dhasmana was asked to comment on evidence he gave to the General Medical Council (GMC)[16] in which he had said of the paediatric work being done at Bristol that, having worked in Great Ormond Street, and having seen centres like Chicago and Alabama, he felt that Bristol was 'at a very low, primitive level … either because of the facilities, or theatre, or ITU, or availability of beds'.

He told the Inquiry that these comments related to the position in 1984 and 1985 when he was a senior registrar:

> 'There was only one surgeon doing the paediatric work, Mr Wisheart, and I thought for a centre to work in that type of facility with one surgeon working — and if I remember it correctly, our ITU was not big enough, really, to accommodate more than one patient – I may be wrong – one paediatric patient at that time. You had to juggle with your adult list to fit in the paediatric cases, and I was uncomfortable with some of the waiting list that some of the children were really going through. … Maybe "primitive" was a little bit too harsh on Bristol, really. … I would say, if not "primitive", I would say it was at a lower level, really; it was not very high up, even on my scale.'[17]

13 Dr Stephen Pryn, consultant anaesthetist and intensivist, told the Inquiry of his overall impressions of the cardiac surgical unit at the BRI when he was appointed as an intensivist in August 1993:

> 'It was a unit that was often run minute by minute by relatively inexperienced doctors, with their senior cover not being that available, and it was a unit run by trainees who were not used to general intensive care issues, were quite familiar with managing the cardiovascular system, but were relatively poor at integrating that with the other systems, for instance, the respiratory system. … Their background was not in general intensive care.'

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[15] T93 p. 81–2 Mr Wisheart

[16] GMC transcript day 42 p. 19

[17] T84 p. 18–19 Mr Dhasmana

He told the Inquiry that he felt that there needed to be more input from a general intensive care background, and that senior cover needed to be more available, and agreed that it was an awareness of this that had fuelled the appointment of himself and of Dr Ian Davies.[18]

14 Dr Stephen Bolsin, consultant anaesthetist, was asked whether the situation in ICU ever became so critical that he refused to anaesthetise any more patients because of the problems in ICU. He said:

> 'I do not think that specific decision was ever made by me, but I think a parallel decision was sometimes made by the surgeons where they would cancel a paediatric case in order to do an adult case because there were already critically ill children on the Intensive Care Unit. Whether that was because there were not enough paediatric nursing staff to go round, or whether it was because they were worried about the human resources and medical resources available, I am not sure.'[19]

15 Mr Wisheart suggested that the problems perceived by the Hunter/de Leval report might have been a result of the team increasing in size over time. He said:

> 'I believe that historically there was close teamwork, and if we went right back to the beginning of the period of this review, in 1984, there were just two anaesthetists working in paediatric cardiac anaesthesia and they, of course, were unable to have the continual presence that the five or six or whatever number of anaesthetists provided in the 1990s. Interestingly, by their personal commitment and a feeling of being a member of the team, it was actually quite easy to co-operate with them, to get their advice, and there was always a clear knowledge of who to go to. It may be that some of what has been reflected to you is a consequence of the team increasing in numbers and the fact that in some areas of work somebody was responsible on Wednesday, but it was somebody else on Thursday and somebody else again on Friday. It is against that background that the surgeons I think felt not less but more of a pressure to maintain a continual interest, and they had to deal with the differing notions that people might have had on Wednesday, Thursday and Friday, and tried to work that into the system. But I do actually still feel – and I do not want any misunderstanding to come from my remarks – that the commitment of the people who provided that service in the 1990s, I mean, by and large was terrific. I did not, myself, sense that there was any lack of a feeling of being on the same team with them in this area in theatre and so forth.'[20]

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[18] T72 p. 20 Dr Pryn

[19] T82 p. 32 Dr Bolsin

[20] T93 p. 95–6 Mr Wisheart

Equipment and cleanliness in the ICU

16 Julia Thomas set out what equipment was available in the ICU throughout the period of the Inquiry:

> 'The ITU had excellent paediatric equipment. Each bed had:
>
> - 'ECG monitor (HP) with memory, alarm & recorder (attached to central monitoring)
> - 'Arterial, CVP and PAP.LAP monitoring
> - 'Body temperature monitoring
> - 'Oxygen, air vacuum
> - 'Pulse oxometer
> - 'O_2 monitor
> - 'Paediatric ventilators (Bear Cub and Servo C) with CPAP Ventilation Mode
> - 'Humidifier
> - 'Infusion pumps x 6
> - 'Volumetric infusion pumps x 2
> - 'Full resuscitation equipment
> - 'Humidified O_2 with face mask/head box
> - 'Special baby therms (warming cots)
> - 'Pacing equipment
> - 'Cardiac output computer
> - 'End tidal CO_2 monitor
>
> 'The Unit also had a 12 lead ECG machine, echo machine, high frequency ventilator, CPAP equipment, oxygen head boxes, blood gas machine, full resuscitation equipment (defibrillator), cots, paediatric bed and incubator, peritoneal dialysis machine, pressure mattresses.'[21]

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[21] WIT 0213 0042 – 0043 Julia Thomas

17 Julia Thomas also commented on the maintenance of equipment:

> 'The equipment was fully maintained by the hospital Maintenance Department, who were very reliable and would usually respond to a call to see equipment on the Unit within an hour. All the equipment was regularly serviced. … The ventilators were maintained by a small maintenance team headed by a senior technician.'[22]

18 Fiona Thomas, Clinical Nurse Manager of Cardiac Surgery, told the Inquiry:

> 'I mean, equipment in the early time, a lot of equipment, when I remember taking over, when I was a sister and an early Nurse Manager, equipment was bought and donated by the Heart Circle, which was very generous of them. They used to buy a lot of equipment, but there was not necessarily any consistency in the equipment that was bought. It just tended to be what was on offer at the best [price], at that time. You know, reps could come in and say "I have a syringe pump at this price", and that is how we had it. So we had quite a mixture, but, I mean, there was only a couple of companies that made them. I do not think there was any particular programme on how old certain equipment was, whereas nowadays one would say most medical equipment, you should not be using it after it has been used for ten years. So nowadays, I am keeping an eye on how old some of our equipment is. But I think in those days, I do not think we probably were looking at it from that sort of angle. I mean, I think just as technology has advanced and how we are using more equipment today. We are having to look at that continuously.'[23]

19 Fiona Thomas also said:

> '… the thing with cardiac surgery is, it has to be well resourced. If you do not have the equipment, you cannot do the work. If you do not have a good ventilator or heart-lung machine, there is no point in doing the work, if you have no nurse to look after the patient afterwards. It is more expensive work than if you do general surgery, for instance, and you do not need any equipment to look after a patient post-operatively, whereas with cardiac surgery you need to have the equipment. I think a lot of the equipment was getting old and there was no maintenance or renewal programme. We have set up a renewal programme of when equipment definitely needs to be changed. I suppose I inherited it as it was.'[24]

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[22] WIT 0213 0043 Julia Thomas

[23] T32 p. 30–1 Fiona Thomas

[24] T32 p. 79–80 Fiona Thomas

20 As to cleanliness in the ICU, Belinda House, mother of Ryan, told the Inquiry:

> ‘We had one cleaner who was there a long time, she was wonderful. She was rather upset because the cleaning contract had been privatised and they were the same people but they were not allowed to talk to the patients, they had to clean from there to there, they were reprimanded if they were talking and she felt that had taken something away from the patients. They had to clean up at a particular time, and she was concerned that the IT Unit was not as well cleaned as it had been previously, but she had allotted times and it did not matter if a new patient was put into that bed space, she was not allowed to clean because she might have cleaned ten minutes previously.’[25]

21 Julia Thomas said:

> ‘The microbiologists at the BRI were involved with our Unit, carrying out daily rounds of the patients, discussing possible infections and appropriate treatment. We have an infection control nurse on the Unit. The Unit had the facility to isolate infected patients in the isolation bed. Barrier nursing was always instigated if infection was a problem. On the issue of hygiene and cleanliness, I would make the point that, prior to contracting out cleaning services, the ward had a wonderful team of cleaners who stayed with us for many years and cared passionately about the cleanliness of the Unit. Following the cleaning being contracted out in the early 1990s, it has not been of such a high standard.’[26]

Role, training and numbers of nurses

22 Julia Thomas told the Inquiry:

> ‘The paediatric patients always had the most experienced nurses looking after them.’[27]

23 She continued:

> ‘The patients were brought back to the Unit from theatre by the anaesthetist and theatre nurse, who handed over the child to the ITU nurse caring for him/her, and the senior nurse in charge. This handover included information about the actual operation performed, problems (if any) encountered, and treatment and present condition. All patients were ventilated on return. The anaesthetist would set the ventilator for the child and settle him/her into the Unit. The nursing policy for caring for the patients in the immediate post-operative period consisted of two nurses settling the child – one nurse responsible for ventilation and IVs and lines/ fluids, and the other for drains, observations and comfort. When the child appeared settled the senior nurse would leave the bed space, but was available to return if

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[25] T6 p. 107 Belinda House

[26] WIT 0213 0045 Julia Thomas

[27] WIT 0213 0040 Julia Thomas

> any problems arose. There was a written policy along these lines. The surgical Senior House Officer would write up all the drugs required and prescribe the fluids. The consultant surgeon always visited soon after the patient's return to the ICU to assess condition and treatment. The surgeon would decide what parameters of blood pressure, heart rate, central venous pressure, left atrial and pulmonary artery pressures, were acceptable. The anaesthetist would assess the child's ventilatory state, looking at the blood gas, oxygen etc. He/she would leave instructions for those aspects of that patient's care.'[28]

24 Julia Thomas stated:

> 'Continuity of care by the nursing staff was assured by the same nurse always looking after the child on two shifts running. As there was a group of experienced nurses who looked after the children, there was usually good continuity. Liaison between medical specialties was often carried out by the surgical SHO and anaesthetic registrar on duty. The nurses always reported to the physiotherapists, dieticians, and cardiac liaison nurses, about the child they were looking after.'[29]

25 Dr Peter Martin, consultant paediatrician, worked as an SHO at the BRHSC for 12 months from August 1988 to July 1989, four months of which was spent working with Mr Wisheart and Dr Jordan, consultant cardiologist. He also worked as a paediatric registrar at the BRHSC from February 1991 to January 1992. Comparing the ICUs at the BRHSC and the BRI, he said:

> '... myself and colleagues thought it was rather bizarre that the sickest children post-operatively were managed in a unit where the resident staff were generally not paediatrically trained and the nursing staff were also not paediatrically trained [the BRI]. This was in stark contrast to the children requiring less intensive surgery who were looked after on a paediatric ICU with paediatric anaesthetists, resident and paediatric medical staff, as well as of course nursing staff who only looked after ill children [the BRHSC].
>
> 'I think in summary therefore that circumstances transpired to work against those sickest children who required the most skilful input.'[30]

26 John Mallone, father of Josie who spent five weeks in the ICU, said:

> 'I felt there was tremendous continuity in the nurses because they work 8-hour shifts, do they not, and so they got to know us and they got to know their patients, the children who were in there, they treated them as human beings. I found the doctors, they would come round perhaps on a 10-minute ward round twice a day

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[28] WIT 0213 0040 Julia Thomas

[29] WIT 0213 0041 Julia Thomas

[30] INQ 0042 0005 – 0006; letter to the Inquiry

> and I always had the impression that they did not see the children, the babies, as human beings, more just as anatomical problems that had to be solved.'[31]

27 Fiona Thomas said:

> 'In intensive care the aim was that the E grade[32] nurses or above ... looked after the children following surgery, and then there was this F grade RSCN, and the F grade RSCN would work always in the intensive care unit on a Tuesday late shift and a Thursday late shift, which was the days that the majority of children's big cases were done in those days, so she was there. She may not necessarily have looked after those children, but she was actually in the unit for support for the nurses caring for the children coming out of theatre.
>
> 'In the nursery, which was the pre- or the post-operative area, she would be working there and she was also based there for the other 3 days of the week that she worked. She worked with a D grade RSCN who was a newly qualified paediatric trained nurse. She had done no adult training so all her training was in paediatrics. She was employed to work in the nursery because she did not have the experience of any intensive care to work in ITU.
>
> 'Otherwise, we would have had D and E grade nurses working in the nursery for support as well, so she would not have been in there by herself, she would have had an E grade on the other shifts or the F grade, Cathy Warren, on the other shifts as well.'[33]

28 Mr Dhasmana told the Inquiry about difficulties in recruiting nurses for the ICU in Ward 5 of the BRI:

> 'The problem with the BRI, because it is a place in the hospital where it is mainly an adult service, so whenever we wanted to recruit a paediatric trained nurse in the cardiac surgery, we were not very successful because nurses who were trained in children's care, they are in high demand everywhere and there is a shortage in almost all hospitals so obviously they get absorbed there quickly. If somebody lives, say in Bristol or other places and having been trained in paediatric, they did not feel that they wanted to look after adults when a child is not being looked after in ITU. So we had a very real problem in recruiting a pure paediatric trained children's intensive care nurse in our cardiological department. However, we had some very good, very dedicated nurses. They by their own effort, by their own experience and by going to the Children's Hospital, they doubled up their expertise as to get my confidence that I was always happy for them to look after my patients. But because of this we had a core group and there were a small number of nurses who I would

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[31] T95 p. 180 John Mallone

[32] The nurse grading system was introduced in April 1988, when all nurses were graded according to the roles, responsibilities, experience, etc. The pre- and post-clinical grading equivalents were as follows (WIT 0114 0070): Nursing Manager – H Grade; Sisters – G Grade; Senior Staff Nurses – F Grade; Staff Nurses – E/D Grade; State Enrolled Nurse – C Grade; Auxiliary Nurse – A/B Grade

[33] T32 p. 76–7 Fiona Thomas

> feel happy to leave my patients with, and that used to cause some problems and that is where the term "shortage" really comes, because of course you know sickness or illness, nobody can really foresee those things.'[34]

29 Michelle Cummings, mother of Charlotte, told the Inquiry she felt there was a lack of trained staff. Her evidence included this exchange:

> 'I do know, when Charlotte was in intensive care, that she had a student nurse looking after her. I think there was a question, being that it was the BRI, it was not the Children's Hospital, it was a mixed intensive care, whether there were actually enough paediatric trained nurses, and I spoke to many of the nurses about this, and it was something they themselves were extremely concerned about. I know they were extremely concerned over the resources that were available to them at that time. So, yes, there were definitely students there, and at times, instead of having a one-to-one, it was a one-to-two, so one nurse would be looking after two patients, as opposed to just looking after the one. … I cannot say whether they were there all the time. I know Charlotte did not always have a paediatric nurse looking after her, it depended on the shifts and everything, but I know the nurse looking after her was paediatric trained at times, at other times I know she was not. That is all I can say.
>
> 'Q. Of the nurses you were told were paediatric trained, did they seem to you to have other patients to care for as well?
>
> 'A. As I said, sometimes you found that you had a nurse one-to-one, so there was one nurse looking after Charlotte on a continual basis; other times there was one nurse between two patients.
>
> 'Q. And the ward which Charlotte was in was mixed children and adults?
>
> 'A. That is right.
>
> 'Q. So when it was one-to-two, one nurse to two patients, was the other patient sometimes an adult and sometimes a child?
>
> 'A. I do not remember if that was so all of the time. I know in the latter part of her stay in Ward 5 intensive care, there was another child in there at the same time. What happened was that generally the nurses would – whoever was on duty would look after – they would be sharing the two children they looked at. I do not specifically remember anything else at that point.

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[34] T86 p. 18–19 Mr Dhasmana

> ‘Q. From what you suggest, I just want to make sure this is right, so it is not taken the wrong way, there may have been occasions when one nurse was looking after, as it were, on her right, Charlotte and on her left, an adult?
>
> ‘A. Oh, yes, yes.’[35]

30 Belinda House talked about the demands placed on nurses in the ICU:

> ‘Well, the routine, any demands placed on nurses in the ITU situations, it is a very stressful situation, with emergencies happening quite frequently, and often, when we went back to visit the nurses, they had changed, because I think the turnover in ITU is quite high because of the stress. … Yes. The equipment, the ventilator, we were told that the ideal ventilator was a certain type, I cannot remember. A cub ventilator came to mind. If they were lucky they could find one of those but they were not sure because there was a very short supply, so that indicated to us there was a short supply of ventilators when there was a great need, so there must have been a cost. There were empty beds at the time and we asked why. They said there were not the nurses that were needed to look after the patients, so that was why that particular bed was not being used.’[36]

31 Michelle Cummings told the Inquiry that there was no ventilator for her daughter Charlotte at the BRHSC:

> ‘… and there were no beds in the baby unit, and she ended up being put on the bed of a child who had gone down to have his tonsils out whilst they decided what to do with her. I have to say, at this point Mr Dhasmana, who at the time was caring for Charlotte because Mr Wisheart was away, he actually had no knowledge of what had gone on until his return, and he was furious, that is the only way I can describe it. The man was furious. He had not even been told she had been moved at that point, and he was absolutely livid when he got to the Children’s to find us there and in that predicament. In fairness to the man, there was very little he could do at that stage. It caused untold distress for the nurses and doctors who were actually looking after her, let alone the unacceptable gamble that we had to witness being taken with her life.’[37]

32 Michelle Cummings said:

> ‘She went on to — I again thought it was Ward 37, but that was the baby unit. It was Ward 33, the general surgical ward, and what they — as I said, she was on the bed of the child who had gone down for a tonsillitis operation. They then had to ask a parent if they would be prepared for their child to be moved down to the non-surgical ward so that Charlotte could have a bed and that party graciously agreed, and Charlotte was placed very close to the nurse’s office and everything. All this

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[35] T3 p. 142–4 Michelle Cummings

[36] T6 p . 94–5 Belinda House

[37] T3 p. 151–2 Michelle Cummings

> time, she is still being hand ventilated. It got to a point in the afternoon where a decision had to be made, and it was clear that they could no longer continue to hand ventilate her. It was just a totally ridiculous situation. So it was decided to risk just placing her in an oxygen box, and seeing how she coped. Thankfully, she coped. But again, it was a totally unacceptable position that everybody was put in. And an incredible gamble.
>
> ‘Q. And you say in your statement that there were no specially trained nurses around?
>
> ‘A. I meant ITU nurses. There were no intensive care nurses.
>
> ‘Q. Obviously there were no children’s nurses?
>
> ‘A. Yes, but I meant she was not having intensive care nurses looking after her, which, you know, I mean, the attention that these children get when they are in ITU. There was also the other issue over the risk of infection on a general surgical ward, so close, which again, could not be addressed because of the circumstances.’[38]

33 Dr Pryn commented on the standard of nursing care:

> ‘I think in general, the standard of nursing care was quite good considering the circumstances. I think if more nurses had had paediatric intensive care qualifications, then they would have perhaps brought slightly different techniques, but not a major change in the care. …’[39]

34 He outlined what he meant by ‘considering the circumstances’:

> ‘The circumstances being that they were having to look after children one day and adults the next; that the junior doctors that were working with them at the time more often than not were not that experienced with children.’[40]

35 As for the ‘slightly different techniques’, he explained these were:

> ‘Techniques such as the method of stabilisation of nasopharyngeal airways, or the way in which you can involve parents in the care of their child.’[41]

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[38] T3 p. 154–5 Michelle Cummings

[39] T72 p. 30 Dr Pryn

[40] T72 p. 30 Dr Pryn

[41] T72 p. 30 Dr Pryn

36 The Inquiry was also referred to a letter[42] sent by Mr Ashwinikumar Pawade, consultant paediatric cardiac surgeon, to Fiona Thomas in October 1995:

> 'Dear Fiona, As you know, today was the day when I operated on the last child at the BRI. Personally, I have found my last five months with you most enjoyable. I have no complaints whatsoever regarding the promptness, expertise and level of the care that the children received, both in and outside theatre. I am sure that the parents will echo my feelings. Please convey my gratitude to all those people involved, including those in the operating theatre, Wards 5A and 5B, and ancillary staff. ...'[43]

Staffing levels

37 Julia Thomas described the staffing situation at the BRI ICU when she was Clinical Nurse Manager as follows:

> 'The ITU was staffed on the basis of 5.60 WTEs [whole-time equivalents] per bed over a 24-hour period, making a ratio of 1 nurse per patient around the clock. This figure allowed for holidays and sickness. The Unit WTE was well up in the range for staffing ITUs recommended by the Government at that time.'[44]

38 She stated that the ICU at the BRI was fully staffed in that it had one nurse per intensive care bed, and including the Ward Sister, one nurse over and above that number. The number of nurses subsequently increased in proportion to the number of beds as a result of the various expansions that took place over the period 1984 to 1995. In addition, she stated that when she was Clinical Nurse Manager:

> 'This area [the ICU] was staffed by RSCN [Registered Sick Children's Nurse] qualified nurses and senior NNEB [National Nursery Examination Board] trained nursery nurses. A qualified play leader worked in the nursery and playroom five days a week.'[45]

39 Julia Thomas told the Inquiry in her written statement that cases rarely had to be cancelled due to shortage of nursing staff. When this did occur it was mainly due to sickness, either among ward staff forcing the closure of an intensive care bed or theatre staff. If the theatre staff had been working during the night on an emergency case, the theatre lists for the rest of the day would be affected and the first case scheduled for the morning would be postponed.[46]

40 Julia Thomas said that, otherwise, cases had to be cancelled on occasions when there were seriously ill patients in intensive care and the beds became blocked. Adult cardiac cases were sometimes cancelled because beds were occupied by the

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[42] T32 p. 86 Fiona Thomas

[43] UBHT 0129 0005; letter dated 9 October 1995

[44] WIT 0213 0005 Julia Thomas

[45] WIT 0213 0005 Julia Thomas

[46] WIT 0213 0031 Julia Thomas

paediatric cases, which took priority over the adult cases and tended to progress more slowly.[47]

41 She was of the opinion that this situation improved after the expansion of the Unit in 1988, when the number of intensive care beds was increased to eight. The provision of seven high dependency beds enabled the less complicated adult surgery cases to be fast-tracked, leaving the intensive care beds available for the more seriously ill patients.[48]

42 Fiona Thomas, in her written evidence to the Inquiry, stated that the Nurse Manager had overall responsibility for planning of staffing levels and skill mix.[49] On a day-to-day basis, Ward Sisters in the ward areas looked at the staffing levels to ensure that an area had the correct level of staff to cope with the patients having operations on a given day.[50] The Sister in charge of the Unit occasionally sought the advice of the Nurse Manager if the severity of a patient's illness made it necessary for two nurses to care for them.[51]

43 Fiona Thomas explained that although the staffing levels in the ICU were usually one nurse to one patient, there were times when one patient may have required two nurses. In such circumstances if there was also a patient who may not have needed one WTE nurse, one nurse could be allocated to two patients. Alternatively, an extra nurse would be employed, releasing a specialised nurse.[52]

44 As regards the High Dependency Unit (HDU), Fiona Thomas stated that it was staffed with 0.5 nurses per patient, the nursing complement being a combination of Health Care Assistants (HCAs) and trained nurses.[53]

45 She wrote that when she took over as Nurse Manager in 1992, the staffing levels seemed adequate on the ICU and HDU, but in Ward 5A they were not sufficient to cope with the level of dependency of the patients. Patients were being put through the ward more quickly, at an earlier stage of recovery and in greater numbers, so the staffing levels needed to be adjusted accordingly.[54]

46 Fiona Thomas explained her approach to staffing levels:

> 'Each intensive care bed should have, I believe, between 4.5 and 7.5 full time equivalent nurses over a 24-hour period. This would of course depend on how ill the patients were. In Bristol, I recall that we have worked on the basis of 5.8 nurses per intensive care bed. This is a figure that I work on now, even though I do have a

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[47] WIT 0213 0031 Julia Thomas
[48] WIT 0213 0031 Julia Thomas
[49] WIT 0114 0018 Fiona Thomas
[50] WIT 0114 0019 Fiona Thomas
[51] WIT 0114 0010 Fiona Thomas
[52] WIT 0114 0010 Fiona Thomas
[53] WIT 0114 0010 Fiona Thomas
[54] WIT 0114 0019 Fiona Thomas

> slightly different system of calculation. I use the following method of calculation: number of staff required per shift x hours ÷ 37½ + 23%. The figure of 23% covers study leave and sickness.'[55]

47 At a later point in her written statement, she commented:

> 'I believe that the national standards for ITU staffing levels were a bracket of 5.1 to 7.8 qualified nurses per bed. This provided 24-hour cover at an appropriate level. The figures varied within the bracket, according to the level of complexity of care required within ITU. Depending on how ill a patient is, he/she may require one-to-one care, or may be treated by a nurse allocated to a patient requiring similar levels of care (i.e. one-to-two ratio). In the ITU at the BRI we had a ratio of 5.4. This was, I believe, lower than the optimum indicated for pure paediatric units, but reflected the case mix of adults and children we treated.'[56]

48 She went on to say that the staffing levels were no different during the night from during the day, with a one-to-one ratio per patient, and always with a G grade or an F grade nurse in charge of the shift. In addition, the night shift (6 pm to 8 am) was supported by an SHO who was on duty 24 hours a day and the registrars and consultants were on call and could be on the ward within ten minutes if needed.[57]

49 Fiona Thomas commented in her written statement on morale among the nursing staff at the BRI ICU, noting that there are peaks and troughs of morale, but that in 1994 and 1995 it was particularly low. She ascribed this to the changes taking place, redeployment of staff to the BRHSC and the number of very sick paediatric patients coming through the unit. She also stated:

> 'There had been a shortage of staff since, I believe, around mid-1993...'[58]

50 The Paediatric Intensive Care Society's (PICS's)[59] *'Standards for Paediatric Intensive Care'*, published in 1992,[60] said that it was essential for there to be a senior nurse with several years' experience of paediatric intensive care in charge of the unit and a minimum of one trained nurse to one patient throughout the entire 24-hour period. Also, when calculating the nursing establishment, it was necessary to make allowances for staff handover time, holidays, sickness and study leave. Dr Jane Ratcliffe, former honorary secretary of the PICS, confirmed that, taking the various factors into account, the establishment recommended by the PICS was 6.4 WTEs to one patient per 24-hour period.[61]

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[55] WIT 0114 0019 Fiona Thomas

[56] WIT 0114 0085 Fiona Thomas

[57] WIT 0114 0086 Fiona Thomas

[58] WIT 0114 0025 Fiona Thomas

[59] The Paediatric Intensive Care Society was set up as an independent multidisciplinary body in 1987 to develop and promote standards of paediatric intensive care, education, training and research. As such it has a major role in promoting research and education in paediatric intensive care: WIT 0060 0001 Dr Jane Ratcliffe

[60] WIT 0060 0011 Dr Ratcliffe

[61] T7 p. 152 Dr Ratcliffe

51 In the light of this, Fiona Thomas drew the distinction between this recommendation which was for a purely paediatric unit, and what was needed for a mixed adult and paediatric unit. She added that, while there were eight intensive care beds on the ward, the most children she could remember on the unit at any one time was five:[62]

> 'You have to remember that the unit was a mixed unit. That is why when I answered the question it was 5.4 for the whole intensive care unit, because of course there were 8 beds, not necessarily 8 beds would have been [occupied by] a patient, at this stage when we are talking, who would be ventilated and may be considered an intensive care patient.'[63]
>
> 'They [paediatric patients] always received one nurse per patient every single shift. If the patient was more dependent, which sometimes they were and they needed two nurses per shift, then another nurse would have worked with that nurse.'[64]

52 Julia Thomas stated that:

> 'The English National Board for Nursing and Midwifery (1991) guidelines covered the numbers of staff in ICUs [i.e. both adult and paediatric] and recommended staffing at a ratio of 1 nurse per bed per shift.
>
> 'These guidelines recommended 70% of nurses to be children's [nurses] trained in paediatric wards/ITU. I believe the same ENB guidelines recommended regular skill mix exercises to be carried out, which I carried out regularly with Lesley Salmon, the then Associate General Manager of Cardiac Surgery.
>
> 'In 1988, I was made aware of the recommendations of the DoH for a play specialist to be available on all units where children were routinely nursed. This led to the appointment of a full time play leader for our playroom. Prior to this the post had been a part time one.'[65]

53 She went on:

> 'The Department of Health's 1991 recommendations of an RSCN on duty 24 hours a day to advise on care, and the [ENB's] target of 70% paediatric nurses on ITU, were not met. However, as ward 5B was not a designated Paediatric Intensive Care Unit (PICU) I am not sure whether this recommendation applied to the unit. In the British Paediatric Association survey of 1993, adult ITUs which admitted paediatric patients were shown to have less than 1% RSCNs. This study also concluded that 84% of PICUs and 80% of adult intensive care units failed to meet the recommended minimum. Ward 5B employed a specialist paediatric nurse to advise ITU staff on care issues. We always had 1 nurse per ITU bed. We tried very hard to

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[62] T32 p. 48 Fiona Thomas

[63] T32 p. 42–3 Fiona Thomas

[64] T32 p. 43 Fiona Thomas

[65] WIT 0213 0038 Julia Thomas

> employ RSCNs on the unit, but this was difficult to achieve, due to a national shortage of children's trained nurses.'[66]

54 The change in the training of nurses in 1990, which led to nurses receiving more of their training at university, taking a diploma or degree in nursing, had an effect on the arrangements for nursing on the ward, as Fiona Thomas explained:

> 'It was quite drastic on some wards, because some wards did require those extra staff, extra nurses, and third-year student nurses particularly were used as a good pair of hands for patient care. Student nurses up until the change were used as staff caring for patients.'[67]

55 She further explained the situation due to the change in nurse training:

> 'When they were not around, there was a deficit of nurses, of carers, then, one could say, and then the BRI had introduced quite a big training programme for HCAs to try and get more HCAs to try and fill up the gap that was going to be present when there were no student nurses.'[68]

56 The gap left by the student nurses was filled by nursing auxiliaries:

> '... auxiliaries were trained, the training for auxiliaries changed to become health care assistants so an auxiliary could do extra training to NVQ [National Vocational Qualification] level 2 so they were able to be more knowledgeable about certain aspects of nursing care, so they were able to do some of the nursing care roles.'[69]

57 In her written evidence Fiona Thomas stated:

> 'There were occasions when post-registration students, who were undertaking extra courses in cardiac care or Project 2000[70] students, visited the ITU/HDU. Both were supernumerary. However, the ENB students occasionally looked after patients by themselves, but only when it was felt that they were competent and confident. The Project 2000 students never looked after patients by themselves.'[71]

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[66] WIT 0213 0039 Julia Thomas

[67] T32 p. 63–4 Fiona Thomas

[68] T32 p. 64 Fiona Thomas

[69] T32 p. 64 Fiona Thomas

[70] Project 2000 replaced the previous system whereby pre-registration nurses were trained on a ward-based apprenticeship, with a university-based diploma education. All student nurses on the ward under Project 2000 were supernumerary

[71] WIT 0114 0010 Fiona Thomas

58 In her written statement, Belinda House said:

> 'While the nurses there [in the Nursery] were helpful and appeared to do their job very well, we were surprised how few of them there were, particularly considering that there were several children on the ward who had recently come back from the intensive care unit and at times there were no nurses in the room at all.'[72]

59 Fiona Thomas replied to this in her oral evidence:

> '... the children only went back into the nursery from the intensive care when they were well. I mean, the children, in 1990, used to stay in intensive care for quite a while, even once they were extubated and breathing by themselves, they did not go back to the nursery until they were fairly well, because there was nothing in-between. We had intensive care and we had the nursery, there was nothing in-between. To a parent's perception of somebody coming back from intensive care, it may have just looked fairly dramatic, I suppose, they might have come back with a drip or two, but they would not have actually gone into the nursery very much at that stage.'[73]

60 Belinda House also stated that a trainee failed to notice that a ventilator had run out of water. Fiona Thomas replied that it would not have been a trainee's responsibility to refill the ventilator:

> 'The trainee nurses never looked after the children unless they were ... with a trained nurse, so there were many times when the trained nurses had a trainee with them. Maybe that was what the parents were referring to; that trainee was the one who was with the trained nurse. But I agree the water should not have run out in the ventilator. There was a pot we used to have to top up continuously; as time went on and advances were made it used to top itself up, but it had to be filled with water which made sure the ventilator was humidified with oxygen and that went to the child's lungs.
>
> '... it would not have been the trainee's responsibility to do that. She would have been there with one of the trained nurses as well.'[74]

61 Asked by Counsel to the Inquiry whether she could recall cancelling operations due to not having sufficient staff on the ICU, Fiona Thomas replied:

> 'What I do recall doing ... was rallying round, calling extra staff, but I do not remember being able to get agency staff, because agency staff were not clinically able to care for the children, so if we did have agency staff, they would look after the adults and our own nurses would look after the children. ... That is how we

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[72] WIT 0025 0005 – 0006 Belinda House

[73] T32 p. 87–8 Fiona Thomas

[74] T32 p. 89–90 Fiona Thomas

> would manage it. I do not recall cancelling operations; I remember just trying desperately to sort the staffing matters out by phoning around.'[75]

62 Lorna Wiltshire said that while she was Nurse Manager of the Cardiac Unit:[76]

> 'We did use bank nurses, but it was often the case that it was easier to manage with what we had rather than to bring in someone who had no experience on the ward. It was rare to bring in an agency nurse, unless all else failed. We would try to look at who we had and see if we could shift people around. It was quite often the case that sisters dealt with the problems and only came to me if they could not resolve them.'[77]

63 She continued:

> 'If all avenues failed, we had to close a bed. This did happen on occasion. It had to be approved at a higher level, and was only done as a last resort.'[78]

64 Pat Fields was employed as an Operational Nurse at the BRI in November 1990, in order to organise the nursing services within the surgical unit as the unit was using high numbers of agency staff.[79]

65 She said of the nursing situation throughout the Trust:

> 'When the Trust was created, the structure became very fragmented. Everyone had their own budgets, all the way through the structure. By way of an example, if there was a shortage of nurses on one ward, then agency nurses would be used, rather than asking for (or obtaining) help from another ward, because of the budget implications. This meant that units no longer worked together as closely and co-operatively as they had before, always being concerned about the implications for their own budgets, which were jealously guarded.'[80]

She also said that the increase in the use of agency staff was in part due to the changes in nurse training and to clinical grading issues.[81]

66 Mrs Fields was of the opinion that this would have an adverse effect on care throughout the surgical unit:

> 'I felt that the quality of care offered was bound to be reduced due to the large number of agency nurses. My first task was to advise Mr Roger Baird as Clinical

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[75] T32 p. 92–3 Fiona Thomas

[76] Lorna Wiltshire was Nurse Manager during Julia Thomas' maternity leave in April 1990, and subsequently became an Assistant Manager in General Surgery from late 1990 until 1993

[77] WIT 0330 0007 Ms Wiltshire

[78] WIT 0330 0007 Ms Wiltshire

[79] WIT 0154 0002 Mrs Fields; her appointment was part-time for three months, but her contract was subsequently extended

[80] WIT 0154 0006 – 0007 Mrs Fields

[81] WIT 0154 0018, 0022 Mrs Fields

> Director for Surgery that, in order to sustain a good quality service for all patients, we would have to close some beds on the ward, and reduce the number of agency nurses being used.'[82]

67 Mr Dhasmana said that when a shortage of nurses occurred due to an unforeseeable sickness, in order that an operation on a child should not be postponed, bank nurses needed to be recruited to the BRI ICU. He said that this was unfortunate because they may have got nurses who were intensive care trained, but not in the field of cardiac surgery. In such a situation an adjustment was made whereby the bank nurse was placed in the HDU and a suitable nurse was moved from the HDU to the ICU.[83]

68 As regards staffing levels in the Cardiac Theatres, Sister Kay Armstrong, Cardiac Sister, noted in her statement that when she first began to work as a staff nurse in the theatres in October 1984, there were approximately 11 nursing staff including her. This covered the three Level 4 Theatres of the BRI. Between 1986 and 1988, she did not recall more staff being employed, although the allocation of one person to cover nights was increased to two.[84]

69 After the expansion of cardiac surgery in 1988, staff numbers increased, although Sister Kay Armstrong stated that:

> '... it was very hard to find out from management what our staffing allocation should have been.'[85]

70 Sister Armstrong also stated:

> 'The sisters were responsible for the day-to-day running of the theatres but did not hold the budget or have any control over the staff numbers allocated to each theatre. This was very frustrating as we were frequently understaffed without the power to do anything about it.'[86]

71 Sister Armstrong explained the nursing element of the team for each theatre ordinarily comprised an anaesthetic nurse assistant, a scrub nurse and a circulating nurse. In addition, there would be an allocated sister-in-charge. The sister-in-charge would rarely be supernumerary and would often take up one of these positions.[87]

72 Mrs Margaret Maisey, Nurse Advisor to the B&WDHA and later to UBHT, told the Inquiry that on two separate occasions she had had carried out formal reviews of

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[82] WIT 0154 0007 Mrs Fields
[83] T86 p. 19–20 Mr Dhasmana
[84] WIT 0132 0002 Ms Armstrong
[85] WIT 0132 0003 Ms Armstrong
[86] WIT 0132 0003 Ms Armstrong
[87] WIT 0132 0041 Ms Armstrong

nurse staffing and the skill mix. The first one was across all of B&WDHA and the second across UBHT. She stated that, as regards staffing (establishment):

> 'At the time the results of the first survey revealed no significant nursing establishment problems. On the second occasion, the Trust, in general, appeared to be as well as, or better, staffed than comparative institutions in the middle and senior grades on clinical nursing staff. The results of the surveys were discussed at DNAC [District Nursing Advisory Committee] and TNAC [Trust Nursing Advisory Committee].'[88]

73 Mrs Maisey went on in her written evidence to refer specifically to the cardiac ICU at the BRI:

> 'With reference to the BRI cardiac ICU, I am sure that if there had ever been a reason to raise the subject of nurse staffing on the cardiac ICU because of a shortage of staff, the Nurse Advisers, again, experienced professional nurses who would have had no difficulty in raising any subject, would have brought it to the attention of the relevant manager, and, if the situation had not been resolved satisfactorily, to myself. From 1991, when the service was an Associate Clinical Directorate, the situation would have been reported to the Clinical Director, and, if that failed to improve the situation, brought to my attention with the expectation that I would support the Nurse Adviser's recommendations for corrective measures.'[89]

Skill mix

74 Mr Andrew Darbyshire[90] said that the differences between nursing adult and paediatric patients are that, although there are similarities in the physiological care, the anatomy of children is not as straightforward. Also, there is the additional need to understand and deal with the interactions between the parents and the child, so as to deliver 'family-centred care':[91]

> 'But in terms of delivering that physiological care, I think experienced adult nurses, provided they have made the adjustments into paediatrics and the anatomical and physiological problems of the child, could deliver that.'[92]

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[88] WIT 0103 0027 Mrs Maisey

[89] WIT 0103 0029 – 0030 Mrs Maisey

[90] Expert to the Inquiry in Post-Operative Nursing Care

[91] T51 p. 31 Mr Darbyshire

[92] T51 p. 32 Mr Darbyshire

75 Mr Leslie Hamilton[93] was asked whether in his opinion a nurse might not pick up the more subtle signs from a child that there may be a problem or deterioration in condition, if that nurse is not paediatrically trained.[94] He replied:

> ‘Personally, I think the key is that they are used to dealing with patients who have the abnormal physiology that we see after coronary pulmonary bypass, or after repair, closed surgery. I think that is very specific to cardiac patients. As Andrew [Darbyshire] said, if you are an adult nurse, as long as you are in that paediatric environment, your skill will be in picking up those subtle signs.
>
> ‘I think, again, the background of the person is less important than how they are integrated into the unit. To me, paediatric intensive care is very much a team thing and everyone has their own input. The role of the intensivist is to bring all that together. The nurses are the key at the bedside; they are the ones who pick up, usually first of all, that something is not quite right. It may be a surgical problem, it may be something else, but I think it is very much an integrated thing.’[95]

76 Dr Barry Keeton[96] gave his view of the paediatric training and experience required of nurses as follows:

> ‘On the nursing side, clearly it is very desirable that the nurses have had paediatric training, but we must not ignore the very experienced nurses who became very adept at looking after both adults and children within the intensive care environment. Although they may not have had paper qualifications, they have looked after children, and families, for many years and done it very well. Clearly things have changed in more recent years, where they now go off on courses and get their paediatric qualifications, but our senior nursing staff were very expert with the children.’[97]

77 Dr Duncan Macrae[98] told the Inquiry:

> ‘I think on the question of first of all nursing skills, some of the best paediatric cardiac intensive care nurses I have come across have actually been adult nurses who have come to paediatric intensive care nursing, adult nurses with intensive care training, who have been absorbed and trained within the unit by the paediatrically trained people there who really have been excellent nurses.
>
> ‘Having said that, the overall feel of the paediatric nursing needs to come from nurses with paediatric training, so it is possible for units to function with a proportion of intensive care trained nurses who are not specifically paediatric

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[93] Consultant cardiac surgeon at the Freeman Hospital, Newcastle; Expert to the Inquiry in Paediatric Cardiac Surgical Services

[94] T51 p. 32 Mr Hamilton

[95] T51 p. 32–3 Mr Hamilton

[96] Consultant paediatric cardiologist, Expert to the Inquiry in Paediatric Care

[97] T51 p. 36 Dr Keeton

[98] Director of Paediatric Intensive Care at the Royal Brompton Hospital, London; Expert to the Inquiry in Post-Operative Intensive Care

> nurses but there very definitely needs to be a balance, or indeed a majority, of paediatrically skilled people to set the overall tone and policy of the unit.'[99]

78 Mr Darbyshire took up the point:

> 'I take on board the point that Duncan [Macrae] made, that an adult ICU nurse may well be able to offer very good physiological care for children within the ICU, and maybe from a medical perspective that is how you would judge a good nurse; what information you get to enable you to do your job. I think from a paediatric nursing perspective there is a little bit more to it and I think paediatricising a unit is something that paediatric nurses are qualified and trained to do.
>
> 'I think the support of the family, again, is something specific to paediatrics, and the involvement and the relationship between the patient and their parents is very important and is an important facet of, if you like, paediatric training.
>
> 'I think there is a bottom line underneath all the statements I have made that is what is really important is that you have a skilled, experienced paediatric intensive care nurse, and they can come from an adult background. They can come from a paediatric background. It is the experience that they have within the PICU that I think is of fundamental importance.
>
> 'There are all sorts of arguments about what sort of ratio do you need of paediatric trained staff to non-paediatric trained staff; I do not know the answers to those questions. I know recent guidelines have been published that state that a very large percentage should be paediatrically trained.
>
> 'I think the other issue surrounding paediatric nurses in PICU in a mixed unit is how you actually allocate those staff to the patients. Do you have an individual nurse who one day is allocated to adult patients and the next day to paediatrics? No matter how good an adult nurse is, on the first day she looks after a paediatric patient she will not be as good a paediatric nurse as she was an adult nurse and it is how you actually structurally organise that situation in a mixed unit that I think would be of great importance in the delivering of skilled nursing intervention really.'[100]

79 Mr Hamilton added:

> 'Essentially I would agree with both the previous speakers. As a surgeon, I want a nurse at the bedside who is going to pick up the subtle changes that we see after cardiac surgery, so I want an intensive care nurse who is experienced in, and knows about, cardiopulmonary bypass and post-operative cardiac patients. I think it is very important to have the paediatric environment. Whether it is physically separate has to be clearly identified, and I think the senior nurses in the unit need to

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[99] T51 p. 56 Dr Macrae

[100] T51 p. 57–9 Mr Darbyshire

> be paediatrically trained to bring that paediatric component and the care of the whole family into it, so I think those need to be wedded together.'[101]

80 Dr Keeton said:

> 'I would agree with the previous comments that have been made. I obviously have personal experience of evolving from working within a specific cardiothoracic intensive care unit which housed both adults and children to now the much better situation that we have of having a separate paediatric ITU.
>
> 'I think the paediatric bits of nursing — the paediatric nurses do not have a monopoly of it. There were some very good adult-trained intensive care nurses who were extremely good at looking after children and within our unit we had a group of nurses within the intensive care unit staff who liked looking after children and who did it quite well, and in fact they are the nurses now who have gone off and got their paediatric qualifications and now some of them are running the paediatric intensive care unit or the cardiac bit of the new paediatric intensive care unit which we have.'[102]

81 Julia Thomas explained how an even skill mix was ensured on the BRI ICU between 1984 and 1995:

> 'Each shift in the ITU and theatre is run by a G grade or F grade nurse, both day and night. The senior nurse delegates work to her team of nurses, assessing their experience in relation to each patient's needs. All students are supernumerary. Rotas are worked out every four weeks, thus allowing an even skill mix over [a] 24-hour period.'[103]

82 Julia Thomas stated that the experience and skill mix of the nurses on the ICU at the BRI varied over the period 1984–1995, but all the senior nurses from F grade to G grade had taken a recognised intensive care course and had at least three years' ICU experience.[104] The E grade staff nurses had at least one year's ICU experience and many had done an ENB intensive care or cardiac course. The D grade staff nurses were sometimes newly qualified, but had some ICU experience and an interest in gaining more.[105]

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[101] T51 p. 59 Mr Hamilton

[102] T51 p. 60 Dr Keeton

[103] WIT 0213 0012 Julia Thomas

[104] WIT 0213 0038 Julia Thomas

[105] WIT 0213 0039 Julia Thomas

83 Although the skill mix varied during this period, the majority of the staff were graded between G and E grades, with ICU experience, and over 50% of staff had attended recognised ICU courses. As for paediatric qualifications:

> 'Between two and four nurses on the ITU were RSCN trained. At any one time other senior nurses had undertaken shortened paediatric courses, including SEN [State Enrolled Nurse] children trained nurses. All nurses caring for children had undertaken the Unit's in-house training in paediatric ITU nursing. This was a three-week training, undertaken on the Unit, following strict protocols laid down by a senior paediatric nurse.'[106]
>
> 'Qualified nurses undergoing post-graduate courses worked on the Unit. These nurses were never allowed to look after paediatric patients, unless they were upgrading their paediatric nursing skills, in which case they would be working alongside, and supervised at all times by, a cardiac/ITU experienced nurse. These nurses wore student uniforms so that they were readily identifiable by medical and nursing staff as supernumeraries.'
>
> 'We also had general student nurses on the Ward. They were never left alone with any of the patients and worked as supernumeraries at all times with named mentors. The Unit had a core of nurses qualified to look after children. They were very well qualified. ... we would always try to recruit a children's trained nurse but there was a huge shortage, so the next best thing was to recruit a nurse with general or cardiac ITU experience and then training the nurse to look after children on the ITU. On the whole, the children were looked after by an ITU nurse with an ENB 100 qualification.'[107]

84 Julia Thomas explained that the cardiac ICU course (ENB 249) was only introduced nationally in 1992. It is now offered at the BRI.[108]

85 Catherine Warren took the general ICU course (ENB 100) in 1990 and trained as an RSCN in 1991–1992. As an F grade senior paediatric nurse, she was in charge of writing the protocols for care standards following her qualification as RSCN, and also carried out audit work. She also attended outpatients' clinics so parents could talk to her after they had seen the consultant.[109]

86 After April 1992, when Ms Warren returned to the Unit with the RSCN qualification, she worked only with children, either in the Nursery or on the CICU,[110] whereas before this she had worked on the CICU caring for both children and adults. This change came about because she was the only nurse who had both experience of cardiac care and a paediatric nursing qualification.[111] Depending on the severity of

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[106] WIT 0213 0039 Julia Thomas

[107] WIT 0213 0006 Julia Thomas

[108] WIT 0213 0006 Julia Thomas

[109] WIT 0213 0007 Julia Thomas

[110] Cardiac ICU

[111] WIT 0483 0001 Ms Warren

the child's condition and the experience of the other nurses, she stated that she cared for most of the children immediately post-operative.[112]

87 Catherine Warren was the only nurse who rotated between Wards 5A and 5B.[113] She worked on Ward 5B on the two days of the week when children were being operated on, caring for the children when they returned from theatre. Otherwise she worked in the nursery. Since Ms Warren had also completed the cardiac course, her knowledge was used extensively throughout the unit to advise all staff on how to care for the children.[114]

88 From 1992 there was a D grade nurse who was a newly qualified RSCN working solely in the nursery. The other nurses in the nursery were D and E grade.[115] A play leader[116] was also employed from the mid-1990s.

89 Fiona Thomas stated that since she became Nurse Manager, in 1992, she carried out skill mix reviews with the General Manager, every year or every two years, depending on workload and when expansion plans were scheduled to take place.[117] She explained that skill mixes had always been easily addressed in intensive care because of the existence of national guidelines on staffing levels. She stated that she had always found the General Managers very accommodating when discussing skill mix, and, although they may have questioned why extra members of the team were needed, she never encountered any particular problem in justifying the need to recruit.[118]

90 She went on to say that on a day-to-day basis, skill mixes were readily determined by the knowledge of the case mix of patients expected. Staffing levels and mixes were always appropriate to the case mix.[119]

91 She agreed that the overall mix and expertise of the ICU staff differed from that set out in published guidelines, because the guidelines stipulated that only paediatric nurses should at all times care for paediatric patients, which the ICU at the BRI could not meet. She put the lack of specialist paediatric nurses down to the difficulty in recruiting such nurses to a mixed adult and paediatric unit.[120]

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[112] WIT 0114 0085 Fiona Thomas

[113] Ward 5B contained the ICU and the High Dependency Unit, while Ward 5A contained the Admission and Continuing Care Beds and the nursery

[114] WIT 0114 0012 Fiona Thomas

[115] WIT 0114 0012 Fiona Thomas

[116] Ms Helen Passfield

[117] WIT 0114 0010 Fiona Thomas

[118] WIT 0114 0019 Fiona Thomas

[119] WIT 0114 0071 Fiona Thomas

[120] WIT 0114 0086 Fiona Thomas

92 When asked how frequently children in intensive care at the BRI were cared for by nurses of whom none was paediatrically qualified, Sister Sheena Disley replied:

> 'It would be fairly common for there not to be an RSCN, but it would be extremely uncommon for it not to be a highly skilled nurse above E grade level who had had considerable orientation and training for it. That would just not happen.'[121]

Involvement of clinical staff

Cardiologists

93 Dr Jordan, consultant cardiologist, in his written statement to the Inquiry stated that:

> 'It was difficult to maintain any continuing liaison between the surgeons and anaesthetists at the BRI and the cardiologists at the Children's Hospital. This actually became more of a problem as the number of adult patients increased and with this the actual number of anaesthetists and of cardiac ITU nurses, so that the role of the paediatric cardiologists inevitably appeared less important.'[122]

94 Dr Jordan did not regard the fact that the cardiologists were based at the BRHSC as being a problem in itself. Rather:

> 'The main problem as I saw it was that the system had grown up as being managed by the surgeons and anaesthetists and we were not routinely involved in post-operative care. Another problem was that for much of the time there was no regular time for the surgeons and anaesthetists to carry out their visits, and these seldom coincided, so it was impossible to co-ordinate the visits which I did make with their attendance on the ward. The situation was actually better at weekends when I was able to at least make an effort to get there when the surgeons or anaesthetists were expected.'[123]

95 However, as Dr Joffe, consultant cardiologist, told the Inquiry:

> 'Dr Jordan specifically made a point of going to the BRI every day and often twice a day, so it was not as if there was no presence whatsoever at the BRI. He found it slightly easier than I could because earlier on he was still involved in adult cardiology, had an office at the BRI, and needed to be there anyway, and indeed, he and later Dr Martin [consultant cardiologist, BRHSC] were running an outpatient clinic for adolescents and adults who had grown from the childhood period, usually post-surgery, at the BRI. Therefore, they had some time when they had to go. So,

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[121] T32 p. 136 Ms Disley

[122] WIT 0099 0045 Dr Jordan

[123] WIT 0099 0045 – 0046 Dr Jordan

> apart from the weekends, I would say that on a daily basis there was at least one call by a paediatric cardiologist who would look at all the patients, not only his or her own, but all paediatric cardiac cases, and make recommendations about management, if necessary. In addition, we, or certainly I, tried, I think on two occasions, to establish a regular routine ward round at the BRI, twice or three times a week, and discussed this with Mr Wisheart at the time, and the intention was there, on both sides, but with all our other demands and the variation between timetables of surgeons and paediatricians, et cetera, it was just not possible to organise.'[124]

96 As to his own input, Dr Joffe said that he regretted that he had not had the available time on every occasion to go to the BRI, from the BRHSC where he was based, in order to see his patients post-operatively. He told the Inquiry:

> 'I do regret it. I think we may have made a difference to the overall outcomes, but it is very hard to put hard figures on to that, so it is an impression. But I wish we had the time to have spent in the BRI for that purpose. Unfortunately, we did not.'[125]

97 Dr Joffe went on:

> 'The physical separation was real, although of course not insurmountable. The distance between the two hospitals was really quite small: 150, 200 metres, maybe. But the hill, when you were walking up it, felt as if it was almost half a mile, rather than 200 metres. It was extremely steep, so it was difficult coming back up; it was easy going down. This may sound trite, but it does make a difference, and it also makes a difference in terms of the ordinary communication that exists in a unit where consultants and various doctors can meet with each other and bump into each other in a corridor, and so on, which facilitates overall management.'[126]

98 Dr Robin Martin's evidence to the Inquiry included this exchange:

> 'I personally found it difficult to get actively involved in the care of the patients down there [at the BRI]. Patients were under the care of the surgeons, the surgical team were looking after the patients in conjunction with the anaesthetic team. It was very difficult to arrange a time when you could be there when other people were there to discuss the individual case, so usually when I went down I would find there was no one else actually physically there that I could talk to about the case and —
>
> 'Q. The communication between yourself and the surgeon would necessarily have particular difficulties because of that?
>
> 'A. It would be difficult, yes. There would be occasions when surgeons or anaesthetists might specifically ask for an opinion about this or that and of course

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[124] T90 p. 65 Dr Joffe

[125] T90 p. 62 Dr Joffe

[126] T90 p. 67 Dr Joffe

> we would give that opinion and there would be some discussion. But just in the day-to-day management it was very difficult to get very actively involved.'[127]

99 Julia Thomas stated:

> 'The paediatric cardiologists visited their patients on the Unit on a regular basis. They would be contacted in an emergency. They would often come into the Unit to assess the child, give advice, or perform an echocardiogram.'[128]

100 Dr Pryn said:

> 'There was a definite failure to involve the cardiologists enough. When they were called, they came down from the Children's Hospital and they were very helpful, but they were not called as a routine, and they were not there as a routine.'[129]

Surgeons

101 The Inquiry heard evidence that the surgeons would fit in visits to the ICU around their other commitments.

102 Mr Dhasmana said:

> 'The Registrars we had in our unit, they were career grade, were going to be cardiothoracic surgeons in the future, so in a way they were more focused on the cardiac surgical aspect of these patients. They may not be necessarily experienced in the paediatric … we used to have one or two SHOs all the time who had expressed their opinion or ambition to become a cardiac surgeon in the future, and, of course, they had experience somewhere else, but at times we would have an SHO sent from rotation, another time – there were two posts, from rotation, from the surgical grade coming to cardiac surgery. Of course, in the beginning, the first few weeks, although they were very bright boys and they picked up very quickly, but in the first few weeks it used to be a hard time for all of us to train them in order to look after the children.'[130]

103 Mr Dhasmana agreed that until the concept of the intensivist was developed in the 1990s, he was conscious that the management of the ICU was in the hands of a resident whose interest was in surgery but not necessarily in cardiothoracic surgery, and not necessarily in paediatrics, or in the hands even of someone who had no particular interest in either field, yet this person would be the only resident presence on the ICU, apart from the regular rotation of the nursing staff. He said:

> 'That did put a lot of pressure on us, really, especially on me. That is why I used to hang around almost up to midnight or 1 o'clock in the morning, really. …

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[127] T77 p. 35–6 Dr Martin
[128] WIT 0213 0041 Julia Thomas
[129] T72 p. 39 Dr Pryn
[130] T84 p. 92 Mr Dhasmana

> Supposing I finished a case at 6 o'clock and I had got a paediatric patient or very sick adult patient, I would stay around in the ward up to 8 or 9 o'clock, because I always believed it is the first two or three hours when you get all the major problems. Then I would leave a message and also, you know, we did have a Registrar. It is not that when I am operating he is with us, but during other times he is there. One is not supposed to leave an SHO with a very sick patient unattended but I am always sure I am around there, but then I would go home, I would have a little meal or snack, snooze around the telly, if you understand what I mean. I would come back again around 11 o'clock, and especially I would come back because that is the night staff which would have settled by this time, so I would have really gone round, I would have seen that and talked to the nurses, and for children I had a type of co-ordinator, they knew about my feeling and somehow they would have one of those, who would look after the children.'[131]

104 John Mallone spoke of seeing his daughter Josie in the ICU:

> 'She was actually on a steep incline on this incubator with obviously lots of wires going into her arteries and she was on a ventilator as well. … Mr Wisheart was there – this was at 3.00 in the morning. One concern I had was – that we both had at the time – was that he was operating at the end of a day when he had been at work since 9.00 in the morning. He started this operation at 7.30 in the evening and did not finish it until 3.00, finally went home some time after 4.00 and he was back on the ward at 8.00 in the morning. I could not understand how anybody could do that, physically stay awake that long and perform complex surgery, but he was there and he said he thought the operation was okay; he had performed the coarctation and everything was going to be all right, I think, at that stage.'[132]

105 Dr Theo Fenton worked as a senior registrar in paediatric nephrology at Southmead Hospital in Bristol between 1992 and 1994 and was called on separate occasions to dialyse two of Mr Wisheart's patients in the ICU at the BRI. Dr Fenton stated:

> 'I remember that Mr Wisheart was on the Intensive Care Unit on both occasions, despite it being quite late at night. He discussed the two patients with me in some depth and I remember being impressed by his conscientiousness.'[133]

106 Mr Wisheart agreed that he and Mr Dhasmana attempted to remedy some of the less attractive aspects of the split site by spending rather longer in the ICU than they might otherwise have done:

> 'I think that is correct, because we represented the regular cardiological input ... we were the cardiac specialists who were regularly there, yes.'[134]

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[131] T84 p. 93–4 Mr Dhasmana

[132] T95 p. 161–2 John Mallone

[133] INQ 0042 0001; letter to the Inquiry

[134] T93 p. 75 Mr Wisheart

Anaesthetists

107 Dr Pryn explained the anaesthetists' ward round. If he were the on-call anaesthetist on a Monday, he would wait until his patient in theatre was safely established before visiting the BRI ICU for a complete ward round. That would normally take place at 10 to 10.30 in the morning:

> 'So this would be the way the anaesthetic ward rounds were done on a Monday or Friday. On Tuesday, Wednesday or Thursday it would have been as previously stated, around 9 o'clock.'[135]

108 Dr Pryn said that when he conducted a ward round at 9 o'clock he found that complex decisions, with which he disagreed, had been taken in a hurry, at the earlier registrars' ward round.[136] This happened 'relatively frequently'.[137]

109 Dr Pryn commented on what would happen if a decision had been made at the surgeons' 8 o'clock ward round which he would have disagreed with, on a day when he did not have a round at 9 o'clock:

> 'It would either have been picked up on when the anaesthetists did their round, at 10, 10.30, on Monday or Friday, or it would not have been picked up at all. At weekends, the anaesthetic consultant on for the weekend would always do a thorough ward round, around intensive care, with the Surgical Registrars on for that weekend. It was better at weekends because there was not this pressure of time, assuming we did not have an emergency case. Quite often we had emergency cases to do on a Saturday morning, which meant that again the anaesthetist could not get to do their ward round because we were doing an emergency case.'[138]

Intensivists

110 Dr Macrae explained the role of the intensivist:

> 'Traditionally, when cardiac surgery started in children, the key people involved were a paediatric cardiologist who was largely responsible for pre-operative and post-operative care, mainly in the non-surgical sense, and a surgeon and cardiac anaesthetist who were mainly involved in the immediate operative and post-operative care. There was not such a thing as a specialist in intensive care itself. Most of that fell to a combination of the skills of the anaesthetist to look after ventilators and some of the devices, arterial lines and access, that sort of thing, and the surgeon, who broadly speaking perhaps understood the inside of the heart, and between them they decided what the best support and treatment for that child is, with additional support from cardiology. But the difficulty of course was that at the end of an operation, a surgeon and indeed his anaesthetist would probably have to

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[135] T72 p. 44 Dr Pryn

[136] WIT 0341 0011 – 0012 Dr Pryn

[137] T72 p. 50 Dr Pryn

[138] T72 p. 51 Dr Pryn

> go back to the operating room, or perhaps even another hospital, to do some other procedure, leaving the patient in the intensive care unit often being looked after by very skilled nurses, but a hotchpotch of resident doctors in training who may or may not have particular skills in intensive care; they were there to monitor and call people back to help if possible.
>
> 'The history of my job at Great Ormond Street was that there was funding for another surgeon and the surgeons looked at one another and said "We do not really want another surgeon; we want someone to look after the things we now do in the intensive care unit, so let us put the money towards someone to do that, to take that load off our shoulders so we do not have to worry about the intensive care unit while we are back in the operating room".
>
> 'I think perhaps that helps to explain the perception of this skill gap, the sort of vacuum that was there, and increasingly over the last ten years, that gap has been filled by people who are called intensivists, many of whom are anaesthetists who specialise in intensive care, some physicians or paediatricians who have done the same.'[139]

111 Dr Masey commented on the introduction of the intensivists:

> 'Over the time that I was there in the 1980s I felt that it would be advantageous to have personnel who had within their contracts actual time set aside for Intensive Care.'[140]

112 The Inquiry heard that two intensivists were appointed in Bristol: Dr Pryn and Dr Davies.

113 Dr Pryn was appointed in August 1993:

> 'I was also appointed as an intensivist: prior to my, and Dr Davies', appointment[141] there were no anaesthetic consultant sessions on the cardiac intensive care unit (CICU). Dr Davies and I covered three morning sessions a week, alternating months. During my CICU month I anaesthetised for a paediatric cardiac list on Mondays and, on my non-CICU month, I anaesthetised for two cardiac theatre lists per week on Monday, Wednesday or Thursday (of which one was often paediatric).'[142]

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[139] T51 p. 19–20 Dr Macrae

[140] T74 p. 45 Dr Masey

[141] Dr Davies was appointed in April 1993 and took up his appointment at the BRI in July 1993

[142] WIT 0341 0002 Dr Pryn

114 Mr Wisheart was asked how the intensivists, once they began, related to anaesthetists and surgeons. He said:

> 'Well, they were anaesthetists, so they related relatively easily, but not totally with the anaesthetists, because again different people have different views. The intensivists began in 1993 with two sessions a week,[143] that is, two mornings a week devoted to intensive care, so on those mornings they played, if you like, a role in relation to the detailed care of the patients, but that was only on two mornings a week.'[144]

115 Mr Wisheart told the Inquiry about the advent of the intensivists:

> 'I think it is like all major changes, and this represented quite an important change. We debated it and part of the difficulty, I think, in it was that there was a rather long and difficult transitional period. My view to intensive care was very much that people needed to be committed to it, and it was very hard to function in intensive care if you just came in and went out again, so to speak, and did not pick up the consequences of what you had advised or instituted or done, so there had to be an element of continuity. The difficulty with the transitional period, when we first had intensivists, was, of course, that we only had them part of the time and therefore, it was still necessary for the surgeon, and I think Mr Dhasmana – I do not know what he said on this point, but I do not think there was a great deal of distance between us – so we continued to feel that in fact the continuing responsibility lay with us.'[145]

116 Dr Pryn was asked about the ward rounds:

> 'When I first started at the BRI, that round, the surgeons used to insist that all the surgical registrars and all the surgical SHOs go on that round as part of their training, so you can imagine a round of maybe 10, 12 people, surrounding a bed, thinking about complex issues in two to four minutes: not conducive to discussion.'[146]

117 Dr Pryn told the Inquiry he felt that the consultant cardiac surgeons were concerned that they would lose control of clinical decisions relating to their patients to the intensivists:

> 'I believe it came from all surgeons. I think Mr Bryan and Professor Angelini voiced those opinions openly, but I believe that Mr Wisheart felt that he did not want to lose clinical control and so did Mr Dhasmana, initially, although he warmed to the concept of us taking over some of the management of his cases at a later stage.

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[143] Compare with Dr Pryn's evidence in para 113, above

[144] T40 p. 147 Mr Wisheart

[145] T93 p. 74 Mr Wisheart

[146] T72 p. 43 Dr Pryn

> I have to say that Professor Angelini now has completely gone over to our role and is now very keen on the intensivist's role. This was just initially.'[147]

118 Dr Pryn said:

> 'The early days were an uncomfortable time. Our uncertain role was compounded by the fact that we were only available on CICU for three morning sessions a week.'[148]

Consistency of approach

119 Dr Pryn told the Inquiry of protocols he introduced shortly after his appointment in 1993 to improve care. His evidence included these exchanges:

> 'The particular one I am thinking about is, say, the drug infusion protocol, where some people were using that type of protocol already, but others were not. It was 50:50 whether somebody was going to use it or not. I thought that needed to be standardised throughout. That was the reason for that protocol.'[149]
>
> 'As far as the daily clinical note written in the child's notes, they were of a relatively poor quality because they did not thoroughly assess the level of sickness of the child and, in particular, they did not thoroughly assess or document all the organ systems, and they did not document the clinical plan that was in the minds of the clinicians looking after the child. So my attempt at this daily structured note was to make it easy to document the support the child was on, i.e. how sick they were and what the daily plans were, and any changes in the plans throughout the day. … It was based on a daily note that I saw from one of the London hospitals, I think it might have been Great Ormond Street, but basically, it was tick boxes to start with, as to what level of support the child was on, and then different sections for the different organ systems and a section at the end for the daily plan.
>
> 'Q. So by introducing sections for every organ or matter that you wanted clinicians to look at, you were increasing the chances of those being considered in a systematic way and documented in a systematic way?
>
> 'A. That is what I wanted to achieve, yes.
>
> 'Q. Did you achieve it?
>
> 'A. Well, unfortunately, what tended to happen was that this was seen as an anaesthetic note and the trainee surgeons would often write their notes separate to this and not use the form. We went with it for probably a couple of years before I finally admitted defeat and went back to an unstructured form.'[150]

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[147] T72 p. 42 Dr Pryn

[148] WIT 0341 0010 – 0011 Dr Pryn

[149] T72 p. 27 Dr Pryn

[150] T72 p. 35–6 Dr Pryn

120 Dr Susan Underwood, consultant anaesthetist, told the Inquiry:

> 'The number of people working in intensive care, offering input in intensive care, is always a problem and how to organise the rounds is always difficult when people have other commitments as well. The biggest confusion arises between the medical staff and the nursing staff, and when the intensivists came and really pressed on trying to document things more clearly, this helped focus the mind and improve the prescriptions to which I referred before on the charts at the ends of the beds, so that if decisions were changed for good reason, it would be clear to the nursing staff who were trying to implement them which decision was current. So I think that like many things in intensive care, this was an evolving process and at one point it is true that the rounds took place at different times. In fact, before this, there would be the junior surgical round first thing in the morning and then the anaesthetist popping in before theatre, and then the consultant surgeon arriving individually and then the anaesthetist coming on bypass and so on. So I think over the years, it has gradually improved, although, until recently, it has not been really completely co-ordinated, because it has been evolving from a situation where people were years ago popping in and out to do their best, into a team led by an intensivist now.'[151]

Communication between the specialties

121 Mr Dhasmana was asked what, if any, measures he took to make sure that each part of the team responsible for the patient was performing adequately. He said:

> 'I thought I was trying to get the communication right but it appears it was not very good, communication amongst the staff. As a result I used to put in a lot of presence there just to make sure that what we talked about in the morning was being carried out during the day. What we are talking about in the evening would be carried out in the night; what we left in the night was carried out for the remaining part of the night because the rest of the staff were moving or changing. So the communication was not very good and I used to find that sometimes that could create confusion specially amongst nurses really because it is possible a different set of doctors may have advised differently on the same line because, as you know, for any management there could be more than one way of dealing with the problem.'[152]

122 Mr Wisheart commented on the Hunter/de Leval criticism that:

> 'The overall post-operative management at the Royal Infirmary appears to be highly disorganised with conflicting decisions between surgical senior registrar and the SHO who do the rounds at 8.00 am, the anaesthetists who see the patients at 9.00 am, and the intensivists who work three days a week.'[153]

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[151] T75 p. 94–5 Dr Underwood

[152] T86 p. 18 Mr Dhasmana

[153] UBHT 0061 0356 – 0357

He said:

> 'I thought that there was not a particular difficulty. The people involved in the intensive care of children following surgery came from a number of disciplines, and of course, in order to provide that care, they had to work together. Sometimes their views would coincide and at other times their initial views would be different … so frequently there were discussions, and some of those would have been quite vigorous discussions … usually an agreed way forward would emerge from that discussion.'

However, Mr Wisheart conceded that:

> 'Occasionally, however, a difficulty might arise if one party instituted a course of action, for whatever reason, without discussing it with the other party and the second party then comes along and may not agree with what has been done. … but it was usually resolved if the two people simply talked to each other … Whether there were issues that [when] … the anaesthetists did their ward round at 10.30 or 11 … when we were mainly in the operating theatre, but whether there were issues that emerged then that the nurses on the ground were more conscious of than I was when I came back at midday or lunchtime or whatever to see how things had progressed, I cannot say, but I was quite surprised when I saw this description.'[154]

123 Asked whether there was any formal mechanism for briefing and handover, Mr Wisheart told the Inquiry:

> 'The formal mechanism was that there was a surgical SHO and registrar and there was an anaesthetic registrar who at any time was either on call or present and available and I would have expected them to discuss any issues that would appear to occur between them … it must be correct to say that there were occasions when it did not happen, but it had been my understanding that they were relatively rare.'[155]

124 Mr Wisheart was asked by the Chairman of the Inquiry about the difficulties of having ward rounds at different times and the possibility of advice being given at 8 o'clock that might be changed at 9 o'clock, or countermanded by someone of a different specialty:

> 'Q. (The Chairman) Of course, if that has then to be communicated to a nurse who then has to speak to a parent who may have been up all night, that X is going to take place soon, that is the advice given at 8 o'clock, but then at 9 o'clock that decision is changed, you can see that the, as it were, rollercoaster of emotion which is already there in a parent might be even more exacerbated, if you can

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[154] T40 p. 142–3 Mr Wisheart

[155] T40 p. 145–6 Mr Wisheart

> exacerbate a rollercoaster. Is that not a problem in a very real and personal sense, as well as the organisational sense of managing the care of the child?
>
> 'A. ... I think that, taking the point of the consultant coming in at 9 o'clock, the junior having seen the patient at 8 o'clock or 8.30, or whatever … The junior surgeons and the junior anaesthetists were both present at 8 o'clock, so there is absolutely no reason why their views should not have been co-ordinated, or if they were not unanimous, some way found to resolve it. I think the question of coming in at 9 o'clock and changing the orders is one that has received some prominence in evidence, and of course I can only speak from my own perspective; I cannot speak for the other four cardiac surgeons, because I think that comment actually picked up adult and paediatric cardiac surgery. I would say that occasionally that happened, but the notion that it was the general rule I think lacks perspective. Of the occasions when it happened, it would only rarely, I think, have had consequences of the type that you have described. Usually it would be some adjustment of what was happening, which would not necessarily impinge in any dramatic way upon the parents. Of course, it would have to be communicated and discussed with the nurse, naturally, and if it were important, it would need to be discussed with whoever else had been involved in the earlier decision, so that everybody was working to the same plan. So I think that occasionally it may have happened the way you mentioned, but I think quite rarely. I think there is a perspective which needs to be applied to that.'[156]

125 Dr Bolsin was asked what steps were taken to address the difficulty of there being blurred responsibilities between anaesthetists and surgeons and the difficulty of the one group, because of timing, talking to the other. He said:

> 'One of the big advances was bringing in an anaesthetic registrar into the Intensive Care Unit who became the communication point for the consultant anaesthetists with the surgical side. So that whenever the surgeons did a ward round there was always an anaesthetic presence. If we as anaesthetists had done our ward round earlier he would be able to pass on our view of what was happening to the patient. … I think the fact that things improved over time indicates that people were aware of the problems and were trying to address them as best they could.'[157]

126 John Mallone, father of Josie, told the Inquiry of her care at the BRHSC:

> 'About three weeks into her stay in ICU I think, a doctor who we had never seen before, a middle-aged man, came and introduced himself, I cannot remember his name, and said he was a consultant and went straight over to Josie's ventilator and said "That looks a bit low" and turned it up, almost doubled the pressure and increased the frequency by 50 per cent I think as well. The following morning she had a punctured lung. That was the thing that staggered me most. He just seemed to walk straight into the ward without consulting any notes or talking to anybody

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[156] T93 p. 92–4 Mr Wisheart

[157] T82 p. 31 Dr Bolsin

whatsoever, I still have no idea who he was, and just interfere with the treatment of a child who had been on quite a continuous routine for something like three weeks post-operatively at that stage, I think.

‘Q. Who had been looking after the child, who had been in charge as you saw it in a practical sense until then?

‘A. In the practical sense Dr Martin, he was the one who we saw most often and he would tell us that he had consulted Mr Wisheart about certain things and we also saw Mr Wisheart from time to time, but on a daily basis it was Dr Martin who was saying what treatment would be followed for that day. I am sure you are aware there are big wall charts that operate for 24 hours and when they would come round in the morning they would look at what had happened in the previous 24 hours and it would be Dr Martin who would say “Okay, I think we ought to do this for the next 12 hours”, until the next ward round and so on.

‘Q. This other doctor was interfering in Dr Martin’s arrangements?

‘A. So far as I know he acted entirely on his own initiative. I think they were shocked when she developed this pneumothorax I think they called it, punctured lung anyway.

‘Q. What sense did you have of the treatment strategy being co-ordinated and organised, in a coherent sense?

‘A. Apart from that one incident it seemed to be very methodical, that the doctors would meet with the nurses and the nurses would say what had happened to Josie since they had last seen them and they would look at the charts and they would look at the notes hanging on the end of her cot and then they would talk about it for a bit and then they would say “I think we ought to do this”, it seemed to have a method to it, it seemed to be well organised.

‘Q. Did you have different doctors coming round at different times; you have mentioned two ward rounds?

‘A. I do not know, I cannot remember what their particular working hours might have been, but the person who seemed to be in overall charge was Dr Martin.’[158]

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[158] T95 p. 181–3 John Mallone

Who was in charge of post-operative care?

127 The Inquiry heard a number of views as to who was in charge of post-operative care. Rachel Ferris, General Manager of the Directorate of Cardiothoracic Services, BRI, said that by the mid-1990s:

> '... there were very severe expressions of stress from the nursing staff, who felt that the situation on intensive care was so difficult because it was not clear who was in charge of the patient in intensive care that they were actually feeling that this was now becoming dangerous, and I expressed this ...
>
> '... we felt that without proper understanding of who was in charge of the patient and what was happening on ITU that we were at risk of, you know, an incident occurring.'[159]

128 The cardiologists' limited involvement in post-operative care has been set out above.

129 Fiona Thomas told the Inquiry of what she saw as the 'subservient' role of the nurses in ward rounds:

> 'The Sister would take the trolley and put the X-rays up. That is the subservience. I think the Sisters were able to say and comment on the care if they felt there was need to … I think if you felt you had something to say on that patient's care, you could say it. Whether it was listened to, was a different matter. … But then I do not think it was probably any different at that stage than probably in many other ward rounds in any other hospital, probably, or any other ward in the BRI.'[160]

130 Mr Wisheart was asked whether, as the surgeon who had conducted an operation, he would have overall charge of intensive care. He agreed that ideally a regular presence was required and a regular review by someone who knew the details and the facts of the case:

> '… and that is essentially me. Well, my team and myself. … I was able to undertake a regular review. I was not able to maintain a constant presence, rather a repetitive presence. I was not there all the time, but I was there regularly, keeping the review in mind, but then, you see, Dr Pryn was also there each day[161] and in a sense, the fact that he was not there for a period gave him a slight distance that would enable him to see changes possibly more clearly than I would have seen them. So it is a team effort, but I absolutely agree, it was part of my fundamental attitude, that I was maintaining the continuity and the overview.'[162]

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[159] T27 p. 111 Mrs Ferris

[160] T32 p. 66–7 Fiona Thomas

[161] Dr Pryn was appointed in 1993

[162] T93 p. 73 Mr Wisheart

131 Mr Wisheart went on:

> ‘It is certainly my view that there was by and large a very good co-operation between the members of the team in intensive care. There were areas that the anaesthetists certainly had the predominant interest. There were areas where the surgeon had the predominant interest, and there were also overlapping areas, but no aspect of the care of the child was outside the interests and comment and suggestion of any member of the team. If the anaesthetists suggested to me something that I would have regarded as predominantly my territory, then that would have been helpful and hopefully would have been properly considered. With all due sensitivity, of course, the surgeon from time to time might have suggested things to the anaesthetist and, by and large, that was properly received and it was just debated and common ground established. So my own view is that there was a good understanding mostly, in intensive care, and good co-operation …’[163]

132 Mr Wisheart emphasised that there was, in his view, a team approach to the running of the ICU:

> ‘As far as I am concerned, we were a team; we were colleagues. Whether they were anaesthetists, paediatric nephrologists, cardiologists, nurses, physiotherapists, whatever, we were a team, each with input, each with a freedom to make any comment they wished to make and contribute to the debate.’[164]

133 It was put to Mr Wisheart by Counsel to the Inquiry that this was not a team that found it very easy to talk to each other because ward rounds were carried out at different times by surgeons and anaesthetists. He said:

> ‘There were some practical difficulties, but if somebody wanted to talk to somebody, a way would usually be found and, for the great majority of the people, it was found.’[165]

134 Fiona Thomas agreed that the conflict over the intensivist’s role, once appointed in 1993, was essentially a struggle for who would be in charge of the patient post-operatively:

> ‘Yes, it was, because at that time there were surgeons who would care for their patients predominantly in the intensive care unit and then the anaesthetist would come in as well and give their input as well, give their clinical knowledge, and there were various different anaesthetists and of course just one surgeon, and I think there was a view that the management of the patients in intensive care could be managed better if there was one person in that day managing the care of any patient. I think this is why the intensivist role was suggested and other units in the

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[163] T93 p. 75–6 Mr Wisheart
[164] T93 p. 77 Mr Wisheart
[165] T93 p. 77 Mr Wisheart

> country had different management of patients and in the intensive care unit ... I think there were some consultants, probably anaesthetists who had come from other areas, were bringing in ideas to look at, maybe to have one person in charge … there were times when anaesthetists and surgeons disagreed with care and management of children, whether it was a drug therapy or what it was … I do remember them being there, having great debates over changing drugs, changing drug therapies, because a tiny change of a drug therapy to a child is an absolute major change and it could have a major affect on the child, but often they did that together for support and to get the best care for that child in a way, so there were two angles really to that. One was to get the best care for the child and at other times they may disagree with each other.'[166]

135 Belinda House was asked who was in charge of Ryan's care in the ICU:

> 'Mr Wisheart was always there. He always turned up, especially if there was a problem, but I feel it was more the anaesthetists at that point that were in charge of Ryan's care.'[167]

136 Dr Pryn commented on the input of the paediatric cardiac surgeons and the adult surgeons:

> 'They basically would come in, have a look at their case and tell the nurses to do something, write it up on a drug chart and go away. … I think fundamentally, the surgeons have always considered these cases their cases, for their management. If they want to do something to the management, they can; it is their case.'[168]

137 He commented on how the presence of the intensivists for three sessions a week had an impact on the attitude of the surgeons. His evidence included this exchange:

> 'It meant that they could discuss their decisions if they wanted to with another senior colleague on their selected three days, or three mornings, I should say, which is a very small percentage of the week.
>
> 'Q. But did it change, those three mornings a week, the hierarchy of control over the management of a case? Who was in charge of a child when the intensivists were in?
>
> 'A. No, I do not believe it did change the hierarchy. I think Mr Wisheart and Mr Dhasmana always felt in charge of their case. Sometimes, especially early on, I felt more like one of their senior registrars than a fellow consultant, and I was there to make sure their bidding was done, so to speak. I think in general, I did not have a big problem with that, as long as I agreed with the management. The main problem I had was with the speed with which we could change management.

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[166] T32 p. 36–7 Fiona Thomas

[167] T6 p. 95 Belinda House

[168] T72 p. 52 Dr Pryn

> For instance, Mr Wisheart would often come in and say: “What needs to happen today is that we need to wean these inotropes before we extubate the child”, and I entirely agreed; we did need to wean those inotropes. Then he would write on the chart: “These inotropes are to be weaned by 0.1 ml per hour if [so-and-so] happens”. Actually, if you work it out, that would have taken three days to wean off the inotrope, so a long time, and the child may be improving more rapidly than that and I would want to cut the inotropes down even faster. Once or twice I did. I remember on one occasion he was extremely angry with me for weaning inotropes faster than he had prescribed, but I did so because I was there with the child and it needed to be done. So he had quite tight control of what happened with his patients.’[169]

138 Dr Pryn felt that this was slightly less true of Mr Dhasmana:

> ‘I think he warmed to the concept of intensivists sooner than Mr Wisheart, and I think he saw that we were welcome allies.’[170]

Involvement of parents

139 The Inquiry heard that it was policy at the BRI to promote family-centred care.

140 Julia Thomas dealt in her written statement to the Inquiry with the involvement of parents:

> ‘The ward philosophy was to promote family-centred care throughout the child’s stay. We encouraged parents to be involved with their child’s care at all times. This included full care pre-operatively and post-operatively in the nursery, washing, dressing, feeding, and generally caring for their child. In the ITU the amount of participation varied depending on the parents and the severity of the illness. Some parents found the whole intensive care experience extremely upsetting and could not visit for long. Others were there all the time and were keen to do as much as possible for their child. We encourage parents to wash their babies, change nappies, and give eye and mouth care. Naso-gastric feeding was taught to parents, especially if their child was in ITU for a long time.’[171]

141 She went on:

> ‘We were very careful to keep the parents fully informed about their child’s progress. The nurses explained all the procedures they were carrying out, and what

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[169] T72 p. 52–4 Dr Pryn

[170] T72 p. 54 Dr Pryn

[171] WIT 0213 0046 Julia Thomas

> drugs and treatment the child was receiving. The parents were able to read the care plan for their child, and were involved in discussions about any treatment changes required.'[172]

142 However, she also stated:

> 'The babies were more stressful to look after in many ways. The parents often required a lot of support, which was time-consuming. Encouraging the parents to participate in their child's care also took time, to teach them about feeding naso-gastrically, eye and mouth care, etc.'[173]

143 Michelle Cummings, mother of Charlotte, said:

> 'I think sometimes it can be quite helpful for parents to help. When you have the operation and it is short-term … I found it a great help to feel I was included in Charlotte's care, that I was able to do basic things like wash out her mouth and wash her down, not do huge amounts, but it made me feel included. I think that is quite a help for parents.'[174]

144 Karen Welby, mother of Jade, said:

> 'While Jade was in for her second operation in 1984, a little boy who was admitted whose mother could not cope at all, she delivered into the hospital and then left a few hours later and said she would be back after his surgery and after his intensive care. The nurses were very, very busy and they did not have time to play with him, or feed him. Obviously they would have made the time to feed him, but I took over his care, as well as Jade's. … he was a bit younger than Jade and I had two, both in a high chair, feeding them both at the same time.'[175]

Discharge

145 When the doctors deemed discharge appropriate, the senior nursing staff made the arrangements. The Cardiac Liaison Nurse talked to the parents about the arrangements. If she assessed the home environment to be unsuitable, or if the children were not yet well enough for discharge home, they would be transferred to Ward 36 of the BRHSC for further in-patient care.[176]

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[172] WIT 0213 0047 Julia Thomas
[173] WIT 0213 0042 Julia Thomas
[174] T95 p. 88 Michelle Cummings
[175] T95 p. 102 Karen Welby
[176] WIT 0213 0045 Julia Thomas

146 Patients were transferred from the ICU in Ward 5B to the nursery in Ward 5A prior to discharge. When the surgeon adjudged the child to be well enough, they were sent home or back to the BRHSC if they needed further treatment or to gain in weight.[177]

147 The Cardiac Liaison Nurse would be involved in planning the patient's discharge, contacting the GPs and social workers.

148 When a child was returned from the BRI to the BRHSC, a nurse from the BRI accompanied them. Details of the drains, drips and lines for the child were given by telephone before they were transferred.[178]

Post-discharge care

149 Post-discharge support and counselling are dealt with in Chapter 16.

150 Julia Thomas explained that, in addition to the involvement of the health visitor and Helen Stratton, Cardiac Liaison Nurse, or Helen Vegoda, Counsellor in Paediatric Cardiology, parents received a discharge booklet, and:

> '… on discharge home, a doctor's letter and tablets to take out were provided, and the parents were spoken to at length about what to expect when their child went home. This included advice on mobilising, infection risk, eating, pain, behaviour, and starting school … Transport home was organised by the ward clerk and may have involved the ambulance services if the parents could not provide transport. The child was always seen at outpatients between four to six weeks after discharge at BRHSC.'[179]

151 As to the management of discharge and future care, Dr Jordan told the Inquiry:

> 'The routine was for appointments to be made at the Children's Hospital for the cardiac surgeons' clinic. Although these ran at the same time as the cardiologists' (Wednesday afternoons) it was chance whether the cardiologist responsible for the pre-operative care was the one who was in the clinic that day. When patients were seen by the junior surgical staff there were sometimes problems in management of drug regimes and often no appreciation that follow-up in a peripheral clinic was more appropriate.'[180]

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[177] WIT 0114 0090 Fiona Thomas

[178] WIT 0121 0005 Ms Woodcraft

[179] WIT 0213 0046 Julia Thomas

[180] WIT 0099 0046 Dr Jordan

Chapter 16 – Support and Counselling

Introduction

1 Support, counselling and, in the case of the death of a patient, bereavement services were available to parents of children who received paediatric cardiac care at Bristol, both at the BRI and the BRHSC during the period of the Inquiry's Terms of Reference. These services were provided by a variety of individuals and bodies. Many were UBH/T staff who did not have a defined, or named, role in providing support or counselling but who nevertheless came into regular contact with patients and their families.

2 Others had a defined role in providing this service, namely the Bristol & South West Children's Heart Circle, the UBH/T Chaplains, the Social Work Department and those responsible in the UBH/T for responding to bereavement. During the period of our Terms of Reference two posts were created at UBH/T. The first post, that of Counsellor in Paediatric Cardiology, was taken up by Mrs Helen Vegoda in January 1988. The second post, that of Cardiac Liaison Sister, was held by Miss Helen Stratton from November 1990 until February 1994.[1] As will be seen later in this chapter, Mrs Vegoda and Miss Stratton had different roles.

Terminology

3 The Inquiry commissioned a background paper from Dr Charlotte Humphrey.[2] She sought to set out the needs for care which parents of children in acute healthcare settings, such as those receiving paediatric cardiac care, might have. She wrote:

> '… "support" is defined as including all activities or arrangements within the health care environment which help meet the psychological and social needs of parents whose children are receiving care, whether or not they are specifically intended to fulfil this purpose. Support thus covers a wide range of issues from practical arrangements for parents to stay in hospital and help in their children's care to the giving of information, encouragement, advice and sympathy. …
>
> 'Given this broad definition of support, it follows that anyone involved in the provision or organisation of care at an individual or institutional level may have a part to play in ensuring that parents' needs are provided for and taken into account. Support may also be provided from sources outside the healthcare setting including self-help groups or facilitator-led support groups.'[3]
>
> 'Within the broader framework of psychological and social support, counselling is the activity which occurs when a person (either regularly or temporarily in the role

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[1] The two posts were given various titles, see later in this chapter

[2] Charlotte Humphrey PhD, Professor of Health Care Evaluation, Florence Nightingale School of Nursing and Midwifery, King's College London, formerly Senior Lecturer in Sociology, Royal Free and University College Medical School, University College London: BRI Inquiry paper on support and counselling for parents of children in acute health care settings, December 1999, INQ 0025 0001 – 0023

[3] INQ 0025 0005; Dr Humphrey's paper

> of counsellor) offers time, attention and respect to another person or persons to explore their feelings and concerns …
>
> ‘Counselling skills, such as listening, reflecting and conveying empathy, are not exclusive to the counsellor. Almost all healthcare professionals need such skills in the course of their interactions with patients, for example in giving information, clarifying treatment options and helping people adjust to new and sometimes unwelcome circumstances. The difference between these generic skills and those of a formally defined counsellor (or psychologist or psychotherapist) is that the latter is expected to have advanced training and qualifications in their field and is likely to approach the counselling process within a specific theoretical framework …’[4]

4 Mrs Valerie Mandelson[5] defined ‘support’ as being: ‘… listening skills, empathy, being alongside a person at a time of great emotional stress and distress’, and ‘counselling’ as:

> ‘… something on a deeper level … something that is more formal, that is something that is entered into with the person who is the parent or the family, or the client …
>
> ‘Bereavement counselling actually provides a means of expressing grief in a much deeper way, and working on some of the tasks of mourning, facing the reality of the loss, perhaps experiencing the pain of that loss, and working with families in adjusting to daily existence without a very much-loved child and all the stresses that that might bring in terms of family stress, marital stress, self-esteem; and I guess, working with families, helping them find future direction …’[6]

5 In a letter to the Inquiry, Mrs Mandelson said:

> ‘There is debate amongst counselling professionals as to how we can usefully distinguish between support and counselling. I feel that many service users would be unlikely to be able to tell if they had been “supported” or “counselled”.’[7]

6 Mrs Vegoda told the Inquiry that by ‘support’ she meant:

> ‘I was with the parents when the child went into the catheter lab. When the child had actually gone in, if the parents wanted me to be around, I would come out with them, often take them back to my room and they were often upset. At that point I saw that as support, because I felt they just needed somebody with them.

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[4] INQ 0025 0005 – 0006. Dr Humphrey also referred to a paper (Bor R, Miller R, Latz M, Salt H. *‘Counselling in Health Care Settings’* (1998), London: Cassell) which identified four levels of counselling: information-giving, implications counselling, supportive counselling and psychotherapeutic counselling – and suggested that only the first two of these would routinely be provided by healthcare professionals responsible for patients’ care

[5] Manager and Senior Counsellor, Alder Centre, Alder Hey Children’s Hospital, Liverpool: Expert to the Inquiry on Support and Counselling Services and see later in this chapter

[6] T47 p. 180–1 Mrs Mandelson

[7] INQ 0026 0008; letter to the Inquiry

> They often were in tears, they needed someone to make them a cup of tea, and I think that was pure support.'[8]

7 As for 'counselling', Mrs Vegoda said:

> '… counselling might come in, for example, if I met a family where the child had been newly diagnosed and the parents, for example, were saying things like, you know, "It is my fault" and "I feel very guilty", or they were very angry about the child having a condition. Then I would try and use my counselling skills, because I would try and help them to see that that was not so … I felt the counselling was helping them to come to terms and accept what was normal, and also to deal with it.'[9]

8 Miss Stratton told the Inquiry:

> '… my personal definition of counselling is someone who has a professional qualification to carry that out.' [10]

The split site

9 The basic chronology of the split site contributes to an understanding of the split of support, counselling and bereavement services for paediatric cardiac patients between the BRI and BRHSC during the period 1984–1995. The salient facts are set out very briefly here.

10 In 1984 paediatric cardiology was based at the BRI. Open-heart surgery was also performed at the BRI, paediatric patients being cared for, along with adult patients, in Ward 5 at the BRI. However, closed-heart surgery was performed at the BRHSC, paediatric patients being cared for in Ward 33.

11 In 1987 the cardiac catheterisation suite opened at the BRHSC. Cardiology was based there, along with closed-heart surgery, but open-heart surgery remained at the BRI.

12 In October 1995 the paediatric cardiac services were united at the BRHSC. Thus, throughout the period of the Inquiry's Terms of Reference, until October 1995, the paediatric cardiac service was split between the BRI and the BRHSC, with many paediatric cardiac patients being transferred between sites for treatment, resulting in a split in the provision of support, counselling and bereavement services.

Priority

13 The priority attached to the support, counselling and bereavement services by UBH/T management and staff, in terms of the provision of funding, time and interaction with those providing the service, will be a recurring theme.

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[8] T47 p. 95–6

[9] T47 p. 96 Mrs Vegoda

[10] T46 p. 53–4 Miss Stratton

14 The Directorate of Surgery stated in its document *'Services for Patients'*:

> '… a positive and happy atmosphere is maintained throughout the department, and to this end counselling of patients and their relatives before and after surgery, is a priority'.[11]

15 A number of witnesses to the Inquiry commented on the priority they felt was attached to the service.

16 Mrs Jean Pratten[12] told the Inquiry:

> 'I am certain that children's paediatric surgery at the Bristol Royal Infirmary was never properly resourced and funds eventually only became available when the crisis arose.'[13]

17 She told the Inquiry that the Bristol and South West Children's Heart Circle raised in the region of £1,000,000 for projects at the UBH/T:[14]

> 'I would have to say that the financing of the support and counselling services was inadequate. Even when posts were created through funding from the Heart Circle, the posts were still effectively "supernumerary" as reflected by the relatively low priority afforded to support and Counselling Work by the Trust Management generally.'[15]
>
> 'I have throughout felt that the psychological and social needs of families was never made a priority by the Trust and that the combined lack of management support and co-ordination often hindered and complicated the support that we tried to make available.'[16]

18 Mr James Wisheart, consultant cardiac surgeon, said:

> 'Against a background of historic under-funding and under-provision, I am in no doubt that for most of the period under review the priority of the clinical staff was for the development of the resources for the basic medical service … Only in recent years has there appeared to be a resource available for purposes of this type.'[17]

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[11] HAA 0097 0007 – 0010; *'Services for Patients'*, July 1991

[12] Jean Ruth Pratten, Justice of the Peace, first Secretary of the Bristol and South West Children's Heart Circle from 1972 until 1989, and Chairman from 1989 to 1997

[13] WIT 0269 0011 Mrs Pratten

[14] See later in this chapter

[15] WIT 0269 0011 Mrs Pratten

[16] WIT 0269 0011 – 0012 Mrs Pratten

[17] WIT 0120 0238 Mr Wisheart

19 Mr Janardan Dhasmana, consultant cardiac surgeon, said:

> 'Although they [management] accepted in principle, finding the money and resources was always a problem.'[18]

20 Dr Freda Gardner[19] told the Inquiry that she became involved in Wards 5A and 5B in conducting her research:[20]

> 'It is only possible for me to comment on psychological care of children and their families. In my view the psychological care of children was never given a high enough priority at the BRI by UBHT. In spite of staff making great efforts this problem was further complicated by the fact that the majority of patients on Ward 5 were adults. There is no doubt that the Heart Circle made enormous efforts to provide for the needs of children. Without the resources they provided, there would have been very few facilities for the paediatric patients and their families.'[21]

She stated that she was also aware of: 'numerous frustrations experienced by Mrs Jean Pratten in her exhaustive efforts to help managers, staff, parents and patients on both sites for many years.'[22]

21 In Dr Gardner's view, 'Support and counselling were never a priority' for management and clinical staff.[23]

22 Graham MacIntosh[24] stated in his evidence to the Inquiry:

> 'My impression is that the support and counselling work needed as part of the practice of the clinical area of cardiac surgery for children was at best seen as an added luxury. As with all large organisations and institutions on occasions counselling can be seen as a method whereby compliance is achieved rather than as an empowerment process for the individuals concerned to grow in their self awareness and capacity to take responsibilities upon themselves.'[25]

23 By contrast, Kathryn Hale[26] stated in her evidence to the Inquiry:

> 'Counselling and support within BRHSC was given a high priority and was regarded as part of the case management. In this sense it did not present as a separate discipline, but was seen as an integral part of the entire care process for

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[18] WIT 0084 0104 Mr Dhasmana

[19] Dr Freda V Gardner PhD CPsychol, went to Bristol in 1990 to continue a PhD thesis on mother-infant interaction in infants with cardiac disease, and became a British Heart Foundation Clinical Research Fellow in 1993 in the academic unit of the University of Bristol headed by Professor Gianni Angelini; WIT 0534 0001

[20] WIT 0534 0001 Dr Gardner

[21] WIT 0534 0005 Dr Gardner

[22] WIT 0534 0005 Dr Gardner

[23] WIT 0534 0007 Dr Gardner

[24] Social Worker, BRI from 1997

[25] WIT 0401 0006 Mr MacIntosh

[26] Senior Nurse, BRHSC, October 1983–June 1989

> each child in which all members of the clinical team had a part to play. This meant that, whilst from a financial point of view, counselling itself did not feature particularly highly in specific fund allocation, it was given high priority in respect to the ongoing training given to nursing staff "on the job", in order that they felt competent to support and counsel the families in their care.'[27]

24 Janet Gerrish[28] said:

> 'I realised the importance of support and counselling and considered it high priority in supporting the parents of children undergoing paediatric cardiac surgery.'[29]

25 However, Graham Brant[30] told the Inquiry:

> 'I do not believe this was a priority but an added extra, some nurses were better at supporting and counselling parents than others.'[31]

26 Mrs Vegoda commented on the priority given to counselling:

> 'I felt that particularly once Julie Vass[32] was in place, that management and the Trust did support and was aware of counselling and support needs of families.
>
> 'But I am also aware … that maybe where there was not a priority was in not allowing some space within the cardiac team to make room for looking at the needs, the emotional and psychological needs of families.
>
> 'So I think the Trust personally did support the posts.'[33]

27 Whilst some parents who gave evidence to the Inquiry were given support and counselling,[34] others felt that they had received neither support nor counselling during their child's treatment.

28 Erica Pottage, mother of Thomas:

> 'Looking back, I felt the care we received as parents was appalling … I felt very alone in a strange town … I did not receive any counselling and had nobody to talk to about my worries and concerns.'[35]

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[27] WIT 0180 0037 Ms Hale

[28] Director of Nursing Services, Central Unit 1982–1986, and Hospital Manager, BRI 1986–1989

[29] WIT 0150 0043 Miss Gerrish

[30] Charge Nurse, Ward 5B from 1993, formerly a Staff Nurse, BRI 1991–1993

[31] WIT 0513 0016 Mr Brant

[32] Julie Vass (formerly Crowley), line manager of Helen Vegoda

[33] T47 p. 169 Mrs Vegoda

[34] See witnesses' comments later in this chapter

[35] WIT 0260 0004 Erica Pottage

29 Others, whose children died, felt that they had received no support or counselling after the death.

30 Antonio Chiarito, father of Maria:

> '[The staff] said that they had taken Maria to the Chapel of Rest, if we wanted to see her again. We went to see her … but she had already been taken away. We both found this distressing … Since I have taken up my new employment, as a psychiatric nurse, I now understand how to treat people during times of emotional crisis. I do not think the staff at the BRI knew how to do so. I think that someone should have taken the time to explain things, and to answer our questions. As it was, I got the impression they were covering up for some mistake.'[36]

31 The UBHT responded to Mr Chiarito's comments:

> 'Evidence has been given to the Inquiry as to the bereavement and counselling facilities made available by the Trust.
>
> 'Unfortunately, they were insufficient to meet the needs of some parents.'[37]

32 Rosemary Walker, mother of Ryan:

> 'After Ryan died, we did not really see anyone in the hospital. We did not know what to do, or where to go. We were not even offered a cup of tea or coffee – there was certainly no offer of counselling.'[38]

33 Paul Bradley, father of Bethan:

> 'We did not receive the option of any bereavement counselling. No help was offered to us to know how best to cope, discharge and manage grief positively. It would have meant a great deal to us if someone still expressed an interest …'[39]

34 Jean Sullivan, mother of Lee:

> 'The lack of aftercare which was shown to me also caused me considerable distress. Had I received some counselling it may have helped me to come to terms with Lee's loss … I was not given any assistance whatsoever to cope with what had happened and I feel that when I look back on the manner of Lee's death and the dreadful scene which I witnessed I am filled with bitterness.'[40]

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[36] WIT 0291 0015 Antonio Chiarito

[37] WIT 0291 0022 UBHT

[38] WIT 0458 0013 Rosemary Walker

[39] WIT 0229 0020 Paul Bradley nonetheless spoke of the assistance he received from Mrs Pratten and Mrs Vegoda, see later in this chapter. He also told the Inquiry that, with Mrs Vegoda, he and his wife produced a booklet entitled *'Remembering Your Child',* sponsored by the Bethan Amanda Bradley Fund set up in his daughter's name and designed to assist other parents in knowing how to remember and grieve for their child. See T53 p. 38–9 Paul Bradley

[40] WIT 0016 0014 Jean Sullivan

35 Lorraine Pentecost, mother of Luke:

> 'Nobody had said anything to me. When I was outside the hospital I realised that I did not know what I had to do. I therefore went back to the Intensive Care Unit and asked a doctor who told us that the hospital needed to do a post-mortem to establish why Luke had died. I remember being told to go home and have another baby. I said that a baby was not something you went out to get from a supermarket … I was sent an appointment card for Luke to have a check-up. The date of his examination fell a few days after his funeral.'[41]

36 Others told the Inquiry that after the death of their child, not only were they not offered support, but also staff appeared anxious for them to leave the hospital.

37 Rosemary Riddette-Jones, mother of Luisa:

> 'One thing which I felt very strongly about was that we were not supposed to speak to the other parents on the general ward. One just didn't speak about the death of one's child.'[42]

38 In response, the UBHT commented:

> '… the Trust's policy was for the parents to get home as soon as possible, and for the General Practitioner to be informed of the situation immediately so that appropriate support could be given locally…'[43]

39 Karen Meadows, mother of Sarah:

> 'We went back to the hostel and picked up our stuff. We drove the hundred miles back to Torquay in despair. We felt that once our child had died the hospital ceased to feel that we had any medical needs …'[44]

40 Malcolm Curnow, father of Verity:

> 'Both my wife and I felt under pressure to leave the hospital. We were not given adequate time to mourn, or to be left alone. I felt as if we were on a conveyor belt. One of the nursing staff asked us to clear our room …'[45]

41 Philippa Shipley, mother of Amalie:

> 'We were told that we would have to leave the hospital as our presence there would upset other patients and their families.'[46]

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[41] WIT 0267 0014 – 0015 Lorraine Pentecost

[42] WIT 0421 0012 Rosemary Riddette-Jones

[43] WIT 0421 0019 UBHT

[44] WIT 0415 0009 Karen Meadows

[45] WIT 0004 0009 Malcolm Curnow

[46] WIT 0392 0020 Philippa Shipley

Longer-term support and counselling

42 Many of the organisations or individuals, including UBH/T employees, involved in the provision of counselling and support continued to provide, or offer to provide, this service once the family returned home after the discharge or death of a child, whether by maintaining personal contact, or through support groups and remembrance services.

43 However, it was the policy of the UBH/T not to offer longer-term counselling, but to make arrangements for this to be provided locally.

44 Tracey Morgan, mother of Daniel:

> 'The hospital did not offer us any counselling. I think it would have been helpful if they had been able to do so. I have since received psychiatric treatment, but this had to be arranged through my GP.'[47]

45 In response, the UBHT confirmed its policy at that time on bereavement counselling:

> 'It was not the practice of the hospital to offer any counselling but to advise the General Practitioner immediately of the death of the child so that appropriate assistance could be arranged locally …'[48]

46 Mrs Vegoda and Miss Stratton confirmed that it was part of their roles to make contact with local support services to facilitate this longer-term support and counselling.[49]

47 Helen Johnson, mother of Jessica, said that Mrs Vegoda had arranged for her to be visited when she returned home by a health visitor. Her evidence included this exchange:

> 'Q. I think it is right, is it not, that there was some follow-up support which Helen Vegoda took some steps to organise?
>
> 'A. Yes.
>
> 'Q. In particular, with the Social Services department?
>
> 'A. Yes.

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[47] WIT 0288 0011 Tracey Morgan

[48] WIT 0288 0012 UBHT

[49] See later in this chapter

> ‘Q. And I think it is not necessary to go to the correspondence, but you are aware of correspondence, for example, in 1993, between Helen Vegoda and the Social Services department?
>
> ‘A. Yes, that is true.
>
> ‘Q. And that Helen Vegoda was in contact also with your GP and health visitor?
>
> ‘A. Yes.
>
> ‘Q. Did the health visitor continue to visit you and Jessica after her discharge from hospital?
>
> ‘A. Yes.
>
> ‘Q. How did you find that? Was that of assistance?
>
> ‘A. I found that of assistance, yes.’[50]

Role and responsibilities of UBH/T staff

48 As has been seen, it was not only staff who were specifically responsible for counselling and support that came into contact with distressed and bereaved families.

Surgeons

49 The surgeons received no formal training or support. They spoke of their practices in dealing with bereaved families.

50 Mr Wisheart said:

> ‘I, together with a nurse and/or the counsellor, always talked with the parents of a child who died as soon as possible after that death …
>
> ‘I invited the parents to meet with me again when the stress and emotion was less immediate. I normally suggested that six weeks or later would be appropriate …’[51]

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[50] T44 p. 137 Helen Johnson

[51] WIT 0120 0234 – 0235 Mr Wisheart

51 Mr Dhasmana told the Inquiry:

> 'I always made a point of talking with parents after a bereavement, or if the child had suffered a permanent disability … I always offered to see the parents again, if they desired. …[52]
>
> 'In the case of a child suffering a disability i.e. neurological damage, I would talk with the parents and inform them of the problem. Unfortunately the information I could provide was incomplete, as the extent of neurological injury and permanent disability would not be known for a few weeks post-operatively.'[53]

Cardiologists

52 In his written evidence to the Inquiry, Dr Joffe said that:

> 'On occasions, when I learned that a patient of mine at BRI was critically ill, I made every effort to see the parents. If a child died, I was always ready to arrange to talk to the parents at a mutually suitable time, if requested by the surgeons or the parents themselves.'[54]

And:

> 'At BCH, as far as I am aware, the majority of staff were sensitive and understanding of parents who were under stress ...'[55]

In his oral evidence he touched on bereavement while dealing with the issue of communication with parents:

> 'I believe it comes with experience of being with people and unfortunately I have had to be part of the process, not only of informing people of the total picture but also of being present at bereavement situations and inevitably there will be a difference of opinion about how that should be handled. But I think one does one's best in one's own perception of the requirement.'[56]

And then the following exchange:

> 'Q. You mentioned the question of bereavement and what one says in respect of bereavement which puts the clinician dealing with bereavement in a very difficult position because you do not know really how to deal with the news, I suspect,

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[52] WIT 0084 0103 Mr Dhasmana

[53] WIT 0084 0103 – 0104 Mr Dhasmana

[54] WIT 0097 0317 Dr Joffe

[55] WIT 0097 0318 Dr Joffe

[56] T91 p. 36 Dr Joffe

> except by having done it in a number of distressing circumstances over a period of years?
>
> ‘A. Yes.
>
> ‘Q. The fact of death must, I suspect, be distressing to the clinician even if not as distressing as it is to the parent?
>
> ‘A. Undoubtedly, yes.’[57]

53 Dr Houston, consultant paediatric cardiologist and Expert to the Inquiry, added:

> ‘I think nowadays the students get some training in this, but certainly when I qualified we did not, we worked with our colleagues and you would know how various colleagues put things and you would learn from that and decide how you did it yourself.’[58]

Nursing staff

54 The nursing staff were involved with children and their families throughout their care.

55 Unlike the clinicians, they received some training. Barbara Sherriff[59] told the Inquiry:

> ‘From approximately 1980, the training department ran a 2 day counselling course and a 5 day course entitled “Caring for Dying Children” for nursing staff …
>
> ‘The training department ran a specific course for nursing staff entitled “Talking to Relatives” from 1984.’[60]

56 Julia Thomas[61] stated:

> ‘The hospital offered basic and advanced counselling courses for nurses and many of the senior ITU nurses had undertaken one or both of these. The nurses in ITU had a supporting role, but did not always have time to look after both the ill child and the carers. This is where Helen Stratton’s role became indispensable as she would support the families, leaving the nurses more time to nurse the patients.’[62]

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[57] T91 p. 38 Dr Joffe

[58] T91 p. 40 Dr Houston

[59] Nursing Officer/Clinical Nurse Manager/Unit Manager, BRHSC, 1981–1991, Service Development Manager 1991–1992, Assistant General Manager from 1992

[60] WIT 0234 0026 – 0027 Ms Sherriff

[61] Sister-in-charge of the Cardiac Surgery ICU 1982–1988 and Clinical Nurse Manager of the Cardiac Unit 1988–1992

[62] WIT 0213 0049 Julia Thomas

57 Canon Charmion Mann[63] stated:

> ‘It was clear when I began in 1985 that the nursing staff were not always aware of the particular religious requirements of other faiths in the treatment of patients and a deceased person … I undertook the preparation and presentation of a training session for BCH nursing staff to explain the impact of different customs and religious beliefs in the care of patients and treatment of the families. This training session took place with every intake of nurses …’[64]

Support for nursing staff

58 Staff were offered support by the Chaplains at UBH/T, and by Mrs Vegoda and Miss Stratton.

Staff generally

59 Ms Joyce Woodcraft[65] told the Inquiry:

> ‘Some nurses and doctors will find it very difficult to hide their own emotions on the death of any patient. This is particularly true of a baby or child that has been “specialed” by a nurse for a long period of time. A more senior nurse may take over parental support if this was deemed necessary, but did not happen frequently in my experience.’[66]

60 The Reverend Robert Yeomans,[67] in common with others, stressed the demands placed on staff working in paediatric cardiac care. He told the Inquiry:

> ‘I felt staff showed immense sensitivity when dealing with parents and were supportive every step of the way. They provided comfort throughout and became involved in all cases. Staff too, were upset when patients died, and may have found it difficult because of their own grief or lack of experience, to give parents what they wanted at the time. It can be very difficult to anticipate and give what bereaved parents want in their grief, distress and anger, when, at that moment of time, they may be inconsolable.’[68]

61 The Reverend Yeomans explained that, whilst ordinarily the work of hospital chaplains is supported by volunteers, this was not felt to be appropriate for Ward 5:

> ‘Volunteers are seen as the vanguard of the Chaplaincy services, to ensure that everyone is visited on every ward where possible. It was felt that volunteers were needed to assess both spiritual and religious needs and they thus were an important part of the process …

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[63] Assistant Anglican Chaplain 1985–1988 and Chaplain to the BRHSC 1988–1994

[64] WIT 0273 0013 Canon Mann

[65] Senior Sister, BRHSC ICU 1985–1994

[66] WIT 0121 0020 Ms Woodcraft

[67] Spiritual and Religious Advisor to UBH/T

[68] WIT 0274 0009 Rev Yeomans

> ‘We did not have any volunteers on Ward 5 during the period to [the] end of 1995. I felt that the particular demands, both in respect of experience and skills would be too demanding …’[69]

62 Likewise Mr MacIntosh told the Inquiry:

> ‘I have no recollection of any specific instance when I was aware of feeling a concern about the sensitivity of staff dealing with such parents. I would however, be very surprised if there were not occasions when the stress and severity of the situation blunted the capacity of staff to give sufficient time in order to be sensitive.’[70]

63 Sarah Appleton[71] said:

> ‘My impression was that nurses were caring towards parents and children within the context of working in a highly stressed environment …’[72]

64 Julia Thomas said:

> ‘I cannot rule out the possibility of occasional personality clashes which may have interfered with the counselling process, but if a nurse was finding certain parents difficult to relate to they would hand their support over to another staff member, involving one of the two Helens in the situation …
>
> ‘I believe our staff shows great sensitivity in their dealings with parents of very ill children. As a manager, I had no complaints about individual nurses. I received many thank-you letters and I believe many nurses had letters from families they had supported.’[73]

65 Mrs Pratten said:

> ‘… in my experience … I did not ever witness instances of insensitivity … on the part of nurses or of doctors. Some situations were certainly very upsetting for the medical staff … my overall impression was that even in the circumstances that could be difficult for all concerned the staff were genuinely giving of their best.’[74]

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[69] WIT 0274 0005 – 0006 Rev Yeomans

[70] WIT 0401 0006 Mr MacIntosh

[71] Social Worker, BRI 1989–1994

[72] WIT 0385 0007 Ms Appleton

[73] WIT 0213 0051 – 0052 Julia Thomas

[74] WIT 0269 0012 Mrs Pratten

The Bristol and South West Children's Heart Circle

Background

66 Mrs Pratten was the founder of the Bristol and South West Children's Heart Circle. She told the Inquiry that the Heart Circle was founded in 1972 'to help parents of children with Heart Disease help one another, particularly when faced with the problems of Cardiac Surgery' and 'to provide amenities and equipment not funded by the NHS'.[75]

67 She stated in her evidence to the Inquiry that in 1969, when her daughter underwent open-heart surgery at the BRI:

> 'There was minimal support for parents and at that time no specialised Cardiac Unit. Children were admitted to a Paediatric Orthopaedic Ward and Intensive Care was a two-bedded side ward attached to a Women's Surgical Ward.'[76]

68 She went on:

> 'In 1970 I started discussions with medical staff to look into the viability of such a group and became the first secretary …'[77]
>
> 'Membership of the Heart Circle is open to all families who wish to be on the mailing list, and in 1997 there were over 1,000 families … There is no subscription. The Heart Circle also helps all families whether or not they are members.[78]
>
> 'Local branches were set up[79] so that families could meet together locally. Social and fundraising activities were organised and medical staff from Bristol visited each group from time to time to speak on their speciality to help families gain more understanding of the problem and feel more involved with Bristol.'[80]

69 She explained how, initially, it was she who provided support and counselling to families:

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[75] WIT 0269 0001 Mrs Pratten

[76] WIT 0269 0001 Mrs Pratten

[77] WIT 0269 0001 – 0002 Mrs Pratten

[78] WIT 0269 0002 Mrs Pratten

[79] The branches were in Cornwall, North Devon, South Devon, Somerset, Wiltshire, Gloucestershire and Mid-Glamorgan

[80] WIT 0269 0002 Mrs Pratten

> ‘Following the opening of the Cardiac Surgery Unit in 1972 I was invited to visit the unit at least once a week to talk to families and staff, and this continued at the Bristol Children’s Hospital until I retired. Certainly at this stage the role of providing the care and support to the families was something that I undertook on my own … I was able to talk through issues with the parents and ensure that particular areas of concern were appropriately addressed by relevant medical staff. I was also able to identify parents’ needs. Frequently I had parents in my home on the day of their child’s surgery to while away the time, and this continued until the volume of work increased and the first accommodation for parents was opened in 1978 …’[81]

70 She referred to the commencement of the involvement of social workers:

> ‘In the late 1970s Mrs Edna Culverhouse was appointed full-time Medical Social Worker on Ward 5. Her personal commitment to families was outstanding. She could be found on the Unit at any time of the day or night when the need arose. She continued in post for some five years or so, and after she left, there was only part-time social work support due to lack of resources, and her high standard was never again matched.’[82]

Financial and other support provided by the Heart Circle

71 Mrs Pratten said:

> ‘Although fundraising has never been or never will be the primary aim of the Heart Circle, money raised by children, parents, friends and medical staff has made an extremely important contribution to the Cardiac Surgery Unit … and the Bristol Children’s Hospital. It is impossible for me to calculate in retrospect the amount of money involved in projects initiated by the Heart Circle at BRI and BCH but it must be in the region of £1,000,000, all of this money being raised voluntarily by members of the Heart Circle.’[83]

72 She gave examples of the support provided by the Heart Circle:

> ‘We provided small items of equipment if they were considered to be for the improved care of children and beyond the budget of the NHS. In 1992 Dr Jordan asked if we would make a substantial contribution to the purchase of a Doppler/ Echo Machine. We agreed to provide £25,000 …’[84]

73 Mrs Pratten subsequently provided the Inquiry with a breakdown of the sums raised by the Heart Circle.[85] She pointed out that the administration costs of the Heart Circle during the period were minimal as no office accommodation was rented nor staff employed.

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[81] WIT 0269 0002 – 0003 Mrs Pratten

[82] WIT 0269 0003 Mrs Pratten

[83] WIT 0269 0011 Mrs Pratten

[84] WIT 0269 0009 Mrs Pratten

[85] WIT 0269 0504 – 0505; letters dated 26 June and 12 July 2000

1984	£16,000	1990	£55,000	
1985	£22,000	1991	£70,000	
1986	£34,000	1992	£114,000	
1987	£26,000	1993	£96,000	
1988	£52,000	1994	£86,000	
1989	£56,000	1995	£81,000	Total: £708,000

74 The Heart Circle also bought and insured a portable Doppler machine for the cardiologists to take to peripheral clinics. Mrs Pratten said:

> '… they would take it down to Treliske or Taunton or wherever with them, so they had a better means of diagnosis. That was an important piece of equipment that we felt was not going to be funded by any other source …
>
> 'Nobody else was prepared to fund it. So if we felt that a Doppler … was a better means of diagnosis in the peripheral clinics and would save families having to come all the way to Bristol, then that was a worthwhile piece of equipment to buy.'[86]

75 They provided accommodation for parents. Mrs Pratten explained that, prior to assistance from the Heart Circle, families of children undergoing surgery had stayed in bed and breakfast accommodation:[87]

> 'The first major project undertaken by the Heart Circle was to identify a property where parents could stay while their child was in hospital. It took Dr Jordan and I almost six years of discussion with hospital management before they accepted the need but in 1978 a small house belonging to the hospital was given over. This was completely refurbished and furnished by the Heart Circle and opened in 1978 and I believe was the first such accommodation in the country.
>
> 'Demand for this was so great that a year later the house next door was similarly opened and shortly after that a third house, making twelve rooms in all.
>
> 'In the early years these houses were managed by the Warden of the Nurses Home … However, later the management was taken over by the Children's Hospital which meant that parents on that Unit were not given the priority intended and I had to undertake hard negotiations to enable the six bedroomed house to be handed over for families on the Cardiac Surgery Unit.

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[86] T47 p. 59 Mrs Pratten

[87] WIT 0269 0007 Mrs Pratten

> ‘The Heart Circle continued to keep these houses in good maintenance although later the two smaller houses were little used by the Children’s Hospital as the Heart Circle had been instrumental in the provision of two purpose-built blocks of bedrooms and the refurbishment of other accommodation in the Children’s Hospital itself. However, the largest house continued to be used for parents on Ward 5 until the transfer. We also negotiated the provision of two bedrooms along the corridor from the Unit for parents at the time of surgery and again all costs were undertaken by the Heart Circle.’[88]

76 However, she went on to say:

> ‘It was understood that as the houses were hospital property there could not be exclusive use … but because they were funded by the Heart Circle, and our families had particular problems, they would be given some priority. This was the original agreement under which the Heart Circle funded these rooms but regular changes in their management at Bristol Children’s Hospital meant that this principle was not followed …’[89]

77 The Heart Circle provided play facilities and, when the unit at the BRHSC was upgraded in 1986, obtained a small room for play, again fitted out and equipped by the Heart Circle. A Hospital Play Therapist, Helen Passfield, was appointed with the support of Julia Thomas, and funded by the Heart Circle.

> ‘… not only did she prepare children for surgery through play, spend time with them in Intensive Care if they were there for a long time, but she was also a great support for parents. This post continues in Bristol Children’s Hospital and is still being funded by the Heart Circle.’[90]

78 Mrs Pratten told the Inquiry:

> ‘I think the hardest job there was to get a room assigned for play, because the hospital did not see the need for a separate area for play away from the “nursery” as it was called, where the sleeping beds were …’[91]

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[88] WIT 0269 0006 – 0007 Mrs Pratten

[89] WIT 0269 0007 Mrs Pratten

[90] WIT 0269 0008 Mrs Pratten

[91] T47 p. 58 Mrs Pratten

79 The Heart Circle also gave grants to families with significant need,[92] for example, where their child had a prolonged stay in intensive care; provided furniture for a nursery;[93] negotiated the conversion of a store room into a quiet room for parents and provided furniture;[94] set up a kitchen for parents and provided a washer-dryer;[95] and within Intensive Care, made a designated area for children and provided cots and other furniture and portable telephones;[96] published an information booklet for parents with the support of Children in Need;[97] provided two caravans at Burnham-on-Sea to allow parents or families to take subsidised or free holidays;[98] and made a video for parents to introduce them to the Unit.[99],[100]

The posts of Helen Vegoda and Helen Stratton

80 The Heart Circle played a major role in the development and funding of the posts of Mrs Vegoda and Miss Stratton. Mrs Pratten stated in her evidence to the Inquiry:

> 'In about 1986 Dr Joffe approached me about setting up the post of Family Support Worker based at Bristol Children's Hospital. The Heart Circle agreed to fund the first year's salary (£15,000) and then £5,000 per annum over the next three years.
>
> 'Helen Vegoda was appointed and the Heart Circle set up her office in the Bristol Children's Hospital.'[101]

Asked about the Heart Circle's annual income at that time, she estimated it would have been £50,000–£60,000.[102]

81 Mrs Pratten stated that with the assistance of Julia Thomas:

> 'In 1990 a further post was set up in the BRI for Ward 5, namely that of Cardiac Liaison Sister. There was an obvious need for a suitably qualified nurse on the unit to whom parents can turn to discuss their anxieties and receive good information. Helen Stratton was appointed on a three-year contract, later extended by six months, which was fully funded by the Heart Circle at a total cost of over £70,000. The management of this post was under the Unit, but again it did not fit into any established structure.'[103]

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[92] WIT 0269 0008 Mrs Pratten

[93] WIT 0269 0009 Mrs Pratten

[94] WIT 0269 0009 Mrs Pratten

[95] WIT 0269 0009 Mrs Pratten

[96] WIT 0269 0009 Mrs Pratten

[97] WIT 0269 0010 Mrs Pratten

[98] WIT 0269 0010 Mrs Pratten

[99] WIT 0269 0006 Mrs Pratten

[100] See also the 1988 Annual Report for the BRHSC and BRI at HAA 0138 0003 which records that the play room and two parents' rooms at the BRI had been furnished by funding from the Heart Circle; and the first edition of the Bristol and South West Children's Heart Circle *'Newsletter'* at UBHT 0213 0069 – 0093, November 1989, reporting that caravans were provided for the use of Heart Circle families

[101] WIT 0269 0003 Mrs Pratten

[102] T47 p. 4 Mrs Pratten

[103] WIT 0269 0003 – 0004 Mrs Pratten

82 She went on:

> 'It was always understood that when Helen Stratton's contract terminated the post would be taken over by the NHS but this was not to be. I was very concerned that all the experience and knowledge that had been gained by Helen's work would be lost. I therefore approached Dr Freda Gardner, Consultant Clinical Psychiatrist and Senior Lecturer in Mental Health, and commissioned a report on the *"Needs of Children with Heart Conditions and their Families"* because I was devastated that there was no longer a designated sister on the Unit.
>
> 'Dr Gardner's document[104] was produced in 1995 and Professor Angelini charged the Heart Circle £11,000 for Dr Gardner's time.[105]
>
> 'The Heart Circle again agreed to fund the post of Cardiac Liaison Sister and this proved so successful that after six months the funding was taken over by the NHS. The report had made the precise needs of families more explicit and this contributed to the increased acknowledgement by senior medical and managerial staff that such a post was vital.'[106]

83 Mrs Pratten told the Inquiry that when the paediatric cardiac service was united at the BRHSC, the UBHT would not allow the Doppler machine, part funded by the Heart Circle, to be transferred to the BRHSC as it was being used for research. The Trust offered the Heart Circle £4,000 in respect of their financial contribution.

84 Mrs Pratten wrote to Mrs Rachel Ferris, General Manager of the Directorate of Cardiothoracic Serices, UBHT, on 6 November 1995:

> '… you give a total amount of £4,000 with no breakdown and I have not been given an inventory of what has been taken up to BCH and what remains on Ward 5. I should be grateful, therefore, if you could indicate how this £4,000 is made up and what percentage relates to the echo machine. When it was purchased, the Heart Circle donated £25,000 …
>
> 'This information will have to be supplied to the Charity Commissioners, who in 1994 expressed their concern to us about the purchase of equipment for hospitals.'[107]

85 Mrs Ferris replied to Mrs Pratten on 5 December 1995:

> 'Professor Vann Jones and I are keen to acknowledge the huge commitment made by you and the Heart Circle in paediatric surgery at the BRI over the last 23 years. We know that the equipment that you have purchased totals many many thousands

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[104] WIT 0269 0013 – 0066 Mrs Pratten; see also paras 20 and 21

[105] WIT 0269 0005 Mrs Pratten

[106] WIT 0269 0006 Mrs Pratten

[107] UBHT 0225 0010; letter from Mrs Pratten to the UBHT

> of pounds, and that the purchase of equipment has been just one aspect of the support you have given. It would be helpful if you would let me have a list of some of the things that you have done so that they can be included in our presentation.'[108]

86 Mrs Pratten commented in evidence:

> 'It was jolly good to get £4,425 at that stage. They kept saying they did not have the money anyway and eventually it came out of the special trustees and what was done instead of money passing hands, they bought a machine for the new cardiac intensive care in the Children's Hospital.'[109]

Comment on the service provided by the Heart Circle

87 Witnesses to the Inquiry were unanimous in their praise for the assistance and contribution of the Heart Circle.

88 The UBHT stated in its evidence to the Inquiry:

> 'The Trust greatly appreciates the financial and human support that The Heart Circle has provided over the years to acknowledge the limitations of the non-clinical aspects of the paediatric cardiac service that could be provided from NHS funds.'[110]

89 Marion Stoneham[111] stated:

> 'The South West Heart Circle was a very well established voluntary body when I took up post. The leader of this was an extremely active worker across the region. The South West Heart Circle offered great support to parents and families of the patients …'[112]

90 Dr Susan McMullen[113] stated:

> 'The work of Jean Pratten and the Heart Circle was extremely valuable and was valued very highly by the staff themselves. Their work was valued not only by Social Workers whose work was complemented by the Heart Circle, but also by nursing staff.'[114]

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[108] UBHT 0225 0003, T47 p. 62–3 Mrs Pratten
[109] T47 p. 63 Mrs Pratten
[110] WIT 0269 0503 Mrs Pratten
[111] Manager of the Children's and Obstetric Sub Unit from 1986
[112] WIT 0149 0002 Miss Stoneham
[113] Team Manager, Social Services, BRI 1987–1992
[114] WIT 0487 0012 Dr McMullen

> 'I believe that members of the Heart Circle worked extremely well and very effectively with the Social Workers, throughout the period, to provide support for patients and families.'[115]

91 Julia Thomas, writing in the first edition of the Bristol and South West Children's Heart Circle *'Newsletter'*, thanked the Heart Circle for its generosity to Ward 5:

> 'Without you, I believe, we would still be in the situation we were in in 1976'.[116]

92 Parents expressed only positive comments regarding the work of Jean Pratten and the Heart Circle in general. Many parents expressed their appreciation of the personal support given by Mrs Pratten.

93 Susan Warburton, mother of Sam:

> '… found her extremely kind and motherly'.[117]

94 Tony Collins, father of Alan:

> 'Jean Pratten of the Bristol Heart Circle also came to see us on the day of Alan's admission to offer any help or assistance she could whether in material or financial terms.'[118]

95 Jayne and Richard Leonard, parents of Katie:

> '… Jean Pratten of the Bristol and South West Children Circle also arrived on Intensive Care and asked us if we needed any help at all.'[119]

96 Richard Lunniss, father of William, explained that he:

> '… had an immediate affinity with Jean because I trusted her as she had a daughter who had also gone through heart surgery'.[120]

97 One mother told us:

> 'When I first arrived at the Bristol Maternity Hospital I was seen by Jean Pratten within minutes of my arrival. She was absolutely wonderful with me and gave me a great deal of encouragement.'

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[115] WIT 0487 0014 Dr McMullen

[116] UBHT 0213 0083; Heart Circle *'Newsletter'*

[117] WIT 0416 0003 Susan Warburton

[118] WIT 0021 0009 Tony Collins

[119] WIT 0367 0005 Jayne and Richard Leonard

[120] WIT 0516 0003 Richard Lunniss

98 Paul Bradley, father of Bethan:

> 'The chairperson from the local charity Heart Circle, Jean Pratten, visited us on the ward. She gave us a very useful booklet concerning children with congenital heart disease and what we as parents might expect in the next few years. This was very useful information on the new circumstances we suddenly found ourselves in.'[122]

99 Alison Leeming, mother of Jamie:

> 'When we arrived at the Children's Hospital we were very impressed with things. We were given a room in the hostel run by the Heart Circle. We thought the hostel was very friendly and we liked it very much.'[123]

100 Another parent stated:

> 'I felt very alone with my sick child, so it was good to be able to communicate with other parents, and share our concerns.'[124]

The Children's Heart Circle in Wales

101 David Brokenshaw provided a statement to the Inquiry about the treatment and death of his daughter Alys. He and his wife met Helen Vegoda when Alys was first treated at the BRHSC. Alys was transferred to the BRHSC in March 1989, and until her operation in May, Mr Brokenshaw commuted between Rhondda and Bristol.

102 He told the Inquiry:

> 'Whilst I was commuting … a cheque arrived from The Children's Heart Circle in Wales. Until the arrival of this cheque I had not heard of the organisation. I assumed that Helen Vegoda had contacted them on our behalf. The fifty pounds was gratefully received as it contributed towards the petrol and bridge expenses of travelling back and forth …'[125]

> 'Following Alys' death about a year later we received a letter from the CHCW [Children's Heart Circle in Wales] requesting support. I attended a meeting and was elected to the committee. The following year I stood for Secretary and was elected. We spent a good few years running the charity and giving grants … However, once the National Lottery started funds dried up.'[126]

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[122] WIT 0229 0004 Paul Bradley

[123] WIT 0537 0004 Alison Leeming

[124] WIT 0264 0014. This parent was one of a number of parents who gave a witness statement to the Inquiry and gave only partial consent to publication of the statement, as they did not wish to be publicly identified

[125] WIT 0514 0003 David Brokenshaw

[126] WIT 0514 0005 David Brokenshaw

UBH/T Chaplaincy

Organisation and role

103 One of those involved in counselling both at the BRI and the BRHSC during the period of the Inquiry's Terms of Reference was the Spiritual Advisor to the UBH/T. The Reverend Michael Jarvie held this post until his death in 1992, and was succeeded by the Reverend Yeomans in 1993. The role involves acting as full-time Anglican Chaplain to the BRI, and overseeing other chaplains.

104 The Reverend Yeomans stated:

> 'In 1993 when I joined the UBHT I felt that the Chaplaincy services were very good and I still do … With the Trust's agreement, I organised the pattern of Chaplaincy provision – obtaining funding to develop the service and appoint more staff, modify leaflets and notices. However, the basic service remained the same.'[127]

He produced for the Inquiry a plan of the structure of the chaplaincy services, showing the other chaplains in post.[128]

105 In 1993 he drafted a booklet[129] on hospital chaplains for the hospitals' staff, setting out the role of a chaplain and contact names. He told the Inquiry that it was the first leaflet of its kind. The booklet has gone through a number of amendments, and the current version[130] provides detail of how patients of different faiths[131] will wish to be treated, and their attitudes to death, disposal of bodies, post-mortems and organ donation.

106 The Reverend Yeomans described his role:

> 'My job description specified that I was to respond to the spiritual and religious needs of patients, their families, carers and staff. I am employed full time, i.e. 6 days a week.'[132]

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[127] WIT 0274 0006 Rev Yeomans

[128] WIT 0274 0019. These were as follows. Full-time Anglican Chaplains to the BRHSC and St Michael's: Reverend Charmion Mann (1985–1994), Reverend (now Canon) Helena Cermakova (1995 onwards). Part-time Free Church Chaplains to BRHSC and St Michael's: Reverend A Howell (1983–1993), Reverend J Pye (1988–1993), Reverend M Pullan (1993 onwards). Part-time Free Church Chaplains to the BRI: Reverend Will Minnis (1976–1995), Reverend Bill Welch (1995–1997). Part-time Catholic Chaplains for both sites: Father Francis Collins (1981–1987), Father William Webb (1988), Father John Fairhurst (and while he was on secondment, Father Claudio Rossi) (1989–1990), Father Bernard Charles (1991–1996)

[129] UBHT 0270 0002; *'Hospital Chaplains Booklet'*

[130] WIT 0274 0021 – 0065 Rev Yeomans

[131] Baha'i, Buddhist, Chinese, Christian of various denominations, Hindu, Humanist, Jain, Jehovah's Witness, Jewish, Muslim, Pagan, Rastafarian, Sikh and Zoroastrian

[132] WIT 0274 0001 Rev Yeomans

107 In relation to the paediatric cardiac service, he stated that he visited Ward 5 as often as possible:

> 'I made it a high priority to mingle with those on the ward and to befriend not only the parents but also the children. I would make it known to parents who I was, and that I was available to discuss anything they wanted with them.[133]
>
> '… I visited everyone regardless of denomination, faith or no faith … The Catholic Chaplain and the Free Church Chaplain came to the BRI one session a week …'[134]

108 He also explained his role in providing support for staff:

> 'In addition to supporting parents I would occasionally sit down with staff to discuss what happened and debrief them.'[135]
>
> 'When a child died I was always careful to ensure that the staff had attention too. Sometimes I would speak individually to staff, as well as to staff collectively. Staff as well as parents were upset when a child died. It has to be acknowledged that the death of a child has a particular effect on everyone involved.'[136]

109 In 1987 Canon Mann, who worked principally at the BRHSC and St Michael's Hospital (a maternity hospital), set up the body known as 'Friends for Patients' to provide day-to-day support and to befriend parents whose children were sick but not seriously ill: 'Essentially they gave practical help wherever possible.'[137]

110 In her statement to the Inquiry she said:

> 'The Cardiac Counsellor for BCH and I set up a Bereavement Support Group for parents from 1992–3. This was found to meet a deep need for those parents who attended …
>
> 'I also provided support to staff who, naturally, also became upset when a child was ill or died … We also set up a support group (I think this began in 1988) for staff working in Casualty and ITU at the BCH, and in St Michael's … Marion Stoneham, the General Manager at St Michael's and the BCH, was very supportive and agreed to fund outside speakers to speak at seminars on bereavement.'[138]

Canon Mann told the Inquiry that she also attended functions of the Heart Circle whenever possible.[139]

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[133] WIT 0274 0003 Rev Yeomans
[134] WIT 0274 0004 – 0005 Rev Yeomans
[135] WIT 0274 0005 Rev Yeomans
[136] WIT 0274 0008 Rev Yeomans
[137] WIT 0273 0010 Canon Mann
[138] WIT 0273 0009 – 0010 Canon Mann
[139] WIT 0273 0011 Canon Mann

111 Canon Mann was succeeded in February 1995 by the Reverend Helena Cermakova. The Reverend Cermakova stated:

> 'Once a year there was a remembrance service arranged by Helen Vegoda specifically for children who had died following cardiac surgery. I believe this had started in 1994. I first helped to organise the remembrance services when I joined in 1995.'[140]

Funding and support for the Chaplaincy Service

112 The hospital chaplains were appointed and paid by the UBH/T.[141] They had line managers within the UBH/T.[142]

113 The Reverend Cermakova stated:

> 'There was (and is) a Chaplaincy budget which covers items such as wages, books … Ian Barrington[143] … is responsible for that budget with me.'[144]

However:

> 'In respect of the "Friends for Family" Group, this was partly funded by the Mothers' Union and by UBHT.'[145]

114 Commenting on the support which the chaplains received from the UBH/T, the Reverend Yeomans said:

> 'Clinicians and staff were very supportive of our services. We worked closely with the surgeons, especially Mr Wisheart and Mr Dhasmana. Nursing staff would be closely involved, and would often attend the funeral if a child died. The management were also welcoming to the Chaplaincy and supported us.'[146]

115 Father Bernard Michael Charles[147] (who had little contact with paediatric cardiac patients or their families) stated:

> 'I think that the Personnel Manager [at the BRHSC], Mr Ian Stone, was responsible for Chaplaincy as a whole in the hospitals and that, since I was a member of the Chaplaincy team, he was my Manager … I am satisfied that the hospital management did give high priority to support and counselling work, and that the Personnel Department at least saw the hospital Chaplaincy as an important aspect

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[140] WIT 0272 0010 Rev Cermakova

[141] See, for example, the evidence of the Reverend Cermakova, T46 p. 31

[142] For example, the Reverend Yeoman's line manager was Janet Maher, WIT 0274 0001

[143] General Manager, Children's Services from 1991

[144] WIT 0272 0011 Rev Cermakova

[145] WIT 0272 0012 Rev Cermakova

[146] WIT 0274 0008 Rev Yeomans

[147] Catholic Hospital Chaplain, 1991–1996

> of the support and counselling structures in the hospitals and that because of this, our work was much appreciated.'[148]

116 The Reverend Will Minnis[149] did not recall being called to see paediatric cardiac surgery patients or their families on Ward 5, but in relation to the Chaplaincy service generally, stated:

> 'I felt staff were very supportive of Chaplaincy services.'[150]

The effect of the split site

117 The chaplains who gave evidence to the Inquiry did not express concern that the split site affected their ability to provide counselling.

Comment on the service provided by the Chaplaincy

118 Parents gave evidence about the support provided by the Reverend Cermakova and the Reverend Yeomans.[151]

119 Sharon Peacock, mother of Andrew:

> 'Since I have lost Andrew, I have received much support from Helen Vegoda … and Helena Cermakova, the hospital chaplain. Helen helped me to prepare for my meetings with Dr Martin, and talked with me about all the questions that I wished to ask. She also helped with the fertility treatment appointments that I underwent, and would visit me to give support both before and after my operations. Helena and I have meetings often, and speak on the telephone regularly. I do not think I could have coped without their help and support. Helena conducted Andrew's funeral service, and has always been very supportive.'[152]

120 Carol Kift, mother of Steven:

> 'No member of staff came to see us after Steven died. The only person who had been supportive, the hospital chaplain, was away over the weekend so we did not see her either. She had helped us to organise Steven's baptism and had been supportive for us whilst we were at Bristol. We were touched when she wrote to us to offer her condolences after Steven's death.'[153]

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[148] WIT 0277 0006 Father Charles

[149] Free Church Chaplain, 1976–1995

[150] WIT 0282 0009 Rev Minnis

[151] See, for example, Lesley Smith, mother of Katherine; WIT 0286 0014

[152] WIT 0011 0031 Sharon Peacock

[153] WIT 0461 0005 – 0006 Carol Kift

Bristol City Council Social Services Department

Organisation, accountability and funding

121 Dr McMullen was Principal Medical Social Worker (Teaching) (PMSW(T)) at the BRI from 1975 to 1987, and Social Work Team Manager at the BRI from 1987 to 1992.

122 In her written statement to the Inquiry she explained how changes to the structure and accountability of social services in 1974 and 1987 had affected the role of social workers, and caused a move away from their performing a role as counsellors.

123 Prior to 1974 social workers (then 'Medical Social Workers') had been employed by the hospitals and paid by the health authority. In 1974 the responsibility for the management of, and payment for, social workers passed to local authorities, in this case to Avon County Council.

124 Dr McMullen stated:

> 'Medical Social Workers are trained to support patients and families, and they form part of the treating team. It was my experience that the changes in 1974, when responsibility for payment and management of Social Workers in hospitals moved from the Health Authority to Local Government, started a process that had a far reaching impact on the counselling role of Social Workers in hospitals. Management of Social Workers became the responsibility of Social Services provided by local authorities in 1974. Many of these managers had little comprehension of the function of a hospital Social Worker. This change began the erosion of Social Workers' ability to provide counselling in hospitals. Gradually, the role of the Social Worker in a hospital became much more focussed on carrying through the legislative duties imposed on Local Authorities, with far less emphasis on counselling.'[154]

125 She also highlighted changes brought about in 1987:

> 'In the restructuring of 1987, Social Services Management was entirely separate from that of the hospital, there was an inevitable lack of understanding by management of the work needed to be undertaken by Social Workers in a hospital setting. Statutory functions imposed on the Social Services Department of the Local Authority recognise the work of Social Services in dealing with: adults and children at risk; identifiable social problems, for example inadequately housed people, benefits entitlement and (in co-operation with health staff) planning the patients' discharge into the community. This change in perception, which I believe was driven by the change in the statutory role of Social Workers, coincided with a

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[154] WIT 0487 0008 Dr McMullen

> greater recognition by others involved in healthcare of the role and value of counselling during the mid-1980s.'[155]

126 Dr McMullen explained that, in the 1987 restructuring, the post of PMSW(T) was abolished, and she was then appointed Team Manager for the Social Work team covering the BRI and the oncology centre, and was responsible to the local authority Social Services manager.

127 She stated that, as a result of the restructuring in 1987, although contact between team managers was maintained through informal networking, there were no structural links between the Health District and the Social Services Department and as a result social workers in different hospitals would be managed by different Social Services areas.

128 The Social Work team at the BRI reported to Bristol North Social Services, and the team at the BRHSC reported to Bristol Central. The General Hospital team reported to Bristol South Social Services:[156]

> 'At this period, it was clear that Social Services Headquarters management did not value hospital social work nor the co-operation with health staff that was inherent in it. There was therefore continuous pressure to reduce the number of social workers in the team and to reorganise work along lines that more closely fitted a locality team model rather than a health one. My task therefore seemed to be to protect the essential nature of hospital-based work while changing that which could be changed without too much damage. There was much greater understanding and value given to the role of the hospital social worker by staff and management within the hospital than there was from social services management.'[157]

> 'My work was structurally separated from the Social Work Team manager at the Bristol Children's Hospital …'[158]

129 Mr MacIntosh, Social Worker at the BRI throughout the period of the Inquiry's Terms of Reference, and Acting Team Manager at the Social Work Department from January 1997 to November 1998, also commented on the changes in the role of the hospital social worker. He stated that until 1990/91 social workers within the BRI Social Work Team were employed as generic social workers. Following the Children Act 1989 and the NHS and Community Care Act 1990 it was recognised that this was no longer viable:[159]

> 'The expectations of Social Workers in hospital to provide medical counselling as a general part of their work with individuals was historically established and there

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[155] WIT 0487 0008 Dr McMullen
[156] WIT 0487 0009 Dr McMullen
[157] WIT 0487 0004 Dr McMullen
[158] WIT 0487 0006 Dr McMullen
[159] WIT 0401 0002 Mr MacIntosh

> was a general expectation that this continued until the changes had started to take place in the late 1980s. Social Workers were at that time funded by Avon County Council.'[160]
>
> 'My recollection is that there were considerable managerial, political and financial constraints on providing Social Work staff to meet needs related to healthcare treatments (both locally and nationally). I believe that the inability of the Social Work Team in the BRI to take on additional work created by an expanding service of Cardiac Surgery (as with other areas of specialised clinical practice) resulted in prioritisation of work towards statutory duties and responsibilities only. These constraints continue to this day.'[161]

Role and training

130 Dr McMullen did not herself have regular day-to-day contact with Ward 5, but managed the social worker who was directly responsible for it:[162]

> 'The emotional impact of such work on the individual would be high …'[163]

Their role was 'to identify, by a number of means, that appropriate referral [to Social Services] of patients and their families had taken place and then to offer the help the family wanted if this was possible … ensuring that, on discharge, the patient and their family had available to them and were aware of appropriate support from Social Services.'[164]

131 Of the first social worker to be attached to Ward 5, she said:

> 'I am aware that Edna Culverhouse had considered it part of her counselling function as a Social Worker to be with a family whose child was undergoing surgery and to provide support … there was increasing pressure from Social Services for Social Workers in the hospital environment not to undertake this sort of generalised supportive work.'[165]
>
> 'After surgery and by prior arrangement, the Social Worker on Ward 5 sometimes made contact with appropriate Support Services in the home area. To some extent this was dependent on outcome … Usually there was little contact … It was much more usual for such contact to be made in the case of … those who needed some form of aftercare in the form of the provision of accommodation and support after discharge from hospital. If, however, the child died, the family often left Bristol very rapidly.'[166]

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[160] WIT 0401 0002 Mr MacIntosh
[161] WIT 0401 0002 – 0003 Mr MacIntosh
[162] Social workers responsible for Ward 5 were: Edna Culverhouse (1974–1983), Patrick Smith (1987–1988), Sarah Appleton (1989–1994), Robin Dunford (1994 onwards)
[163] WIT 0487 0009 Dr McMullen
[164] WIT 0487 0010 Dr McMullen
[165] WIT 0487 0011 – 0012 Dr McMullen
[166] WIT 0487 0012 Dr McMullen

132 Mr MacIntosh stated:

> ‘To the best of my knowledge and since I started in 1984 there was no involvement by BRI Social Workers in providing information, support and counselling before or during surgery … Support given to families with children receiving surgical cardiac care by the BRI Social Work Department was, in my understanding, responsive to circumstances rather than as a planned method of addressing a stressful and potentially damaging time for all parties involved.’[167]

133 He went on:

> ‘I cannot recall an instance of a family being newly referred to the Social Work Department who had lost a child, or whose child had suffered permanent disability.’[168]

134 The move away from the traditional counselling role for social workers was also confirmed by the social workers attached to Ward 5 from whom the Inquiry received evidence.

135 Mr Patrick Smith, a social worker at the BRI, was attached to Ward 5 (and three other wards) from February 1987 to November 1988.[169] He stated:

> ‘… referrals or requests for [social work] services were received by me at any time during the working week … 9.00 a.m. to 5.00 p.m. …
>
> ‘Additionally, I met the senior nurse on duty on a weekly basis on Ward 5, to discuss the patients on the Ward and to screen any referrals or patients which may have benefited from social work assistance.’[170]
>
> ‘As well as responding to referrals, I would also introduce myself to parents/families on the Ward. I considered that it was very important to build a relationship with the families, and that they knew who I was and that I was available to talk or help whenever they wished.
>
> ‘I had an office close to Ward 5 which meant parents or patients could find me.’ [171]

136 His role as social worker, he explained, involved a range of tasks:

> ‘… providing information and advice, for example about welfare benefits, transport, the Heart Circle, etc. At other times … negotiating services on behalf of parents, for example obtaining financial help towards subsistence, transport, bills,

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[167] WIT 0401 0005 Mr MacIntosh

[168] WIT 0401 0005 Mr MacIntosh

[169] WIT 0402 0001 Mr Patrick Smith

[170] WIT 0402 0004 Mr Patrick Smith

[171] WIT 0402 0004 Mr Patrick Smith

> etc., as a result of the additional expenses incurred due to the admission to hospital … via Social Services or from organisations like Heart Circle … to discuss leave arrangements with employers, housing problems, childminding arrangements or transport problems.'[172]

137 The Social Services Department, he explained, kept the keys to the accommodation provided for parents by the Heart Circle and provided a list of bed and breakfast and hotels.[173]

> 'On my visits to the Ward I would check the progress of a child post operation … If things had not gone as well as expected then I would meet the parents to see if there was anything I could help with.'[174]

138 Ms Appleton joined the Social Work Department at the BRI in January 1989, and was the link social worker to Ward 5 from then until 1994. She explained her role in relation to parents as being:

> '… if they required support over and above what was given by Helen Stratton or Helen Vegoda, i.e. it was not a counselling role'.[175]

139 She described her role as being largely concerned with families having financial difficulties, for whom she carried out tasks outlined by Patrick Smith. These included: liaising with housing associations to seek a change of accommodation if current accommodation was not suitable for a child recovering from surgery; assisting parents to claim DSS benefits; liaising with employers about compassionate leave for parents; identifying charitable sources which could provide financial relief, such as the Heart Circle, the Guild of Friends and the Samaritan Fund. Additionally, the Social Work Department within the BRI kept the keys to the accommodation for families funded by the Heart Circle and the Ward Clerk informed families that this accommodation was available to them:

> 'A small charge was made for each night's stay, although this was sometimes waived.'[176]

140 Subsequently, her role changed:

> 'As a response to the implementation of the NHS and Community Care Act and the Children Act 1989, responsibility for children and adults was split, and I then dealt with adults.'[177]

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[172] WIT 0402 0004 – 0005 Mr Patrick Smith
[173] WIT 0402 0005 Mr Patrick Smith
[174] WIT 0402 0005 Mr Patrick Smith
[175] WIT 0385 0002 Ms Appleton
[176] WIT 0385 0006 Ms Appleton
[177] WIT 0385 0002 Ms Appleton

141 Mr Robin Dunford was employed as a childcare social worker responsible for covering all wards and departments of the BRHSC from April 1990 to April 1994. In May 1994 he took over from Ms Appleton as (adult) social worker for Ward 5.

142 He stated to the Inquiry that he worked very closely with Mrs Vegoda. They would have weekly meetings, but she referred families to him only if they needed practical assistance, such as assistance with travel expenses or accommodation. Mr Dunford stated:

> 'On occasion if covering for Helen Vegoda I would accompany parents to a pre-op visit to the Bristol Royal Infirmary as this was part of the orientation process.'[178]

143 Mr Dunford also explained that he liaised with Miss Stratton in Mrs Vegoda's absence, and liaised with Ms Appleton when they were both in their respective posts at the BRI and the BRHSC, particularly in relation to patients being referred back to the BRHSC post-operatively, and to avoid duplication if families needed financial support.

Support for the social work team

144 Members of the social work team commented on how they believed other UBH/T staff saw their role.

145 Mr Dunford told the Inquiry:

> 'There were occasions when I needed to discuss cases with consultant cardiologists or surgeons … All … I spoke to were very approachable and helpful.'[179]

146 Mr Smith stated:

> 'I recall that the clinical staff, the sisters, staff nurses, consultants and ancillary staff were all supportive of Social Services and made appropriate referrals.'[180]

147 Ms Appleton commented:

> 'I never quite felt part of the multidisciplinary team. My feeling was that the general staff excluding Helen Stratton regarded my role as peripheral…'[181]
>
> 'Although the nursing staff respected my role and were supportive and made referrals when necessary they didn't see it as particularly central to the running of the ward.'[182]

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[178] WIT 0384 0003 Mr Dunford

[179] WIT 0384 0003 Mr Dunford

[180] WIT 0402 0006 Mr Patrick Smith

[181] WIT 0385 0003 Ms Appleton

[182] WIT 0385 0007 Ms Appleton

Comment on the split site

148 In addition to the organisational effects of the split site on the Social Services Department set out earlier, social workers also commented on the effect of the split site on their work.

149 Mr Smith:

> 'I do not recall any significant problems with the split site in relation to discharging my responsibilities.'[183]

150 Mr Dunford contrasted facilities at the two sites:

> 'At the Children's Hospital parents had accommodation and support of other families. It was a child centred environment. This was not available for them at the Bristol Royal Infirmary. It was difficult for parents if children were admitted straight to the Bristol Royal Infirmary as they appeared to miss out on some of the pre-operative preparation.'[184]

151 Dr McMullen:

> 'We tried to liaise between the BRI social work team and the BCH team – usually but not always successfully. I think the difficulties resulted from the amount of pressure everyone was under. I remember that the BRI social workers had a far more limited amount of Samaritan Fund money to give to families than these same families were used to receiving from the BCH social workers and they were sometimes made to feel they were seen as unhelpful by some families.'[185]

UBH/T bereavement services

152 The Inquiry heard that, at the BRI, parents whose children had died were assisted through the various practical steps by Diane Kennington, who became the Patient Affairs Officer at the BRI in 1983.

153 She told the Inquiry that her duties in 1983 were very much the same as they are currently:

> 'My role is to see relatives through a very difficult time, immediately following the death of a patient in hospital. At that time there are requirements of the registration

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[183] WIT 0402 0003 Mr Patrick Smith
[184] WIT 0384 0006 Mr Dunford
[185] WIT 0487 0015 Dr McMullen

> of death, arrangements for the funeral and obtaining the signature on the consent form for a hospital post mortem …'[186]
>
> 'I was often called to the Ward 5B immediately following a death so that I could give some help regarding the necessary procedure and formalities. I was asked to register the death of a child for parents who very often lived perhaps in Cornwall or Wales … Other parents were given my name and telephone number in the usual way so that I could give information regarding the Coroner and again offer any help I could at this time. Helen Stratton was Cardiac Support Nurse and she passed the care of the parents over to me which provided the continuity which was felt to be important.'[187]
>
> 'I speak to all the bereaved families. They are told to ring me the day after the death has occurred and I can then give them information about the Coroner's involvement …'[188]

154 Catherine Warren[189] informed the Inquiry that after a child died at the BRI:

> 'Before the parents left the unit, we would provide them with the contact number for the Patient Affairs Officer at the BRI (Diane Kennington) … We would also give them a leaflet called *"After your Child has Died"*,[190] which was specific to Ward 5.'[191]

155 Mrs Kennington's only previous post in the NHS had been that of a cashier. Her role in seeking 'consent' for hospital post-mortems is considered in the Inquiry's Interim Report.[192]

156 The Inquiry heard that, at the BRHSC, hospital porters filled the role played by Mrs Kennington. Mr Frank Long worked at the BRHSC at various times and in various positions between 1984 and 1994.[193] In about 1989 the Head Porter at the BRHSC retired and in the 6–12 months before a replacement was found, Mr Long and his colleagues (Mr Graham Milkins[194] and Mr Leonard Dudridge) split the responsibilities of Head Porter, which included responsibility for bereavement services, between

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[186] WIT 0214 0001 Mrs Kennington

[187] WIT 0214 0014 – 0015 Mrs Kennington

[188] T43 p. 95 Mrs Kennington

[189] Senior Staff Nurse, Paediatric Intensive Care Unit from 1995

[190] WIT 0483 0033 – 0034; *'After Your Child has Died'*

[191] WIT 0483 0006 Ms Warren

[192] Interim Report: *'Removal and Retention of Human Material'*, COI, May 2000. See Annex C for the full Interim Report

[193] Mr Long began as a kitchen porter at the BRHSC in about 1984, shortly afterwards becoming a full-time relief porter at the maternity hospital and the BRHSC. He worked as an auxiliary nurse from about 1986 to 1988–89, before returning to his post as full-time relief porter at the BRHSC

[194] Mr Milkins previously worked as a porter at the BRHSC in the early 1980s. Following employment as a driver and cleaner, he took up the post of porter at the BRHSC in September 1993, and became Head Porter at the BRHSC in February 1995 with full responsibility for bereavement services there. See WIT 0276 0001

them. Mr Milkins and Mr Dudridge were responsible for bereavement services at the BRHSC and Mr Long at St Michael's. Given the split site, Mr Long stated that he had:

> '… very little contact with families whose child had undergone paediatric cardiac surgery …'[195]

157 Mr Long stated:

> 'My involvement in bereavement services varied over the years and depending on which post I held.'[196]

But once he became Portering Manager in 1991, he was then:

> '… fully responsible for an important aspect of bereavement services at both St Michael's Hospital and the Children's Hospital … In about 1993 I split and restructured the portering services so that there was a dedicated team for each hospital. From then onwards I dealt with bereavement services only at the Children's Hospital.'[197]

158 He explained his role:

> 'My overall responsibility for bereavement services was to provide information to parents about their legal responsibilities, and how they could meet them (e.g. registration of the death); to give practical advice about, for example, making funeral arrangements; and to act as liaison between the hospital, parents and undertakers …
>
> 'I was contacted soon after a death had occurred, by the nursing staff. They would arrange a time for me to speak with the parents.[198]
>
> 'I worked very closely with the nursing and Chaplaincy staff at BRHSC and St Michael's in order to provide as supportive a service as possible.'[199]

159 As for support and training for him in his role, he stated that when he took up his post as Head Porter he was sent 'on a counselling skills course for 4 days at the BRI'[200] and that his first line manager, Ian Barrington 'was very supportive of the bereavement services', as were his subsequent line managers.[201]

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[195] WIT 0368 0007 Mr Long
[196] WIT 0368 0003 Mr Long
[197] WIT 0368 0003 Mr Long
[198] WIT 0368 0004 Mr Long
[199] WIT 0368 0006 Mr Long
[200] WIT 0368 0008 Mr Long
[201] WIT 0368 0008 Mr Long

Comment on the service provided by UBH/T bereavement services

160 Miss Stratton said of Mrs Kennington:

> 'Diane was always extremely kind and sensitive to parents and adult relatives, often going out of her way to help parents who often lived some distance away.'[202]

161 Dr Ashworth, consultant paediatric pathologist at the UBHT, was asked:

> 'Q. Did you know who Diane Kennington was?
>
> 'A. I did not, no.
>
> 'Q. Or what her role was?
>
> 'A. I understand what it is now, but I did not know then, no.'[203]

Helen Vegoda and Helen Stratton

162 Two posts were created during the period of the Inquiry's Terms of Reference, those of Mrs Vegoda and Miss Stratton. Although both posts were created and funded with the assistance of the Heart Circle, both women were employees of the UBH/T.

163 Although Mrs Vegoda and Miss Stratton maintained contact with Mrs Pratten, their line management, or supervision, was by staff employed by the UBH/T.

Helen Vegoda

Background to the appointment

164 Dr Joffe, consultant paediatric cardiologist, informed the Inquiry:

> 'In the mid 1980s, I became aware of the need for counselling of cardiac patients and their families at BCH during times of crisis. This occurred when the diagnosis of serious congenital heart disease was first confirmed, especially in newborn babies; and when children were admitted for cardiac catheterisation or closed-heart surgery. I anticipated that a counsellor could also support families with children

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[202] WIT 0256 0009 Miss Stratton

[203] T54 p. 25 Dr Ashworth

> undergoing open-heart surgery. With the financial support of Mrs Jean Pratten and the Bristol and South West Children's Heart Circle, the post was developed and advertised.'[204]

165 Ms Stoneham wrote to Mr John Watson[205] in March 1987,[206] enclosing a paper entitled *'Counsellor in Paediatric Cardiology'*[207] setting out a proposal for the establishment of this post. She had already discussed the proposal with Mr Graham Nix, Director of Finance and Deputy Chief Executive of the UBHT. The proposal was that the funding of the post for the first two years was to be undertaken by the Bristol and South West Children's Heart Circle.

166 The proposal was that if, after two years, it was shown to fill a real need, an application would be made to the DHSS, through the SWRHA for funding (the salary for the post being £12,500) on a permanent basis as part of the supra regional service.

167 Ms Stoneham stated:

> 'As I recall, at this time, funding constraints prevented managers from allowing such developments. The Cardiac Counsellor post, however, was initially to be funded by voluntary monies from The Heart Circle. Nevertheless, I had to seek the permission of John Watson, Central Unit Manager, before recruiting for this appointment. Once in post it was very probable that a cardiac counsellor would become part of the established service, which would ultimately have to be funded by the Authority.[208]
>
> 'This was not the top priority but it was high on the agenda. It was recognised as being necessary as there was an increasing concern about the amount of stress people were under. This did not just relate to the cardiac unit, but to the hospital as a whole.'[209]

168 Mr Watson replied to the proposal on 18 May 1987.[210] He stated that he was only prepared to accept the proposed post if the Heart Circle funded it in full. Referring to Ms Stoneham's letter, he told the Inquiry that it, and a letter from Dr Marianne Pitman[211] to Mr Nix dated 10 July 1987,[212] brought the need for a counsellor and the question of funding to his attention:

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[204] WIT 0097 0316 Dr Joffe

[205] Management Consultant and Business Psychologist; he was General Manager of the Central Unit, B&WDHA, from February 1986; from late 1989 to early 1990 he acted as leader of the DHA purchaser team; he moved to the Avon FHSA, becoming its Chief Executive in March 1990. He was the budget holder for the Central Unit; see WIT 0298 0002. Hospitals in his charge included the BRI and the BRHSC. He met his hospital managers at least once a month, including Ms Stoneham as manager of the BRHSC; see WIT 0298 0005 Mr Watson

[206] UBHT 0278 0347; letter dated 12 March 1987

[207] UBHT 0278 0335 – 0338; *'Counsellor in Paediatric Cardiology'*

[208] WIT 0149 0029 Ms Stoneham

[209] WIT 0149 0029 Ms Stoneham

[210] UBHT 0062 0307; letter dated 18 May 1987 from Mr Watson to Ms Stoneham

[211] Specialist in Community Medicine/Consultant in Public Health Medicine, 1980–1996, SWRHA

[212] UBHT 0062 0323; letter dated 10 July 1987 from Dr Pitman to Mr Nix

> 'This was eventually achieved through liaison with the South West Heart Circle, who gave us the go-ahead for funding for such a counsellor. This reinforced the work already done on an informal basis by the nursing staff.
>
> 'I was predominantly dependent upon people such as Marion Stoneham to bring to my attention an assessment of the need for such a counsellor, partly by virtue of liaising with staff and parents about the needs of parents and families with sick children in the Unit.'[213]

169 On 18 June 1987 Mr Nix wrote to Dr Pitman providing details of the counsellor post and stating that unless a permanent arrangement could be made with the DHSS for funding, it had been decided that the appointment could not proceed.[214]

> 'Dr Pitman replied on 10 July 1987, that the cost of a counsellor had been included in the 1988–1989 bid for neonatal and infant cardiac surgery.[215]

170 The draft annual programme for B&WDHA confirmed that the counsellor was to be appointed: 'costing £12,000 per annum'. [216]

171 The need for the post was stressed in the BRHSC and BRI *'Annual Report'* for 1987[217] that recorded that the post of counsellor was 'finally' established at the end of 1987 to address the 'urgent need for emotional and psychological support'. It was reported to be the first such post in the country, and made possible through a donation from the Heart Circle and funding from the Supra Regional Services budget.

Qualifications

172 Mrs Vegoda told the Inquiry that she first qualified as a teacher. She then took a qualification as a social worker and worked for nine years in the Child and Family Psychiatric Unit in a hospital in the West Midlands where she had been seconded. She told the Inquiry that this work was very much 'hands on' work with families.[218]

> 'I worked very closely with both adults and children … the expression that was used was a "therapist" … the children were actually referred, because they had some sort of psychiatric or psychological problems … I worked as one of a team of people doing an assessment of what the problems were and the family background, and then working with either the parents or the children, often in very long-term commitments … That was the main part of the work.'[219]
>
> 'I also worked with parents or children who may have been bereaved …'[220]

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[213] WIT 0298 0031 Mr Watson

[214] UBHT 0062 0319; letter dated 18 June 1987 from Mr Nix to Dr Pitman

[215] UBHT 0062 0323; letter dated 10 July 1987 from Dr Pitman to Mr Nix

[216] HAA 0055 0002; draft annual programme, B&WDHA, August 1987

[217] HAA 0137 0011; BRHSC and BRI *'Annual Report'*, 1987

[218] T47 p. 88 Mrs Vegoda

[219] T47 p. 89 Mrs Vegoda

[220] T47 p. 91 Mrs Vegoda

173 Between 1981 and 1986 she undertook training in child psychotherapy at the Tavistock Clinic in London whilst also employed as a trainee child psychotherapist in Bristol. She explained that the training that she undertook at the Tavistock Clinic was part-time and she did not obtain a qualification in child psychotherapy as she did not complete the course. She stressed to the Inquiry, however, that she underwent a considerable amount of training during the course.[221] She then spent two years working with the mental health charity Mind, as a Regional Administrator for the South West.

174 She stated she had a diploma in sociology from London University.[222] She told the Inquiry that she had also been on a bereavement course organised by Cruse[223] and subsequently became a member of the West Midlands Institute of Psychotherapy and she took a qualification with them.[224] She was also a member of the Bristol Association of Psychotherapy.[225]

Funding

175 Mrs Pratten explained the funding of Mrs Vegoda's post, as set out above. Mrs Vegoda commented:

> 'Whilst I have always considered myself to be an employee of the Health Authority and then the Trust, I was aware that my post was partially funded by the Heart Circle for up to two years following the instigation of my post.'[226]

Appointment

176 Mrs Vegoda told the Inquiry:

> 'I in fact knew Dr Joffe and he telephoned me one day and discussed the idea that he wanted to help create a post that would support the needs of parents, of families. I believe he asked whether I would come in [for] a meeting with Jean Pratten. I think Professor David Baum as well. This was a fairly informal meeting, just to look at the idea of setting up such a post.
>
> 'I did that. … Then there was the formal application and the formal interview. I always understood that the post was, I believe, part funded by the Heart Circle for, I think, two years, but was also part funded by the Health Authority …
>
> 'My understanding was that Dr Joffe had already discussed the idea of having some sort of support counselling role, which I believe he had already discussed with Jean

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[221] T47 p. 87 Mrs Vegoda

[222] WIT 0192 0001 – 0002 Mrs Vegoda

[223] Cruse is a national voluntary organisation which offers free bereavement counselling services

[224] T47 p. 90 Mrs Vegoda

[225] T47 p. 91 Mrs Vegoda

[226] WIT 0192 0006 Mrs Vegoda

> Pratten, and possibly other people. I think he was really picking my brains at that stage. I do not even know whether he was aware that I might apply for it.'[227]

177 Mrs Vegoda took up post in January 1988.[228]

178 Mrs Pratten, who was on the interview panel, told the Inquiry:

> 'I … felt that Helen Vegoda did not have the necessary qualifications for the job, but at the end of the day, we did not take part in the voting for the job because we felt it very difficult, as a voluntary organisation that had never become part of the politics of the hospital, to give our vote … Though we were going to fund the post, we were not going to employ the post.'[229]

Asked what qualifications she felt the post required she said:

> 'Certainly hospital experience. I would have thought nursing experience, or certainly awareness of a cardiac situation, of cardiac children and their needs, and the stresses that the parents go through.'[230]

179 However, she did not criticise Mrs Vegoda's approach to the job. She said:

> 'Helen Vegoda played a very useful part in supporting families. There were families who certainly were helped by knowing her, but the qualifications for that post were not met … I would not criticise her dedication in any way.'[231]

Role

180 The way in which the appointment of Miss Stratton affected the role of Mrs Vegoda will be addressed later in this chapter, in the context of Miss Stratton's developing role.

181 There was also some divergence of evidence as to the role to be filled by Mrs Vegoda. The proposals for Mrs Vegoda's post referred to a 'Counsellor in Paediatric Cardiology'. However, Mrs Pratten told the Inquiry:

> '… when Helen Vegoda was appointed she was a family support worker.'[232]

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[227] T47 p. 103–4 Mrs Vegoda
[228] WIT 0192 0002 Mrs Vegoda
[229] T47 p. 5 Mrs Pratten
[230] T47 p. 5 Mrs Pratten
[231] T47 p. 28 Mrs Pratten
[232] T47 p. 18 Mrs Pratten

182 Once in post, Mrs Vegoda introduced herself in the Heart Circle newsletter *'Heart South West'*[233] in November 1989:

> 'Although I am officially called the Cardiac Counsellor, I prefer to introduce myself as a Heart Family Support Worker.'

183 Mrs Vegoda stated that during the period 1988–1990, she worked with families whose children had congenital heart defects and who came to the BRHSC, the BRI and the Bristol Maternity Hospital.[234] She was based at the BRHSC and also covered Ward 5 at the BRI which meant that she visited the BRI often once or twice a day to see families and to be available at key times such as surgery and admission.

184 She told the Inquiry that she saw the main aspect of her job when she took it in 1988 as being to provide emotional and psychological support and counselling to families and to give information:

> 'It involved being there as a very general support at times of stress. It involved what I would have called "orientation", helping parents to know what facilities were around in the Children's Hospital in Bristol. It had a liaison element to it in terms of the community …'[235]

185 She stated:

> 'I provided emotional and other support at key times during the child's admission, for example, being available to parents accompanying the child to theatre or the catheter lab and supporting them whilst they awaited the child's return. Some of my support was to liaise with parents' employers to obtain leave of absence, give information about voluntary organisations such as the Heart Circle and the Downs Heart Group, and help make preparations for discharge by contacting other agencies, e.g. Social Services, GPs and Health Visitors …
>
> 'On occasions I would sit in with cardiologists and surgeons when a diagnosis was made or when details of surgery were given to the parents. This allowed me subsequently to carry out a supportive role.'[236]

186 Mrs Vegoda informed the Inquiry that she would usually try to ascertain whether a parent understood what treatment or surgery entailed following their meeting with the cardiologists or surgeons, and if it was apparent that they needed clarification, she

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[233] UBHT 0213 0086; *'Heart South West'*, Issue Number 1, November 1989

[234] WIT 0192 0002 Mrs Vegoda

[235] T47 p. 86 Mrs Vegoda

[236] WIT 0192 0002 – 0003 Mrs Vegoda

would ask the consultant or registrar, or one of the nurses to meet the parents to explain the procedures again. She stated:

> ‘I would never explain the medical aspect of any procedure to a parent as I was not qualified to do so. I could provide the details of the process and place of treatment only.’[237]

187 In relation to bereaved families she said:

> ‘At the time of death my support could include staying with the parents until they were ready to go home, accompanying the parents to register the child’s death, meeting them if they returned to the hospital to see their child in the Chapel, and liaise with and be present at meetings with the Surgeon or Cardiologist, usually after the post mortem report was available.
>
> ‘I sent out regular cards to parents on the anniversary of their child’s death and birth, and instigated and organised an annual Remembrance Service for Cardiac families for three years,[238] each attended by over 150 people including medical and nursing staff who took an active role.’[239]

188 She also described her ongoing support for bereaved parents:

> ‘My contact with bereaved parents was open ended, and in some instances continued for several years.’[240]

189 Mrs Vegoda spoke of the need for her to be proactive in establishing her role:

> ‘… one of the things that I was aware of was that I do not know how much the post had been discussed with all members of the cardiac team … both surgeons, consultants, nursing staff or anybody else … possibly had there been more of a cardiac team structure that met very regularly, that looked at non-clinical issues, then possibly I might have slotted into the team as opposed to a professional background.’ [241]

190 She said:

> ‘My memory is that I had to be very proactive in seeing where I was needed. By that I mean the cardiologists and surgeons would not necessarily have brought me in at the diagnostic stage … When I discussed that with Dr Jordan, they were very happy for me to do that and to be there, but it did not happen routinely, and somehow I felt I was always having to be proactive.’[242]

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[237] WIT 0192 0003 Mrs Vegoda

[238] 1994–1996

[239] WIT 0192 0006 Mrs Vegoda

[240] WIT 0192 0005 Mrs Vegoda

[241] T47 p. 114–15 Mrs Vegoda

[242] T47 p. 117 Mrs Vegoda

Communication between Mrs Vegoda and others

191 Mrs Vegoda stated that her job involved liaison within the hospitals with other professionals and voluntary groups, and with services in the community, to obtain services for the families. Her job included: acting on the families' behalf with their employers, council departments, schools and the DSS, for example, to obtain leave of absence or grants, discussing the availability of resources; providing information and 'TLC', the provision of a listening ear, a place of refuge, a cup of coffee both at times of crisis and on a daily non-eventful basis; attending Tribunals at a parent's request to prevent them losing a job, or to appeal against refusal of disability living allowance; and carrying a dead child to the mortuary, having helped to dress him or her.[243]

192 Ms Lorna Wiltshire[244] stated:

> 'The role for Helen Vegoda (BRHSC) was not only to provide support, but also to arrange more practical issues such as transport, accommodation etc.'[245]

193 However, as was set out earlier[246] a number of these tasks was at that time already being carried out by social workers.

194 In April 1988 Dr McMullen wrote to Mr Dhasmana[247] enclosing a copy of a document seeking to clarify how Mrs Vegoda and social workers could work together on Ward 5. The paper set out some general principles:

> 'It is important to work towards clarity about roles for 3 reasons:
>
> 'a. to minimise confusion for the families of the patients;
>
> 'b. to enable staff to know to whom to refer/with whom to continue discussion;
>
> 'c. so that the activity of the 2 workers fits together rather than overlaps.'[248]

195 The paper suggested that both Mrs Vegoda and Mr Smith, the social worker then attached to Ward 5, would take referrals from any source. Mrs Vegoda would, it suggested, meet some families around the time of the diagnosis, she would become involved with some families at BRHSC with whom she would continue to work when they transferred to the BRI, and her counselling would focus on emotional and relationship difficulties related to the child's illness and treatment. Mr Smith, the paper suggested, would work with families where there were statutory responsibilities, he would take referrals from Mrs Vegoda to respond to families' particular needs,

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[243] WIT 0192 0244 Mrs Vegoda

[244] Night Nursing Officer at the BRI from April 1981 to April 1990 when she took the post of Nurse Manager of the Cardiac Unit; Nurse Manager, Cardiac Unit, 1990; and Assistant General Manager, General Surgery, 1990–1993

[245] WIT 0330 0028 Ms Wiltshire

[246] See paras 121–51

[247] UBHT 0160 0004; letter 25 April 1988 from Dr McMullen to Mr Dhasmana

[248] UBHT 0160 0005; paper on counselling

in which cases Mrs Vegoda would continue her involvement with the family, and wherever their roles overlapped significantly, this would be discussed between them. This way of working together was to be achieved by regular meetings.

196 Mrs Vegoda also explained to the Inquiry that her role involved liaison with the Chaplaincy and voluntary bodies. She described the bereavement support group set up in 1992:

> '… Charmion Mann, the then Chaplain to the hospital, and myself, who worked quite closely together, were very aware that there possibly was a need to offer that type of support. We were both offering individual support and support in other ways to bereaved parents, but what was not available from the point of view of the hospital was some sort of group, and we both felt that parents might benefit from being able to talk to other bereaved cardiac families.'[249]

She went on to say that six or eight sessions were held in the evening; they reviewed the situation, and then had another six sessions, but these were not very well supported:

> 'A number of families said they would like to but they could not because of the distance, so in the end, we actually felt that they were not particularly well supported.'[250]

197 She stated:

> 'I also directed families to voluntary organisations offering bereavement support such as Compassionate Friends and CRUSE.'[251]

198 Mrs Vegoda commented on the split site and its effect on the attitude of the nurses on Ward 5 to her. She said:

> '… one of the difficulties of the split site and the fact that I was going down to Ward 5 was that I did not really get to know the nurses well … So I do not think I necessarily developed a sort of close rapport with the nursing staff.'[252]

Support for Helen Vegoda

199 Mrs Pratten stated in her evidence to the Inquiry:

> 'I was concerned that this new post did not fit into any established structure, and none was established for her. In addition there was no clinical supervision provided for this post during The Heart Circle's involvement with it.'[253]

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[249] T47 p. 155 Mrs Vegoda

[250] T47 p. 155–6 Mrs Vegoda

[251] WIT 0192 0006 Mrs Vegoda

[252] T47 p. 138 Mrs Vegoda

[253] WIT 0269 0003 Mrs Pratten

200 Mrs Vegoda agreed:

> 'There were difficulties about the post because … I did not fit into social work and I did not fit into nursing and I did not fit into psychology … From that point of view, it was isolated. There was no peer system that I slotted into … certainly, there was not that peer support.'[254]

201 She told the Inquiry that when the post was first set up she was not part of any formal management structure within the Health Authority. That came into place in 1991 or 1992 when Julie Vass[255] came into post and became her line manager. A formal management structure was put in place:

> 'I do not really think that aspect of the role was discussed until Julie Vass came into post, I think it was around 1991, and I mean, I was certainly aware that I was trying to "find my feet" with the post. What I think I did was focus in on the needs of families, which I was beginning to understand and felt I was making headway with, but I think probably what I was not doing was looking at the whole wider area of how it fitted in with the cardiac team and things like that. That aspect probably was not looked at until I had professional managerial input.'[256]

202 She told the Inquiry that in all matters of clinical responsibility and accountability Dr Joffe supervised her and she saw herself as being accountable to Dr Joffe and the Health Authority.[257] Mrs Vegoda stated that she received good support from Mrs Vass, and regular supervision from Dr Joffe.[258] Of Dr Joffe she said:

> 'I felt he was very aware of his families. I think he was very aware of the emotional and the stress factors on them. That is what we talked about. We obviously talked about different children's conditions and who was coming in and what the needs of those families were, but we were really looking at the emotional content.'[259]

203 Asked whether there was anyone else who could look at her performance as a counsellor, discuss with her areas in which her skills might need to be strengthened or developed, or discuss critically the sorts of initiatives she was taking, Mrs Vegoda replied:

> 'What I did, because I think I was aware that there were gaps, is I went to see Paul Burroughs, who was a child psychotherapist, because I did discuss with Dr Joffe right at the beginning supervision outside the role with him, and talking to Paul Burroughs was quite helpful in terms of how I felt I was dealing with things, but again, I did not feel it was quite appropriate for this post, because he was a very good child psychotherapist, but that was really not what the main thrust of the

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[254] T47 p. 113–14 Mrs Vegoda
[255] Assistant General Manager, BRHSC
[256] T47 p. 107–8 Mrs Vegoda
[257] T47 p. 105 Mrs Vegoda
[258] WIT 0192 0007 Mrs Vegoda
[259] T47 p. 107 Mrs Vegoda

> job was about. I did also see Madeline Dunham who was or is the principal psychologist at the hospital, and she, again, was very helpful.
>
> 'So I think I was getting people to look at aspects of my work, but whether either of those two people were actually aware of how I was performing, other than what I said, I do not know.'[260]

204 Mrs Vegoda said that in the first two years, while her post was part-funded by the Heart Circle, she met Mrs Pratten regularly, although Mrs Pratten's role was supportive and informative rather than supervisory. [261]

205 Mrs Pratten said:

> 'I tried to help her because I realised she did not have an understanding of the needs of children or their relatives. I gave a lot of time to trying to help her to understand the needs of these families and the children.'[262]

206 Mrs Mandelson[263] told the Inquiry that notwithstanding that Mrs Vegoda was not a member of the British Association of Counsellors, nor an accredited counsellor through the British Association of Counsellors, the Code of Practice and Ethics, setting out accepted practice for counsellors, would have required her to have 'outside supervision'.[264]

207 In addition to formal lines of accountability to Dr Joffe and Mrs Vass and contact with other professionals, Mrs Vegoda was asked what other forms of support she had in her role. She explained that a support group was set up specifically for people like her with isolated jobs, in order to support them.[265] She said:

> 'It was a very stressful job, and I think I was aware right at the beginning that I was going to need help … that was part of my reason for seeing Paul Burroughs and then Madeline Dunham, but a number of years after that, and I cannot date it, a support group was set up in the hospital, in fact there were two support groups. One was convened by Charmion Mann, who was the Chaplain to the hospital. That was helpful but it was not terribly structured. About six years ago, a support group was set up by Ann Dent, who has done a lot of work in bereavement research, and that is ongoing. That has been invaluable.'[266]

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[260] T47 p. 108–9 Mrs Vegoda

[261] T47 p. 105 Mrs Vegoda

[262] T47 p. 9 Mrs Pratten

[263] Manager and Senior Counsellor, Alder Centre, Alder Hey Children's Hospital, Liverpool: Expert to the Inquiry on Support and Counselling Services

[264] T47 p. 170 Mrs Mandelson

[265] T47 p. 111–12 Mrs Vegoda

[266] T47 p. 111–12 Mrs Vegoda

208 Despite having an 'isolated job', however, Mrs Vegoda told the Inquiry that when she made suggestions for improvements, she got a response:

> 'For example, I helped to produced … three booklets and Dr Joffe was one of the people that helped to produce them … I got a lot of support for that sort of initiative. I got a huge amount of support for organising the study days for the whole team. I mean, both surgeons and the cardiologists and others involved with cardiac surgery were very, very supportive, and gave their time, and they were very successful. So I feel that when I came up with an idea or initiative, it was supported.'[267]

Comment on the service provided by Helen Vegoda

209 The 1987 *'Annual Report'* for the BRHSC and BRI recorded that Mrs Vegoda and her counselling service had become:

> '… an integral and most valued part of the unit'. [268]

210 Mr Wisheart commented on Mrs Vegoda's contribution:

> 'She played an invaluable role in supporting the parents in many different ways.'[269]

211 As to the reaction of the parents to her role, she said that she received continued feedback which was appreciative, including over 200 letters which:

> '… suggest that my support to cardiac families, both met many of their needs, and was valued and appreciated'.[270]

212 Mrs Vegoda was asked about the survey that she conducted in the first half of 1993,[271] in which she studied the level of information and support being given to families attending, specifically, for catheterisation at the BRHSC. The findings[272] were that at the time of initial diagnosis, 45% responded that they did get support from the hospital source, 53% did not, and of those who did not get support, 25% said they would have liked it. Counsel to the Inquiry asked whether the document painted a picture of parents who, in 1993, were still not gaining access to, or were not aware of, the support that Mrs Vegoda could give them within the BRHSC.

213 She replied:

> 'Clearly it must do, and I can only surmise, looking back at this stage, that that could have been for a number of reasons. It could be that there were some families

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[267] T47 p. 146 Mrs Vegoda
[268] HAA 0138 0006; BRHSC and BRI *'Annual Report',* 1987
[269] WIT 0120 0230 Mr Wisheart
[270] WIT 0192 0246 Mrs Vegoda
[271] WIT 0192 0065 Mrs Vegoda
[272] WIT 0192 0072 Mrs Vegoda

> who had not been to Bristol before and either were not aware that I existed or possibly were sent a leaflet and did not take particular note of it. There may have been other reasons, but, yes, clearly there were families who were not aware.'[273]

214 The study recommended[274] that professionals and families be made more aware of the counsellor, that information be posted at the BRHSC, and that the availability of counselling should be more widely advertised. In evidence, Mrs Vegoda spoke again about the need for her to be proactive. She said:

> 'I have to say that most of the impetus [in advertising the post] would have been left to me. I had to be very proactive about finding ways in which health professionals or parents or voluntary organisations knew about my existence, and I do certainly remember feeling slightly overwhelmed by the fact that the South West was a very large area … I was very aware that there was not necessarily a consistent structure by which I could make sure that all GPs or all health visitors, for example, knew that my post existed. That actually felt rather overwhelming, outside my grasp.'[275]

215 Parents commented on the support they received from Mrs Vegoda whilst at the UBH/T.

216 Jayne and Richard Leonard, parents of Katie:

> 'We do recall that Helen Vegoda, a Cardiac Counsellor at BCH, came to see us to help with anything she could. She advised us on reading material and made it quite clear that she was always available for chats if we felt we needed to speak to her.'[276]

217 Amanda Evans, mother of Joshua:

> 'Helen Vegoda … talked about the hospital in very positive terms, and gave us confidence in the establishment. She helped us to sort out some forms, and went through various details of our stay with us. She said that, if we needed anyone, she was there for us.'[277]

218 Another parent stated:

> I found [Helen Vegoda] extremely patronising and not at all supportive.'[278]

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[273] T47 p. 141 Mrs Vegoda

[274] WIT 0192 0078 Mrs Vegoda

[275] T47 p. 142–3 Mrs Vegoda

[276] WIT 0367 0004 – 0005 Jayne and Richard Leonard

[277] WIT 0417 0009 Amanda Evans

[278] WIT 0408 0007. This parent was one of a number of parents who gave a witness statement to the Inquiry and gave only partial consent to publication of the statement, as they did not wish to be publicly identified

219 Marie Edwards, mother of Jazmine:

> 'I found her extremely irritating, patronising and unhelpful.'[279]

220 Kenneth and Susan Darbyshire, parents of Oliver:

> 'Helen Vegoda … was there from day one giving us moral support at all times. Also she would do the ward rounds with the doctors, every single morning, Monday to Friday. She had this uncanny knack of always popping up when parents were feeling stressed out. She was a real tower of strength to all the heart baby parents.'[280]

221 Alison Leeming, mother of Jamie:

> 'We also met Helen Vegoda who we thought was an excellent counsellor and a lovely woman.'[281]

222 Michelle Cummings, mother of Charlotte:

> 'Helen Vegoda was available at all critical times throughout Charlotte's stay in the BRI and the Bristol Children's Hospital … her support and assistance and comfort were tremendous.'[282]

223 Robert Briggs, father of Laura:

> '… she was helpful. One thing she did was to arrange for us to meet with the parent of a child who had had similar surgery and who had come through successfully, and again this was reassuring to us.'[283]

224 Robert Langston, father of Oliver:

> 'On the day that Oliver died, Helen Vegoda was there for us all the time. She was brilliant all the way through. She helped me get everything in perspective, and also helped us practically with things like arranging the death certificate.'[284]

225 Many parents commented positively about Mrs Vegoda's cards and telephone calls after they had left the hospital(s).[285]

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[279] WIT 0414 0008 Marie Edwards

[280] WIT 0125 0006 Kenneth Darbyshire

[281] WIT 0537 0004 Alison Leeming

[282] WIT 0123 0025 Michelle Cummings

[283] WIT 0136 0004 Robert Briggs

[284] WIT 0184 0012 Robert Langston

[285] See, for example, Tracey Morgan, mother of Daniel, WIT 0288 0011 and Alison Havenhand, mother of Victoria, WIT 0244 0014

226 Lynne Lloyd, mother of Kate:

> ‘Helen Vegoda … sent me a “Thinking of You” card for the next five years on Kate’s birthday and the anniversary of her death. I found this very comforting.’[286]

227 Paul Bradley, father of Bethan:

> ‘Helen Vegoda kept in regular contact with us … For several years, she remembered to send a card on the anniversary of Bethan’s death. She also invited us to a Heart Children’s Remembrance Service held once a year. This was deeply appreciated.’[287]

Helen Stratton

Background to the appointment

228 Dr Joffe stated to the Inquiry that a year or two after the appointment of Mrs Vegoda:

> ‘… it became clear that the overall service was insufficient for the demand with, I believe, the split site proving a barrier to full communication with the BRI. The Heart Circle, once more, gave financial assistance for a second cardiac counsellor post, based at the BRI, and Ms Helen Stratton was appointed and commenced service in January 1991. I was not involved in the development of this post.’[288]

229 Ms Wiltshire told the Inquiry:

> ‘In 1990 the full-time chaplain [Michael Jarvie] was covering numerous hospitals. It was felt that we needed one full-time member of staff designated solely to the cardiac unit who had time to liaise with parents. I spent a considerable amount of time with Jean Pratten (South West Heart Circle) in setting up this post and was included in the interview panel. The post was partly funded by the Southwest Heart Circle and partly by the hospital. We employed Helen Stratton in October 1990.’[289]

Qualifications

230 Miss Stratton informed the Inquiry that she qualified as a registered nurse in 1982, working in intensive care and accident and emergency, and studied for the ENB course in intensive care at the BRI in 1986–1987 following which she began work at the BRI in the Accident and Emergency Department. In late 1988 she was appointed

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[286] WIT 0225 0011 Lynne Lloyd

[287] WIT 0229 0023 Paul Bradley

[288] WIT 0097 0316 Dr Joffe

[289] WIT 0330 0028 Ms Wiltshire

Regional Transplant Co-ordinator for the South West, based at the Renal Unit at Southmead Hospital, a post which she held for two years.[290]

231 She told the Inquiry that she had no professional qualification in dealing with bereavement:

> 'I had experience as a nurse of dealing with bereaved relatives, but no professional qualifications.'[291]

232 Asked whether she had any training in counselling she said:

> 'Not official, formal training, no. My understanding was that it was not part of the criteria for this particular job.'[292]

Miss Stratton stated that her post, as advertised, did not require the holder to be a registered sick children's nurse nor even a nurse, although a nursing background was said to be advantageous.[293]

Funding and employment status

233 Miss Stratton said that she saw Mrs Pratten as her 'boss', who had appointed her to the post, and thought that she was paid through the UBH/T simply for administrative purposes.[294] She said:

> 'I perceived that Jean Pratten, the Chairman of the Heart Circle, was my boss, as the Heart Circle were paying my salary, or funding the post, so I saw her as someone to refer to as a reference. I do remember having a discussion with her that she did not feel it was appropriate for me to have the senior nurse on the cardiac unit as my direct report because I was not actually nursing patients or children, I was not clinical hands-on. So that might have been inappropriate. But I think, suffice to say, it was quite unclear, apart from my perception of it being Jean Pratten because the Heart Circle were paying my salary and for day-to-day things going on the unit, I would probably refer to Fiona Thomas, or Julia Thomas in the beginning of my job, but I cannot remember that ever being formalised. That was just something that I did.'[295]

234 However, Mrs Pratten stressed:

> '… whereas her post was funded by the Heart Circle, she was not at any time employed by the Heart Circle nor regarded as an employee of the Heart Circle …

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[290] WIT 0256 0001 Miss Stratton

[291] T46 p. 35 Miss Stratton

[292] T46 p. 35 Miss Stratton

[293] WIT 0256 0002 Miss Stratton

[294] T46 p. 38–9 Miss Stratton

[295] T46 p. 38 Miss Stratton

> she would have been employed by the NHS Trust, and all employment responsibilities and duties lay with the Trust.'[296]

Appointment

235 As to her reasons for applying for the post, Miss Stratton said:

> 'I had worked with distressed and bereaved relatives, and I wanted to develop my career in another area.
>
> 'When I saw the advert for the new cardiac liaison post at the BRI, I thought this was a good opportunity to use my clinical background and to gain an insight into working for a charity.'[297]

236 Helen Stratton was appointed as Cardiac Liaison Nurse in October 1990, and took up the post in November 1990.

237 In her written statement Miss Stratton told the Inquiry that she did not know whether Mrs Vegoda had been made aware of her role before her appointment:

> '… I am unclear as to whether this new role had been discussed with her prior to my appointment. At my interview I was told that there was a paediatric counsellor at the BCH and I did not know that she was specifically a cardiac children's counsellor until after I was appointed and went to the BCH to meet the cardiac nursing staff. I met Helen Vegoda and had thought that she covered the whole of the BCH. It was only then that I discovered that she only covered the cardiac children and parents. She seemed quite defensive and questioned me about what exactly I would be doing. In retrospect she may have felt threatened by my appointment, and both she and I were somewhat confused by our respective roles and where the boundaries of these lay.'[298]

238 She subsequently told the Inquiry:

> '… when I met Helen Vegoda, she probably did not have an accurate understanding of what my role was going to be, and I perhaps had a misperception of what her role was at the time. I was told there was a counsellor at the Children's Hospital who looked after the parents before I commenced the job …'[299]

239 By contrast, Mrs Vegoda told the Inquiry of various discussions she had with Miss Stratton prior to Miss Stratton's appointment. She said:

> 'I cannot remember the details of our conversations. I do remember that Helen Stratton contacted me. I did not know her. She contacted me because she had

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[296] WIT 0256 0106 Mrs Pratten

[297] WIT 0256 0001 Miss Stratton

[298] WIT 0256 0005 Miss Stratton

[299] T46 p. 44–5 Miss Stratton

> either seen the job advert, or I am not even sure it was not before the job advert came out, and she wanted to talk about my role and she wanted to know about cardiac services in the Children's Hospital generally and on Ward 5.
>
> 'I cannot remember whether we talked very specifically about how the two posts would marry together, but I do know that we met, I think, a few times and we also talked about her actual interview and the areas that she might be asked questions on.'[300]

She stated in her written evidence:

> 'Helen Stratton first contacted me in July 1990 and there are several entries in my diary for June, July, September and October 1990 referring to meetings or contact with her, all prior to her interview and taking up her post … Helen Stratton would therefore have been fully aware of my role in BCH/BRI with cardiac children and their families. I welcomed Helen Stratton's selection for interview, gave her support prior to this, and was enthusiastic about her appointment.'[301]

240 Miss Stratton was referred to Mrs Vegoda's diary that had an entry for 20 July 1990:[302] '11:30, Helen Stratton'. Miss Stratton's evidence included the following exchange:

> 'Q. Did you speak to her by phone before you took that appointment?
>
> 'A. I cannot recall meeting her, and I cannot recall a phone call.
>
> 'Q. She says it happened. Is that probably right?
>
> 'A. I cannot comment. I cannot remember it.
>
> 'Q. The next diary extract that she gives us, she tells us that she spoke to you or saw you before October … "1:00pm. Helen S in room" … So very shortly after, if you began on the Monday, which you might have done, two days later, did you, do you think, meet Helen Vegoda?
>
> 'A. Yes, probably, because I probably thought it was important that we had an opportunity to discuss our roles'.[303]

241 Although Mrs Vegoda had asked whether she could assist in preparing Miss Stratton's job description or sit in on her interview, she was told that this was neither appropriate nor possible.[304] She said that she was not formally consulted about the creation of

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[300] T47 p. 121 Mrs Vegoda

[301] WIT 0256 0015 Mrs Vegoda

[302] WIT 0256 0016 Mrs Vegoda

[303] T46 p. 80–1 Miss Stratton

[304] T47 p. 123 Mrs Vegoda was unable to confirm, for certain, who told her it was inappropriate

Miss Stratton's post or about her appointment, but when she became aware that the post was being set up she was both surprised and concerned:

> 'I asked to see Jean Pratten because I was concerned. I felt quite confused and I did not quite understand what was going on. I went to see Jean, she was very clear that this post was going to be based on Ward 5. The person appointed would have a nursing background, and therefore the two posts would complement one another, but we would be doing very different jobs, on different bases and with different professional backgrounds. I was very satisfied with that.'[305]

242 On that basis Mrs Vegoda said:

> '… there was no question in my mind that there would be any difficulty about the post marrying in.'[306]

Role

243 The Inquiry heard different interpretations of Miss Stratton's role and particularly whether she was to work only at the BRI, or to work at the BRI and the BRHSC.

244 Dr Joffe referred to Miss Stratton as the:

> '… second cardiac counsellor … based at the BRI.'[307]

245 Mrs Vegoda had understood Miss Stratton's role to be 'based at' the BRI. Miss Stratton said:

> '… I got the impression that Helen Vegoda felt that my role was based at the Bristol Royal Infirmary and was not to be at the Bristol Children's Hospital at all, and that was a problem.'[308]

246 Further, Miss Stratton spoke of a general perception that her role would be the same as that of Mrs Vegoda, but at the BRI. She said:

> 'I think there was a perception and I obviously feel wrongly, that I would do the same role that Helen Vegoda did at the Children's Hospital at the Bristol Royal Infirmary. This was an underlying perception that I gradually over months and years realised that people had.'[309]

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[305] T47 p. 118–19 Mrs Vegoda
[306] T47 p. 123 Mrs Vegoda
[307] WIT 0097 0316 Dr Joffe
[308] T46 p. 45 Miss Stratton
[309] T46 p. 89 Miss Stratton

247 However, Mrs Pratten envisaged that Miss Stratton's role would involve attending at the BRHSC. She told the Inquiry that when Miss Stratton's post was created:

> 'It was supposed to be a cardiac liaison post, a Sister post, to liaise between the community and the unit, and to enable parents to liaise with her, so that they had somebody to whom they could turn … it was hoped originally that she could have gone to the outpatients appointment prior to surgery, but that did not work out because it was in the Children's Hospital and I do not think she was made very welcome.'[310]

248 Miss Stratton told the Inquiry that she believed she had had a formal job description but did not have it nor did she recall exactly what it had said.[311] She told the Inquiry that she had not, until she gave evidence, seen the description of the respective roles of Mrs Vegoda and herself as set out in the *'Annual Report'* for the BRI and BRHSC for 1989:

> 'The nursing team on Ward 5 now includes about 75 nurses … supported by Mrs Helen Vegoda, Counsellor to the families of the children and Miss Helen Stratton who has a similar but wider counselling role supporting any families in need and also the staff.'[312]

249 Asked whether there was uncertainty or lack of definition in the role that she was expected to do, Miss Stratton said:

> 'Yes. I clearly had a perception and I had my brief from Jean Pratten of what she wanted. But, you know, in hindsight, I would say that the hospital, the Bristol Royal Infirmary and the staff there, did not have the same perception. Whether that was a communication issue, I cannot be sure.'[313]

250 Miss Stratton was referred to a sample of a standard letter that she sent to parents that described her as a 'Support Nurse Specialist'. In the letter she describes her job as giving: '… any support and advice you may need regarding your child's operation and your stay in Ward 5.'[314] She said:

> 'At the beginning of my job I was Support Nurse Specialist and by the time I had been there a few months it was decided, because of the grading of the post and things, that I should be called Cardiac Liaison Sister.'[315]

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[310] T47 p. 14 Mrs Pratten

[311] T46 p. 36 Miss Stratton

[312] UBHT 0167 0076; BRHSC and BRI *'Annual Report'*, 1989

[313] T46 p. 85 Miss Stratton

[314] WIT 0074 0589; T46 p. 83 Miss Stratton. See also the report from the Secretary of the Heart Circle which refers to the appointment of Miss Stratton as the 'Support Nurse Specialist', who was to help families to understand the medical aspects of their child's problem, as well as undertaking research into the needs of families on Ward 5; UBHT 0213 0016, May 1991

[315] T46 p. 84 Miss Stratton

251 In the letter she describes Mrs Vegoda's role as that of a 'Family Support Worker'. She said:

> 'At the beginning of my job, I thought that was her title. Then she was called the "paediatric counsellor"…'[316]

252 Miss Stratton stated that her role was broad and included working with the Heart Circle in fund-raising activities and attending meetings in the regions which covered the South West.

> 'My understanding of the role was to bring together the BCH paediatric/cardiac activities with those of the BRI. The aim was to ensure the smooth transition for parents and children from the BCH to the BRI. This would include corresponding with the child's health visitor and/or GP. I also had to ensure that parents had accommodation and had practical information on the child's admission to the BRI and their forthcoming stay. This would include advice on transport … I would work in a very practical way with the parents … My understanding was that I was there to support the parents so that when the child was in surgery or in intensive care the liaison nurse could spend time explaining for example why the child was on a ventilator and what the lines were for, and the reason for sedation. The nurses caring for the child often did not have the time to spend with the parents and explain at length what was happening'.[317]

253 Miss Stratton explained how she approached parents:

> 'At the beginning of every month I would get a theatre list with all the adult and children's names on it along with the referring GP. I would write to the parents and introduce myself and say that they may have met Helen Vegoda at the BCH and that my role was to provide support and care while they were at the BRI, in conjunction with Helen Vegoda. I would tell them that I was employed by the Heart Circle.'[318]

254 In relation to bereavement she stated:

> 'Where a child died, I would notify the Health Visitor and would tell them how the parents had reacted and their plans for returning home.'[319]

255 She said:

> '… I kept a red book with patients' names and addresses, the name of the health visitor, how often I had spoken to the health visitor, the name of the GP and other information like whether I had referred the family to the social worker … had the

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[316] T46 p. 85 Miss Stratton

[317] WIT 0256 0002 Miss Stratton

[318] WIT 0256 0008 Miss Stratton

[319] WIT 0256 0008 Miss Stratton

> parents received any support from the social worker and had they received any financial support from the Heart Circle …
>
> 'It had the date of the operation, the date the child was extubated or taken off the ventilator, the date they were moved through to the nursery, the date they went home and the date they died …'[320]

256 In her written evidence, Helen Stratton said in her first year at the BRI:

> 'I discussed with Jean [Pratten] and some of the senior nurses the idea of taking a hand or footprint of the baby or a lock of hair from a baby that had died. The parents could take this away or I would send this to them when they were ready to receive it. Sometimes they would ask for this six months later. The Heart Circle bought a Polaroid camera and I would take a photo of the baby in a Moses basket which again the parents could take away or ask for later. Appropriate cards were purchased by the Heart Circle to place the hair or photo or print in.'[321]

Development of Helen Stratton's role

257 Miss Stratton stated that her role was evolving. She continued to go to Great Ormond Street to establish links with Mary Goodwin, whom she described as carrying out a similar role to her:

> '… and to look at what improvements I could bring to BRI. During my visits to GOS [Hospital] I met with a number of paediatric cardiac nurses of all levels and we decided that it would be beneficial to set up a forum for paediatric cardiac nurses to come together to share ideas and information. It was envisaged that nurses from all over the UK in this speciality would want to join. We had nurses from Birmingham, Liverpool, Ireland, the Brompton, Newcastle, etc. I saw this as an ideal opportunity for the nurses at both the BCH and the BRI to exchange experiences and ideas. The group was called the Paediatric Cardiac Nurses Association. I became the Secretary and wrote the monthly newsletter. We also managed to get a nursing session tagged onto the paediatric/cardiology conference held annually at the Brompton [Hospital]. I took part in getting an agenda together and got Freda Gardner to speak about her research. Martin Elliott, a Consultant Paediatric Cardiac Surgeon [at GOS] came along to talk. I encouraged nurses at both the BRI and the BCH to join so that they could make a contribution and learn from other centres. One sister from the BRI joined and I think that 3–4 of the staff nurses joined from BRI. The nurses at the BCH thought this was a brilliant idea but most of them already belonged to paediatric associations and as they were not solely cardiac paediatric nurses they did not feel it was a priority.'[322]

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[320] T46 p. 161 Miss Stratton

[321] WIT 0256 0007 – 0008 Miss Stratton

[322] WIT 0256 0006 Miss Stratton

> ‘Another initiative that I brought back from GOS was the idea of parents going to theatre with the child if they wanted. Before I arrived I think they could go down as far as the door of the theatre … I wanted the parents to have the choice of coming into the anaesthetic room … From then on I always offered this as a choice to the parents …
>
> ‘Another idea I implemented was that the older children could paint their theatre gown prior to the operation and get the surgeon, anaesthetist and nurses to sign this for them to take it home …
>
> ‘I had come across a book at GOS called *“Heart Children”* … which had concise and easy to understand explanations of commonest cardiac conditions with diagrams.’ [323]

258 Miss Stratton arranged via the Heart Circle for copies of this book to be made available to parents. She said:

> ‘… I was evolving a job given what was happening at Great Ormond Street, but I think in a typical nursing fashion, I was trying to fill gaps where I thought there were gaps in the provision of looking after parents and children at the Royal Infirmary. So if I felt it was appropriate to talk to parents on the unit, I would do that. So it was rather unstructured to start with, because I did not have an awful lot of guidance, apart from what I was learning at Great Ormond Street, to go on.’[324]

259 She also took on a role that was not performed by Ms Goodwin at GOS. She told the Inquiry that Ms Goodwin did not, as a general rule, make herself available to parents during and after surgery. Miss Stratton said:

> ‘I think what happened is that whilst I tried incredibly hard to do the liaison job, the job that I had been tasked with doing, I found that I was filling gaps and doing things that Mary Goodwin did not do, but just because there was a need and someone had to meet that need.’[325]

260 She informed the Inquiry that in her second year she wrote and published an information pack for parents which outlined the process for admission to the BRI for surgery, providing details of accommodation, useful telephone numbers and what would take place during the pre-surgery preparation. She also produced a leaflet for bereaved parents providing the name of Mrs Kennington together with useful telephone numbers and information.[326]

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[323] WIT 0256 0006 – 0007 Miss Stratton

[324] T46 p. 50–1 Miss Stratton

[325] T46 p. 52 Miss Stratton

[326] WIT 0256 0009 Miss Stratton

261 Miss Stratton spoke of her role in supporting staff:

> ‘I suppose quite early on when I was evolving the post, I thought it would be helpful, given the high levels of stress that nurses were experiencing on the unit, to give them the opportunity to have half an hour or forty-five minutes where they could discuss those concerns and although it was never, although I cannot recall, but I cannot remember it ever being pointed out as a large part of the job, I felt that by supporting the nurses they in turn would be able to support the parents more effectively, and some would argue that I took on a role that … was not part of my initial job, but it was important because I had empathy with the nurses who were giving extremely good care in sometimes almost impossible conditions.’[327]

262 Miss Stratton stated:

> ‘Two Sisters at BCH … had become tutors for an ENB course in paediatric intensive care. They asked me to speak on the role of supporting parents to nurses who were doing the course. The nurses at BCH were always receptive to my role and ideas throughout my time as a liaison nurse. They were more receptive to change and new ideas than the nurses at the BRI. The senior nurses at the BRI tended to have a perception that a suggestion for change was a personal criticism of what they were already doing.’[328]

263 Miss Stratton stated that in the third year she was in post she:

> ‘… organised a cardiac study day sponsored by the Heart Circle for all nurses involved with cardiac patients …’[329]

264 Miss Stratton said:

> ‘… I was also aware that there was this cavern between the nurses at the BRI and the nurses at the Children’s Hospital and I wanted in some small way to see how that could be improved, whether that was through communication, whether that was through going to the Children’s Hospital and speaking with people informally, and setting up the Paediatric Cardiac Nurses’ Association, which I did whilst I was there as well.’

She continued:

> ‘I think there were territorial issues in as much as if I suggested that perhaps somebody came down to Ward 5 from the Children’s Hospital to spend some time down there with the nurses, there was a sort of, “Oh, no, you have got adults down there” and, you know, “No, we do not want to go down there”. And vice versa, the

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[327] T46 p. 167–8 Miss Stratton

[328] WIT 0256 0013 Miss Stratton

[329] WIT 0256 0012 Miss Stratton

> children's nurses on the BRI unit did not want to go up to the Children's Hospital because "No, they do not understand what we are doing down here".
>
> 'So I thought that was quite sad, really, and there was very much, "This is my territory. Why would I want to go up to the Children's Hospital to find out what they were doing up there?"'[330]

Communication between Helen Stratton and others

265 Miss Stratton described some of the initiatives she took:

> 'I set up a strong link with the social work department at the BRI which was mirroring the set-up at GOS. I met with Sarah Appleton, the social worker who was assigned to the cardiac unit and discussed my role. We worked well together … We decided to meet once a week to discuss parents/children who were either on the unit or were likely to come in … This link worked extremely well and she developed a rapport with the social worker at the BCH which enhanced the service we could deliver.'[331]

266 Miss Stratton expressed concern at the amount of time the social worker was able to give to Ward 5. She said that Ms Appleton was only allocated five hours a week to the unit to respond to the needs of children and adults:

> 'I did express my concerns to Fiona Thomas, who was also very concerned that the social worker was given five hours for the unit … I know for Sarah, that she was incredibly stretched and I certainly would not have asked her for more hours because she just did not have that time to give me.'[332]

267 Miss Stratton stated that in her second year:

> 'I had also started to arrange support meetings for the theatre and intensive care nurses at the BRI giving them an opportunity to talk about how difficult and upsetting it was for them to look after a child that had died. Sarah the social worker came to facilitate the meetings and the Chaplain sometimes came along as well … The feedback that I had was that the meetings were very helpful and allowed them to offload before going home.'[333]

Issues of 'territory' between Helen Vegoda and Helen Stratton

268 A number of witnesses commented on the way Mrs Vegoda and Miss Stratton appeared to relate to each other.

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[330] T46 p. 96–7 Miss Stratton

[331] WIT 0256 0005 – 0006 Miss Stratton

[332] T46 p. 58 Miss Stratton

[333] WIT 0256 0010 Miss Stratton

269 Ms Joyce Woodcraft, Senior Sister BRHSC ICU 1985–1994, said:

> 'I do not think the relationship between the two counsellors over the years was particularly warm, although I do not believe that this had an adverse impact on the information or support given to the parents.'[334]

270 However, Mrs Pratten told the Inquiry:

> 'It was clear soon after the appointment of Helen Stratton that the two support positions did not function in a complementary manner and neither post, therefore, fulfilled its full potential. This was exacerbated by the problems of the split site with different managements and a general lack of co-operation.'[335]

271 Sheila Forsythe, mother of Andrew, described how she perceived the relationship between Mrs Vegoda and Miss Stratton:

> 'I had a professional relationship with Helen Vegoda. I felt that parents either liked or disliked her – there were no half measures. At a later date Helen Stratton was appointed as a cardiac nurse. My understanding was that Helen Vegoda would deal with the parents in the Bristol Children's Hospital when they were to be counselled or diagnosed of their child's cardiac defect and Helen Stratton would deal with them in the BRI. When questions of a practical day-to-day medical nursing nature could be answered I was aware that there was tension between Helen Vegoda and Helen Stratton but equally I was not aware that this affected the care the parents received.'[336]

272 However, David Charlton, father of Hannah, spoke of meeting both Mrs Vegoda and Miss Stratton. He stated:

> 'We felt that we were into "territory issues" between them.'[337]

273 Miss Stratton was asked in evidence whether she and Helen Vegoda disagreed as to what their respective roles should be: 'I think so. I mean, we never discussed it in detail.' But she continued: 'It never affected our professional relationship that we had differences.'[338]

274 One point of difference between Mrs Vegoda and Miss Stratton was Miss Stratton's wish to attend the BRHSC so as to provide support to parents at the time of diagnosis.

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[334] WIT 0121 0006 Ms Woodcraft

[335] WIT 0269 0005 Mrs Pratten

[336] WIT 0515 0006 – 0007 Sheila Forsythe

[337] WIT 0539 0008 David Charlton

[338] T46 p. 46 Miss Stratton

275 Miss Stratton stated that following meetings at GOS with Ms Goodwin and others:

> '… I think the key thing that came across for me was that I should meet the parents at the earliest possible stage, either when they were meeting the cardiologist at the BCH, or when they saw the surgeon at the BCH.'[339]
>
> 'I also discussed this with Helen Vegoda and she did express some concern as she felt that this was quite a large part of her role. I was quite surprised at this, as I thought there were some clinical aspects which could arise from the meeting that she would not be in a position to explain. For example, if the cardiologist or surgeon had used language or referred to procedures that the parents did not understand, then I felt I would be in a better position to be able to explain this to them.'[340]

276 When Miss Stratton began to go to the BRHSC:

> '… Helen Vegoda asked me what I was doing there. I had discovered that she was not happy about my appointment as she felt that care of the parents on both sites had been part of her role.'[341]

277 Mrs Vegoda said that the fact that Miss Stratton envisaged that her role would involve regular attendance at the BRHSC was not discussed formally with her:

> 'I actually went down to outpatients one day and she was actually there, and I remembered being very confused about why she was there and why she had not said she was going to be there. There were other instances that happened where I understood from nursing staff that she had come up to the ward of the Children's Hospital to see families, or … to look at notes.
>
> 'Although we did have meetings, I tried to clarify and to raise this issue, and somehow it just was not possible to do that. It did not seem possible to have a discussion as to, you know, why she had been in outpatients and her involvement with the Children's Hospital.'[342]

278 In her written statement, Mrs Vegoda stated:

> 'I became aware of a video produced by the Heart Circle which was made available to families prior to their attendance at the BRI hospital. I was advised that the video related to Ward 5 only. I was concerned when Helen Stratton indicated on the video that she would be available to parents from the point of diagnosis to the time the family left the hospital. This was factually incorrect.'[343]

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[339] WIT 0256 0003 Miss Stratton

[340] WIT 0256 0003 Miss Stratton

[341] WIT 0256 0004 Miss Stratton

[342] T47 p. 123–4 Mrs Vegoda

[343] WIT 0192 0249 Mrs Vegoda

279 Mrs Vegoda agreed that it would have been helpful to have a cardiac liaison nurse available to families at the BRHSC, but said:

> 'I think that the difficulty was that there was a gradual breaking down of communication between Helen and myself at a point where it was not possible to discuss how our two roles were merged … I had no idea, in fact, until her statement [to the Inquiry] came out or I sat in on the Inquiry, that she saw that as part of her role and that she was very unhappy about the way in which her role was perceived. Somehow it was not possible to sit down and say, "Well, yes, that makes sense, that you sit in outpatients, so maybe we sit together, or you refer families to me". The communication was not there. I found it increasingly very difficult and very stressful.'[344]

280 Mrs Vegoda stated in her written evidence:

> 'In 1990 Helen Stratton was appointed as cardiac liaison sister and was based at the Bristol Royal Infirmary until she left in 1993. As a qualified and experienced nurse, Helen's role was focused on information, support and counselling to families in respect of the child's condition, diagnosis and prognosis whilst at the BRI.'[345]

She stated that following Miss Stratton's appointment, she [Mrs Vegoda] spent most of her time in the BRHSC unless she was asked to visit families in the BRI. She and Miss Stratton would hand over counselling roles when the child was transferred from one hospital to the other.[346]

281 She estimated that prior to Miss Stratton's appointment she would go to Ward 5 at the BRI approximately twice and sometimes three times per day. Asked whether she thought that Miss Stratton, or someone in Miss Stratton's post, by taking over her work at the BRI, was diminishing or reducing the importance of her role, she said:

> 'No, I really did not. I was very aware that first of all I felt being in two places, it was very far from ideal. I was very aware that I could not work on Ward 5 in the way that I liked working with families in the Children's Hospital, which was a mixture of quite a formal approach with just saying, "This is my room, if you want to come and knock on the door, you are welcome".
>
> 'I also felt that I did not have the background to help families with the information and I felt that it needed somebody down there, apart from the fact that I was very busy and it was quite difficult trying to meet the needs of families down on Ward 5 because of open-heart surgery, which was a very, very stressful time, and obviously

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[344] T47 p. 124–5 Mrs Vegoda

[345] WIT 0192 0004 Mrs Vegoda

[346] WIT 0192 0004 Mrs Vegoda

> bereavements as well, dealing with the families at the BRHSC. I welcomed that post.[347]
>
> 'My understanding of her post was that she was I thought an experienced, qualified nurse; that she would be based down on Ward 5; that she would be there to both support the parents at the time when the child entered Ward 5, just pre-operatively, and would be there to keep them informed about the child's medical condition or could be a contact with medical staff, nursing staff. I was not particularly aware of the liaison role with GPs and health visitors routinely.'[348]

282 Mrs Vegoda said that she had not been aware, until Miss Stratton gave evidence to the Inquiry, that Miss Stratton had felt that her appearance at the BRHSC was seen as encroaching on or threatening Mrs Vegoda's role:

> 'I can only say that it is with great sadness, because I feel that we were not able to communicate but we could have been mutually supportive, had that been the case, but her way of behaving with me was just very, very undermining, and I could not deal with that …
>
> 'I am not suggesting that her work with the families was not, but her actual professional relationship with me, her personal relationship with me, was I think bordering on not being professional, and I think it was more than cold.'[349]

283 Mrs Vegoda prepared a note in 1991[350] for an informal meeting with Mrs Vass, entitled 'Areas of Concern'.[351] This note lists concerns about her relationship with Miss Stratton, such as:

> 'Being told it was inappropriate for me to visit a family on Ward 5 whom I knew longer than her …
>
> 'Not wanting me to know that she was on holiday, and asking that this information be withheld from me.
>
> 'Talking to staff on the Ward about not thinking it appropriate that I visit Ward 5.
>
> 'Refusing to discuss differences or points of disagreement, and cancelling our arranged weekly meetings on several occasions at the last moment by getting someone else to say that she was not available when in fact she was.
>
> 'Lack of communication about families at the unit whom I knew …

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[347] T47 p. 120 Mrs Vegoda

[348] T47 p. 122 Mrs Vegoda

[349] T47 p. 133–4 Mrs Vegoda

[350] The note was not dated and the precise date is not known

[351] WIT 0192 0248 and WIT 0192 0250 Mrs Vegoda

> ‘Not communicating about the progress or welfare of children or important information regarding dates of operation even though it had been agreed that she would.
>
> ‘Lack of communication on her research, or her role in setting up a support group for nurses on ITU at the BCH.
>
> ‘Not replying to notes referring to patients visiting Ward 5.’

Meeting on 9 January 1992

284 As a result of the perceived differences in roles, and of working difficulties, discussions were held in an attempt to resolve the position. Evidence to the Inquiry focused on a meeting on 9 January 1992 that resulted in a separation and delineation of the two roles.

285 Miss Stratton said:

> ‘I did express concerns [prior to the meeting] that I had a problem accepting that Helen Vegoda, who had a very different role to mine in my perception, was doing a job at the Children’s Hospital which, for some reason, did not allow her to come and do that job at the Bristol Royal Infirmary …
>
> ‘I had this slightly idealistic view that both our roles, in my perception of what they were, could have worked very well together if she had carried out her role at the Children’s Hospital and at the Bristol Royal Infirmary, and I had carried out my liaison role at the Bristol Royal Infirmary and Children’s Hospital.
>
> ‘But because of the strong feeling that I could not go to the Children’s Hospital and Helen Vegoda could come to the BRI but, I think, as it says here, only to visit families she already was involved with, I found that was an issue.’[352]

286 Mr Wisheart stated:

> ‘The background to this meeting was that Helen Vegoda was established as a paediatric cardiac counsellor in the BRHSC and the BRI. Helen Stratton was newly appointed as a Paediatric Cardiac Liaison Nurse based mainly at the BRI. The two Helens needed to set out how they would work together in order to fulfil their professional responsibilities. Instead, there was a clash of personalities and some polarisation of viewpoint between them. This led to the meeting … the object of which was to help Helen Vegoda and Helen Stratton resolve their differences and reach a working understanding.

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[352] T46 p. 88 Miss Stratton

> ‘It was not my role to reinforce the polarisation by adopting one of the entrenched positions, rather to facilitate the development of a working understanding by supporting *both* counsellors.’[353]

287 Miss Stratton stated:

> ‘Mr Wisheart chaired the meeting. I put forward my understanding of my role and the outcome of my visit to GOS and how I thought it would be beneficial for both of us to work on this as my perception was that my role was very different from her role. I do not recall that there was any support from either Julia [Thomas] or Mr [Wisheart] and I think that they felt that if Helen Vegoda was unhappy with me going to outpatients, then I should not go there … They agreed that things should stay as they were and that I should meet on a weekly basis with Helen Vegoda to discuss the parents and children who were coming to BRI …’[354]

She confirmed that after the meeting they had weekly meetings.[355]

288 She told the Inquiry:

> ‘… I think there were mixed feelings and possibly an indifference to my role which made me quite a weak player in the framework of everything.[356] And I just got the distinct impression that if I had voiced a view or an opinion … [it] would be treated with some indifference or, after my experience of trying to get to go to the Children’s Hospital, where I felt quite strongly I was “put back in my box”, for want of another expression, I was not keen to go down that road again.’[357]

289 Following the meeting, Mrs Vass wrote to Mrs Vegoda and Miss Stratton to review their discussions. The letter is addressed to: ‘Helen Vegoda, Family Support Worker, BCH’ and ‘Helen Stratton, Family Support Worker, BRI’.

The letter said:

> ‘To recap on our discussions to date, the team covering both Ward 5 and the Bristol Royal Hospital for Sick Children … have been aware of a difficulty in achieving smooth free-flow communications and in generally understanding and accepting each others’ roles.
>
> ‘In previous talks we have sought to assist you both in defining your individual roles … It was agreed that Helen Vegoda would only visit families she was already professionally well involved with, on their admission to Ward 5, once, and then “hand over” the supportive care to Helen Stratton. This would be a rigid

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[353] WIT 0256 0110 Mr Wisheart (emphasis in original)

[354] WIT 0256 0004 Miss Stratton

[355] T46 p. 92 Miss Stratton

[356] Commenting on Miss Stratton’s description of herself as a ‘weak player’, Mr Wisheart said: ‘This was not my impression of her as a senior nurse, a sister and an assertive person’; see WIT 0256 0115

[357] T46 p. 77–8 Miss Stratton

> understanding unless the family or either of you felt strongly that it should be otherwise, in which case further visits are acceptable. It was also agreed that Helen Vegoda would not make enquiries regarding families on Ward 5, of the nursing staff, as they found this time consuming, but would speak to Helen Stratton …
>
> 'In return Helen Stratton would do the very same and families transferred to the Bristol Royal Hospital for Sick Children would be "handed over" to Helen Vegoda's care unless any party involved felt strongly that Helen Stratton should continue to visit …
>
> 'Both of you have ample workload in your respective areas. It has been agreed all round that these roles are "similar but extremely different" and because of this, the need for good communication is essential.'[358]

290 This demarcation was agreed, despite the fact that both appeared to agree that there was a role for Miss Stratton at the BRHSC. Mrs Vegoda agreed that it would have been helpful for the Cardiac Liaison Nurse to attend the BRHSC. But she said:

> 'My memory of that period was that the level of non-communication from Helen to myself was really quite extreme and there was also certainly in a sense for me, that I was undervalued professionally and personally … by Helen, and I can only imagine that that solution was because we could not, sadly, work in a joint role together, or actually be together at that period …'[359]

291 Mrs Vegoda said that whilst she and Miss Stratton continued to have weekly meetings, those meetings were probably to discuss families, rather than the greater issue of their inability to work together:

> 'I can only say that it was a gradual breakdown of communication in the sense that Helen seemed to be doing things, arranging meetings, without me being aware of this, and certainly I was completely unaware of the fact that she clearly, from what she was saying yesterday [in evidence to the Inquiry], was under a lot of stress and very confused about and felt very unsupported in the role. We did not look at her role and my role at all. Somehow – I do not want to sound personal because it is maybe not the arena to do that, but I just found her manner to me impossible.'[360]

292 Of the suggestion that their roles were 'similar but extremely different' Mrs Vegoda said:

> 'Helen was a nurse, and I think an extremely experienced nurse, and my background was obviously different. I think there would have been an area in the middle where we would both have had a role in supporting, … "counselling" families. Helen, obviously with her nursing background would have meant she was

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[358] WIT 0192 0110 – 0111; letter dated 14 January 1992 to Mrs Vegoda and Miss Stratton

[359] T47 p. 127 Mrs Vegoda

[360] T47 p. 128 Mrs Vegoda

> there helping families with the medical nursing aspect. I was more on the emotional, psychological side. But in the middle there would have been some common area, for example, maybe perhaps information giving, perhaps an element of liaison with the community, or preparation to go into the community. And the support aspect. So although our jobs were very different, inevitably, because we were dealing with families, there must have been some common ground.'[361]

293 Mr Wisheart stated in his evidence to the Inquiry:

> 'Helen Stratton expresses the view that because her wishes did not prevail at the meeting, the others present had a wish to continue doing things the way that they had always been done. I disagree with that view. Her own appointment was one of the innovative steps we took as the service evolved.'[362]

Support for Helen Stratton

294 Miss Stratton described the room provided to her within the BRI:

> 'I did not have an office when I started my job, and the BRI gave me a linen cupboard which the Heart Circle painted and furnished with a desk and some comfortable chairs for parents to use.'[363]

295 Michael Parsons, father of Mia, referred to the room as:

> '… a small box room which was full of all sorts of stuff and had a small settee. It was effectively a junk room'.[364]

In his evidence to the Inquiry he stated:

> 'The whole sequence of events that had transpired since we had been told of Mia's death was deeply upsetting … there was being placed in a junk room where we were expected to say goodbye to Mia and finally I got the distinct impression that we were being rushed out of the hospital before we were ready to go … I must stress that all this took place in the box room and Mia was still lying in the Moses basket.'[365]

296 Asked whether she found herself being pushed into acting as a counsellor, Miss Stratton said:

> 'I think increasingly it did become that, … My personal definition of counselling is someone who has a professional qualification to carry that out. I recognised I did not have that qualification. That is when I sought advice and help from Dr Gardner

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[361] T47 p. 129 Mrs Vegoda

[362] WIT 0256 0115 Mr Wisheart

[363] WIT 0256 0010 Miss Stratton

[364] WIT 0010 0008 Michael Parsons

[365] WIT 0010 0008 – 0009 Michael Parsons

> as to how I should support, counsel these parents, given that I did not have a mental health background or counselling, and I took advice from her.
>
> '… but there was nobody else to do it, I felt I could not just walk away from that role.'[366]

297 Mrs Pratten stated:

> 'Sister Julia Thomas was responsible for setting up this post with The Heart Circle … After [she] resigned as Nurse Manager, I never felt that the management of the Unit appreciated the importance of the post of Liaison Sister, and with voluntary funding considered the post to be supernumerary. They did not give Helen Stratton the support she needed in such a demanding and emotionally draining position. Helen was on call for parents almost twenty-four hours a day and she also gave support to the nursing staff.'[367]

298 Miss Stratton told the Inquiry of her meetings with Mrs Pratten:

> 'I used to meet with her two or three times a week at her house and we would sit and discuss issues, but we never had minutes or a formal agenda …'[368]

299 She stated that she began to be concerned both about the time that children spent in the operating theatre and in intensive care,[369] and about the hours that she was working:

> 'I also found I was spending an increasing amount of time dealing with bereaved parents and I asked Mary Goodwin [from Great Ormond Street] how she coped with dealing with bereaved parents on such a regular basis and in particular working late into the evening. I told Mary that I would start a shift at 7.30 am going down to the theatre with the parents and often be there until as late as 11.00 pm waiting for the child to come back from theatre.'[370]

300 She compared her role with that of Ms Goodwin and of Susie Hutchinson, the Cardiac Liaison Nurse at Birmingham Children's Hospital:

> 'Neither … went with the parents to surgery on a regular basis and did not consider it their role to be there when the child returned. Both of them told me that children with similar operations in their units would be back at lunchtime or early afternoon in their hospitals … Both Susie and Mary could call on a strong multi-disciplinary team for support. This included a dedicated accommodation officer, social worker and psychiatric support if necessary.'[371]

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[366] T46 p. 53–4 Miss Stratton

[367] WIT 0269 0004 Mrs Pratten

[368] T46 p. 155 Miss Stratton

[369] See paras 301 and 306 for details of Miss Stratton's concerns about the paediatric cardiac surgical service

[370] WIT 0256 0010 Miss Stratton

[371] WIT 0256 0011 Miss Stratton

301 She stated:

> 'The switch programme started in early 1992. I cannot be precise about the date.[372] It was a combination of the deaths from this programme together with the other concerns that led me to ask Jean [Pratten] if Dr Freda Gardner could supervise my work, help me cope with the extreme exposure to distressed parents, and also help me manage my time better. I think I was beginning to feel out of my depth in my ability to deal on such a regular basis with distressed parents and other demands on the unit. Freda said that I couldn't spend my time seeing distressed parents all day every day because that made me less effective. She pointed out to me that my role was not that of a psychologist or of a bereavement counsellor but that's what I seemed to be spending the majority of my time doing.'[373]

302 Of the support she received from Dr Gardner[374] she said:

> 'I sought supervision from Dr Gardner, in essence because, without a counselling qualification, I felt that I was dealing with often situations that I was unqualified to deal with, and whilst there was nobody else to do it, I went to her for advice and support. I felt, along with trying to support the theatre nurses and the nurses on the unit, I needed to have some support myself.'[375]
>
> 'She helped me in coping … both by giving me advice on how to deal with parents who were extremely distressed, but also advice and help on how to deal with my own feelings, and part of that was to remain always very professional, always to do my job to the best of my ability, and if I thought for one minute that I was unable to do that, I was to withdraw from the ward and the situation, which is what I did.'[376]

303 She stated that by the third year of her post:

> '… I felt unable to continue going to theatre with the parents and children as I was emotionally drained. I ensured that one of the other nurses in the nursery was able to carry out this task.'[377]

304 In her written statement Miss Stratton dealt with her decision to leave Bristol:

> 'Around June/July 1993, I told Jean that at the end of the funding for my post in November I would be looking for other employment. I was beginning to make enquiries about other jobs …[378] Jean was kind enough to say that the Heart Circle

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[372] Mr Dhasmana clarified the reference: 'I think she probably means the neonatal Switch programme, which started in January 1992'; WIT 0256 0109 Mr Dhasmana

[373] WIT 0256 0012 Miss Stratton

[374] She explained that she was introduced to Dr Gardner by Mrs Pratten, and acted as a liaison between Dr Gardner and parents for the purposes of Dr Gardner's PhD thesis. See T46 p. 56 Miss Stratton

[375] T46 p. 101 Miss Stratton

[376] T46 p. 137 Miss Stratton

[377] WIT 0256 0012 Miss Stratton

[378] In a later statement to the Inquiry Helen Stratton stated: 'I do recall that in early May 1993 I attended for a job interview at the Churchill Hospital in Oxford. It is possible that my interview took place on 6 May.' See WIT 0256 0126 Miss Stratton

> would continue the funding of my post if I hadn't found a job in November. In the event, I found a job in February 1994 and the Heart Circle employed me until then. I felt a great loyalty to the Heart Circle and Jean Pratten, and I was determined to see out the 3-year funding …'[379]

305 She also explained:

> 'I remember that in the Summer of 1993 I took two periods of 2 weeks annual leave in fairly rapid succession. I have reason to remember this because it was very unusual to take so much annual leave in so short a period; it used up my entire annual leave entitlement for that year … I think there is a real likelihood that I was on annual leave for the two weeks beginning Monday 5 July 1993 and ending Friday 16 July 1993 … My second period of annual leave that summer took place in early August …'[380]

306 Miss Stratton appeared in a BBC Television *'Panorama'* programme screened on 1 June 1998. In the interview she said:

> 'We would get a call from theatre to say that they were ready and we would go down … a very, very emotional difficult time for parents, incredibly difficult … and we'd go down to the theatre and they'd normally go into the anaesthetic room and they'd have an opportunity to give the baby a kiss and say a few words, etc. …
>
> 'There was always this thought in the background that they were clinging onto the fact that they would see their baby later – that in eight hours' time their baby would be coming back …
>
> '… I think you have to understand that in a situation that is so emotionally charged like that, where people have put their trust, faith and hope in the surgeons there, that if I had in that situation actually said, "I think we should go back upstairs and take the baby back upstairs …" Yes, of course it was what I wanted to say. I wanted to pick the baby up and just run out of the operating theatre, bundle it into the car with the parents and take them anywhere else.'[381]

307 Describing her approach towards the end of her post she said:

> '… I think it is fair to say that on advice from Dr Gardner, I had withdrawn my input to a level where I was not enthusiastic …'[382]

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[379] WIT 0256 0013 Miss Stratton

[380] WIT 0256 0126 – 0127 Miss Stratton

[381] WIT 0256 0108 Miss Stratton

[382] T46 p. 131 Miss Stratton

Comment on the service provided by Helen Stratton

308 Paula Jordan, mother of Joe, said that she ‘developed a close relationship with the ”Cardiac Liaison Sister” Helen Stratton, whose job was to explain things to me and keep me informed of what was happening.’[383]

In her oral evidence the following exchange took place:

> ‘A. When I first heard I was going to the BRI, I was slightly daunted in that we had always been to the Children’s Hospital and I knew where I was, I knew where the sandwich machine was and I knew where I slept and I knew where the wards were, so I felt quite comfortable being there. They told me this was at the BRI and I felt slightly daunted, I do not know where I have to go and all that. But I had a letter before with a contact name and number of someone I could ring, so I rang up a few days before and introduced myself and said I was coming up. She expected me, and she reassured me about the hospital and when we got there, I felt a lot happier, having had the contact before.
>
> ‘Q. Contact with whom? Who was showing you around or assisting you there?
>
> ‘A. A cardiac liaison, I do not know if they call her a sister, officer or nurse, Helen Stratton.
>
> ‘Q. What was her role?
>
> ‘A. She was basically a go-between, between medical staff and parents, so if there is anything you did not know or did not understand, you could ask her and if she did not know or could understand, she would find out for you.
>
> ‘Q. Was that helpful?
>
> ‘A. Absolutely wonderful.’[384]

309 Michael Parsons said in his oral evidence:

> ‘Helen [Stratton], I must say, worked very, very hard and had a very difficult job to do.’[385]

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[383] WIT 0026 0006 – 0007 Paula Jordan

[384] T4 p. 27–8 Paula Jordan

[385] T2 p. 94 Michael Parsons

310 Phillip Wagstaff, father of Amy, said that he was shown around the ICU by Helen Stratton the night before the operation. He was asked as to his understanding of her role:

> 'A. I understood she was actually employed by the Children's Heart Circle, which is a charity and her role really was to sort of help parents through the ordeal, really, to liaise with the parents and the hospital staff.
>
> 'Q. Was that a helpful exercise, being shown around the ITU?
>
> 'A. Yes, it was.
>
> 'Q. Why?
>
> 'A. I think it really prepared us for the shock of seeing Amy with all the tubes and pipes and everything coming out of her, so at least we knew what to expect the following day.'[386]

311 Mrs Pratten stated:

> 'On reflection I believe a three-year contract was too long for the emotional demands on any one person. Because of the absence of clinical supervision and professional support, I asked Dr Freda Gardner if she would provide this for Helen on behalf of the Heart Circle, and she agreed to do so …'[387]

312 Mr Graham Brant, Senior Staff Nurse, BRI, 1991–1993, stated:

> 'Helen Stratton had an extremely difficult job providing support and liaison between the parents and staff. She had to spread her time evenly which meant that at times she was unavailable when needed. She would hold debriefing sessions for staff after a child died, but these often did not take place until two or three days later which reduced the debriefing effect. Helen tried to see all the parents and children pre and post op but often had little time to spend with them. Helen liaised with Helen Vegoda at the BRHSC but I felt there was often a tension between their personalities.'[388]

313 Dr Gardner stated:

> 'Helen Stratton provided an extremely professional service. She made enormous efforts to educate herself when she first came to the post. She found quite early on that her own form of support was very different from that of Helen Vegoda. It soon became clear that the difference in approach made it almost impossible for co-operative working. I was asked by Mrs Jean Pratten to offer supervision to

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[386] T2 p. 27 Phillip Wagstaff

[387] WIT 0269 0005 Mrs Pratten

[388] WIT 0513 0005 Mr Brant

> Helen Stratton, which I did … The situation over time became very stressful. There were times when Helen Stratton was out of her depth (it is fair to say that anyone without significant experience in mental healthcare would have found the situation similarly impossibly difficult). I have no doubt that in these situations she always did her best, and sometimes that was to withdraw from some families …
>
> 'I believe it to be the case that it would have been impossible for her to have provided a better service given the demands at that time.'[389]
>
> 'She left the service extremely distressed and I have no doubt that it may be some time before she recovers from what she experienced as a profoundly distressing period of her life.'[390]

314 David Charlton, father of Hannah who was operated on at the BRI in November 1992:

> '… Helen Stratton was quite supportive in a practical, but not personable or approachable way … She was going through what I imagine were deemed to be effective procedures, but without any real sympathy.'[391]

315 Stephen Willis, father of Daniel who was operated on at the BRI in May 1993, referred to discussions with Miss Stratton whilst Daniel was in surgery:

> 'I have no alternative but to say that the way Helen Stratton handled that interview was insensitive and distressing … and indeed was the worst moment that we were to experience other than being told that Daniel had died.'[392]

316 Kenneth and Susan Darbyshire, parents of Oliver who was operated on at the BRI in July 1993:

> 'She's supposed to be a counsellor, but she really did not know how to strike up a chord with parents. One thing that came across with her was a very strong *lack of empathy*…
>
> 'Looking back on it now, I have often wondered whether her approach towards parents was deliberate, to stop parents from seeing her, or bothering her. Because it worked with us.'[393]

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[389] WIT 0534 0006 Dr Gardner

[390] WIT 0534 0007 Dr Gardner

[391] WIT 0539 0010 David Charlton

[392] WIT 0285 0010 Stephen Willis

[393] WIT 0125 0016 Kenneth Darbyshire (emphasis in original)

317 Erica Pottage, mother of Thomas who was operated on at the BRI in July 1993:

> 'Helen Stratton said most parents in these circumstances want to go home straight away, so we packed up our belongings and my husband drove us back to Teignmouth.'[394]

318 Paul Bradley, father of Bethan who was operated on at the BRI in August 1993:

> '… Helen Stratton did not readily make herself available and was not very proactive. She did not warrant our confidence as someone to confide in. She seemed uneasy with us and with the situation we were in. It was as if she was not sure what to say … She did not command our confidence as a friend or someone who could counsel us through this traumatic period … It was not clear who we could direct our concerns to and if there was such a person it wasn't clear to us who that person was. Our stay at Bristol Royal Infirmary was a deeply lonely experience.'[395]

Split site

319 Commenting on the effect of the split site Miss Stratton said:

> 'I was also aware that there was this cavern between the nurses at the BRI and the nurses at the Children's Hospital and I wanted in some small way to see how that could be improved … I think there were territorial issues …'[396]

320 In answer to a question from Mrs Howard as to whether the split site compromised children's care, she said:

> 'I think the split site meant that there was a communication problem … not between Helen Vegoda and I in as much as we met on a regular basis, but I think with the nursing staff, just because they were not both in the same hospital, there were inevitably communication problems.'[397]

321 She continued:

> '… I think if you asked parents whether, at the times of diagnosis they would have benefited from having a nurse there who could explain the condition to them, could explain what the surgery would involve, could start to prepare them for intensive care and what that meant, I think that most parents would say yes.'[398]

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[394] WIT 0260 0003 – 0004 Erica Pottage

[395] WIT 0229 0020 Paul Bradley

[396] T46 p. 96–7 Miss Stratton

[397] T46 p. 164–5 Miss Stratton

[398] T46 p. 165–6 Miss Stratton

After the departure of Helen Stratton

322 Asked what happened to Miss Stratton’s post between her departure in February 1994 and when the paediatric cardiac service was united at the BRHSC in October 1995, Mrs Pratten told the Inquiry:

> ‘The post went, and I was concerned that there was no thought of putting it back in place, and I was very concerned that all that she had achieved would be lost … I spoke to Dr Gardner and asked her to do research on the needs of families and children, because although I was saying that I thought she had done a good job by and large … I had no documentation to prove it, and I felt that the only way forward, really, was to get a research document looking appropriately at the needs of children and their families.’[399]

323 Dr Gardner produced a report, *‘Assessment of the Psychosocial Needs of Children with Heart Disease and their Families’,* based on questionnaires completed by 150 parents. The paper considered the effectiveness of the services then being offered and suggested areas of improvement.

324 The report concluded:

> ‘The survey revealed the parents’ need for more information from medical or nursing staff. They expressed the need for additional reassurance and information, and advice on the care of their child before surgery and following discharge.
>
> ‘At an emotional level, parents described periods of great distress and expressed the need for help which was in some cases met and in others not.
>
> ‘Practical community-based advice was also needed such as information about financial support and help with other children at home.
>
> ‘There was also evidence that children are discharged from hospital without adequate provision in advance made for psychological, emotional and in some cases practical support.’[400]

325 Dr Gardner recommended:

> ‘The need for information however, requires the appointment of a Cardiac Liaison Nurse Specialist which would also bring the service in line with the Department of Health guidelines and other supra regional cardiac services throughout the United Kingdom. Many centres provide specialist nurses who provide information and explanation and provide a liaison service and co-ordinate community care. This is a service that Bristol currently lacks and the evidence for its need is compelling.’[401]

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[399] T47 p. 40 Mrs Pratten

[400] WIT 0269 0052; Dr Gardner’s report

[401] WIT 0269 0052; Dr Gardner’s report

326 In the report she stated that it could be presumed that all parents would require the skills of the Cardiac Liaison Nurse Specialist at the time of diagnosis and surgery, and recommended that referrals be made at that stage. She recommended that additional emotional and practical support could be given by the Family Support Worker, and financial or social support by a social worker. She stated:

> 'It is important to distinguish between the roles of the Cardiac Liaison Nurse Specialist and Family Support Worker. The Cardiac Liaison Nurse Specialist is primarily involved with all medical information and counselling concerning the condition of the child. In this way the Family Support Worker is released to offer emotional and practical support to the many families who need this form of care.'[402]

327 Dr Gardner also emphasised the continued need for a play therapist.[403]

328 In distinguishing between the two posts, she recommended that the Cardiac Liaison Nurse Specialist:

> '… would be responsible for providing parents with medical and nursing information throughout the period from the initial referral to the first outpatient appointment following corrective surgery. The nurse would be able to reinforce, repeat and supplement the information from the consultant involved with the care of the child, presenting it over a greater period of time and in terms that parents will clearly understand. They would also liaise between hospital and community, planning appropriately for admission and discharge.
>
> 'Some parents need additional help beyond that period and the cardiac nurse specialist would be able to assess any need and refer the family to an appropriate community professional. It is these important services, as described by the Department of Health, that are currently not provided in Bristol and diminish the quality of care … There is clear evidence from other centres such as Birmingham, Great Ormond Street and Southampton of the success of such a post.'[404]

329 As regards the post of Family Support Worker, she recommended:

> '… it is absolutely clear from our survey that the support provided by this service is of great value to some parents …
>
> 'In releasing the post holder from the medical aspects of care (such as preoperative talks) the many services that are currently not consistently provided can be fulfilled.

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[402] WIT 0269 0053; Dr Gardner's report

[403] WIT 0269 0054; Dr Gardner's report

[404] WIT 0269 0053 – 0054; Dr Gardner's report

> '… it was evident that many families were seeking counselling in conjunction with information as distinct from social and emotional support. This was particularly true at the time of diagnosis and in intensive care. This need for information cannot be met by the Family Support Worker. Removing this expectation from the post would release considerable time for the vitally important emotional and practical support that is needed by many families.'[405]

330 Dr Gardner also recommended:

> 'Any professional providing psychosocial support should in turn be supported and provided with professional supervision. There is currently no provision for this.
>
> 'Support for all other members of staff should be available either formally or informally. The benefits of staff support are well documented and should be provided, particularly for nurses in intensive care.'[406]

331 Describing Dr Gardner's paper, Mrs Pratten said that it:

> '… proved clearly that the post was needed … As a result of that research we offered to fund a post in the Children's Hospital [where the service had by then moved], which we did, and after 6 months of that post, the Trust took it over, so it is now a National Health Service post.'[407]

332 Mrs Pratten explained that Kathy Selway initially took the new post, and was the conflation of the posts previously held by Mrs Vegoda and Miss Stratton.[408]

333 Dr Gardner also stated:

> 'Towards the end of 1995, Rachel Ferris … made it clear that she wanted a part-time psychology service for the cardiac unit. I became formally clinically involved from then.'[409]

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[405] WIT 0269 0054; Dr Gardner's report

[406] WIT 0269 0055; Dr Gardner's report

[407] T47 p. 42 Mrs Pratten

[408] T47 p. 44. Mrs Vegoda told the Inquiry that in September 1996 she took on a new role at the BRHSC. She said: 'In 1996 I took on a new role in the Children's Hospital of Counsellor in Child and Family Support, offering counselling and support to families of children not previously receiving counselling. A cardiac liaison nurse was appointed to the cardiac team.' See WIT 0192 0005. Mrs Vegoda described her present role in which she provides child and family support throughout the hospital, although she does not cover oncology and cardiac services as they now have their own support systems, and that it was the intention of her present post to offer some support and counselling and help to families where counselling had not previously been provided. See T47 p. 99. In relation to facilities currently available at the BRHSC Cardiac Unit she said: 'There is a cardiac liaison nurse in place. … Having said that, I am occasionally specifically asked by either nursing staff or somebody in the hospital to see a particular cardiac family, either because they have requested counselling, or because the nursing staff feel that they need more psychological emotional input than can then be provided.' See T47 p. 172–3

[409] WIT 0534 0001 – 0002 Dr Gardner

Guidance and expert evidence on support and counselling

Governmental guidance

334 In her paper for the Inquiry, Dr Humphrey provided a brief summary[410] of published guidance during the period of the Inquiry's Terms of Reference. She wrote:

> 'The 1959 Platt Report on the welfare of children in hospital led to radical changes in, among other things, access and provision for parents …
>
> 'Over the past few years there has been an increasing consensus between government, professional and voluntary organisations on the benefits of parental participation in "family-centred" care. More recent government guidelines in this area published in 1984,[411] 1991,[412] and more recently the 1996 "Children's Charter"[413] reflect this philosophy, giving considerable attention to enabling parents to be with their children in hospital and ensuring access to information and improved contact with hospital staff to facilitate this involvement … In contrast, there appears to be relatively little detailed advice or recommendations specifically about the provision of psychosocial support or counselling for parents of children in hospital except in the context of life-threatening illness (which is not defined) and bereavement. The 1991 report on the welfare of children and young people in hospital represents the first comprehensive set of recommendations from the Department of Health in this area since the Platt report.'[414]

1991 guidance – *'The Welfare of Children and Young People in Hospital'*

335 Dr Humphrey noted the terms of the guidance issued by the DoH in 1991. She wrote that this:

> '… specifies that "Every children's hospital or children's division of a district general hospital must provide facilities to enable the mother and other members of the family to sustain the normal relationship to which the child is accustomed at home", such as accommodation and the use of a sitting room and kitchen, and recommends that "… hospitals collaborate with voluntary organisations helping families … which might also be able to provide accommodation for families near regional centres in some specialties."'[415]

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[410] INQ 0025 0012 – 0017; Dr Humphrey's paper

[411] DHSS. *'Hospital Accommodation for Children'*, Health Building Note 23, HMSO, 1984

[412] DOH. *'The Welfare of Children and Young People in Hospital'*, HMSO, 1991

[413] DOH. *'Services for Children and Young People'*, NHS Executive, 1996

[414] INQ 0025 0012; 'Platt Report', Ministry of Health (Chairman H Platt): *'Report on the Welfare of Children in Hospital'*, HMSO, 1959

[415] INQ 0025 0013; Dr Humphrey's paper

336 She noted that the guidelines also advised hospitals to:

> '… ensure that the Hospital Travel Costs Scheme is publicised within the children's department and that a named member of staff is designated to help advise families on benefits which may be available to help with travel costs. Where a family's financial situation is particularly difficult, parents should be made aware of any assistance the hospital social worker can provide …'

and recommended the agreement of service specifications which:

> '… recognise that parents and members of the immediate family are not visitors, encourage and assist them to be with their child at all times (especially those that are most stressful, i.e. during anaesthesia, treatments, investigations and during post-operative recovery) and enable them to give continuous love, care, comfort and support for their child.'[416]

337 In respect of 'life-threatening illness', the guidance:

> '… encourages health authorities and hospitals to establish links with voluntary organisations active in their areas to achieve maximum co-operation in the planning and organisation of services like social work support. It also recommends that those involved in agreeing contracts should ensure that:
>
> 'all staff are sensitive to the needs of children and their families … and are able to draw upon staff specifically trained in care and counselling;
>
> 'parents are informed in an appropriate manner, as soon as possible of their child's condition and given every opportunity to talk through their feelings;
>
> 'care is taken not to "avoid" parents whose child is dying, while at the same time recognising the need for privacy;
>
> 'where children are taken home, advice is available to parents on the help available from statutory or voluntary agencies to ensure ongoing support and counselling for as long as necessary;
>
> 'parents have the opportunity to return to the hospital to find out anything further they wish to know about any aspect of their child's illness, care or treatment.'[417]

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[416] INQ 0025 0013; Dr Humphrey's paper

[417] INQ 0025 0014; Dr Humphrey's paper

338 In relation to the death of a child, the guidance:

> '… states that it is essential that parents/carers are helped to cope with the sense of loss and grief and also given practical assistance to help them make necessary decisions. Health authorities and hospitals are advised to ensure that:
>
> 'a member of staff trained in care and counselling is designated to give families, including siblings, all the necessary support including help with the arrangement of bereavement counselling and practical issues like burial arrangements;
>
> 'the results of any post mortem investigation are conveyed in a sympathetic manner to the family…;
>
> 'the family's GP is informed as soon as possible so that, as necessary, the GP can help them cope with the medical effects of bereavement.'[418]

Non-governmental guidance

339 Dr Humphrey also commented on guidance and recommendations from non-governmental sources. She wrote:

> '… a number of professional and voluntary bodies have made recommendations in recent years concerning the care of children in hospital. Most of these endorse or reiterate the standards contained in the DoH guidance in relation to parental involvement and support.'[419]

340 She set out those that went into more detail or made additional recommendations. She noted that the British Paediatric Association's 1995 report *'Tertiary Services for Children and Young People'*:[420]

> '… points up the "vital role" of the specialist social worker … It observes that in some regions, specialist social worker posts have been reduced or discontinued because of new funding arrangements.'[421]

341 She also noted that Action for Sick Children published recommendations *'Setting Standards for Children Undergoing Surgery'* in 1994[422] which included guidance in relation to parents' needs, such as the need for information about wards and hospital facilities on admission, and support for parents. Recommendations included the provision of support for:

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[418] INQ 0025 0014 – 0015; Dr Humphrey's paper

[419] INQ 0025 0015; Dr Humphrey's paper

[420] British Paediatric Association. *'Tertiary Services for Children and Young People'*, 1995

[421] INQ 0025 0015; Dr Humphrey's paper

[422] Hogg C. *'Setting Standards for Children Undergoing Surgery'*, Action for Sick Children, 1994

> '… link workers to help prepare families from minority communities and help them to express their wishes and anxieties and to ask questions;
>
> 'for parents who may become distressed and anxious once the child is unconscious.'[423]

342 Dr Humphrey noted that:

> 'In 1988, a working party involving the British Paediatric Association, the King's Fund and the National Association of Health Authorities produced guidelines on the care of dying children and their families.[424] These go into considerable detail into the support needs of parents at all stages from diagnosis to bereavement including, for example, the need to …
>
> 'ensure good communication between parents and professionals;
>
> 'ensure that parents have adequate finance;
>
> 'ensure that parents are aware of the range of people (and self-help groups), both in hospital and in the community, who might help by listening and talking;
>
> 'give parents the opportunity to talk to other parents in a similar situation;
>
> 'offer continuity, friendship and sensitive support responding to individual needs.
>
> 'The guidelines also suggest mechanisms for ensuring that these principles are translated into practice through, for example, education and support of staff involved.'[425]

Expert evidence

343 In addition to the oral evidence of Mrs Vegoda, Miss Stratton, the Reverend Cermakova and Mrs Pratten, the Inquiry heard evidence from Mrs Mandelson, Manager and Senior Counsellor at the Alder Centre, a centre based at Alder Hey Children's Hospital, Liverpool to offer support and counselling to anyone affected by the death of a child.

344 Mrs Mandelson told the Inquiry that the Centre had been open for ten years and provided a range of services to parents who had suffered bereavement, from parents who have lost a child through miscarriage, to those who had experienced the death of an adult child. The Centre also offers training and consultation to other professionals and carers who may be supporting bereaved families.[426]

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[423] INQ 0025 0015 – 0016; Dr Humphrey's paper

[424] British Paediatric Association, King Edward's Hospital Fund for London, National Association of Health Authorities. *'The Care of Dying Children and their Families'*, 1988

[425] INQ 0025 0016 – 0017; Dr Humphrey's paper

[426] T44 p. 11 Mrs Mandelson

345 In her evidence to the Inquiry, Mrs Mandelson commented:

> 'I do feel however that when we are talking about loss and grief work we need to recognise that it does not only apply to families who have lost a child but families who, when their child is diagnosed as having a life threatening condition, can find themselves dealing with potential loss and certainly the loss of a future they might otherwise have expected.'[427]

346 Mrs Mandelson commented on the structures and systems in place at Bristol and the nature of the services provided, and compared them with those in place at other centres during the relevant period.

347 She expressed the view that the necessary 'joined up services' within the hospital seemed to be lacking. In terms of structure, she said:

> '… I think it is very important when we think of the need for line management, and line management not only so that there is accountability, but there is also support and supervision of people carrying out a very difficult job. In a sense, that reflects on the service that they are able to deliver to the users of that service, because anyone who is under a great deal of pressure and stress emotionally, obviously then it is very difficult for them to question the service that they are able to deliver …'[428]

348 Asked about the degree of isolation which came across in the evidence she said:

> 'I think the question of isolation is one that would be quite common in a sense, because I think in the late 1980s this was a fairly new area of work. I think bereavement services, bereavement support, counselling, was something that people certainly in the mid-1980s, they were doing as part of their work rather than being specifically employed in that position. It was an add-on; it was an extra.
> I think there were a lot of people working very hard to raise awareness around the issues and needs of bereaved families and bereaved parents, and I think with that push, we have seen the development of some of these dedicated posts, but very often, in a hospital you might just get one person doing that.'[429]

349 She stressed the need for peer support and peer co-operation and for the person in that role to fit into part of a team so that the support given to bereaved families is part of a continuum of care.[430]

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[427] INQ 0026 0007; Mrs Mandelson

[428] T47 p. 178 Mrs Mandelson

[429] T47 p. 178–9 Mrs Mandelson

[430] T47 p. 179 Mrs Mandelson

350 As to how the services at Bristol compared with those in the rest of the country at the time she said:

> '… I think certainly in the late 1980s, people were becoming very much more aware of the needs of families …
>
> 'The centre of which I am a part opened in 1988 and at the time was the first centre of its kind in the country … We have already heard Helen Vegoda say she paid a visit to the Alder Hey Centre. It seems a centre of excellence.'[431]

351 By the time Miss Stratton left in early 1994, Mrs Mandelson said that it was fairly common to find structures for support and counselling, of one kind or another, in most critical units:

> 'You may well find in some hospitals still it would be specialist social workers; in Leeds, certainly, there are structures that I am aware of through their Accident and Emergency Department doing a lot of work on bereavement support.'[432]

352 Mrs Mandelson stressed:

> 'One of the things that I feel is very important … is the need for protocols. I think it is so easy for people and families to fall through the gap, certainly when there are lots of families, lots of demands on services and resources are scarce. We need to ensure that there are protocols in place for referral, for management of referral systems, etc to try and make sure that happens as little as possible.'[433]

353 Mrs Mandelson noted the distinction drawn between the terms 'support' and 'counselling', but told the Inquiry that what was important was that there were proper protocols or other measures in place to ensure that those most in need were identified and offered care. They would not necessarily identify themselves.

354 She stated in her paper:

> 'What needs to be in place is a continuum of care that offers readily accessible and appropriate intervention at the time when it is needed by patients and families. Research has shown that often when people need help most that is the time they have the least personal resources to access such help. It falls to the professionals employed within an organisation such as the NHS to ensure that a system is in place that enables potential users of a support service to know what is available and how to access it. Whilst, for a number of reasons, not everyone would wish to use such a service, protocols and procedures should be in place which ensure equity of access to information and appropriate interventions.'[434]

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[431] T47 p. 182 Mrs Mandelson

[432] T47 p. 183 Mrs Mandelson

[433] T47 p. 183 Mrs Mandelson

[434] INQ 0026 0008; Mrs Mandelson

Chapter 17 – Communication Between Healthcare Professionals and Patients

Introduction

1 This chapter will focus on communication between healthcare professionals and parents (and patients).

2 One feature of the communication process was the process of obtaining consent to treatment and this is dealt with in detail.

3 Communication goes beyond language. Non-verbal interaction between the staff of the Bristol Unit and parents is also addressed here.

National, regional or local guidelines

4 General advice and guidance to healthcare professionals on communication with patients (and their parents in the case of children) and on obtaining consent before treatment can be found in a number of documents. These guidance documents were issued by (a) the Department of Health (DoH) and (b) professional and related bodies. Some of these documents have model consent forms.

5 In 1971 the Department of Health and Social Security (DHSS) discussed model consent forms with the British Medical Association (BMA), the Medical Defence Union (MDU), the Medical Protection Society (MPS) and the Medical and Dental Defence Union of Scotland (MDUS). As a result of this, agreement was reached on standard consent forms for use in the case of surgical operations: D.S. 30/71 *'Consent Forms for Operations'*,[1] dated 2 February 1971.

6 This guidance included the following:

> 'It is important that the question of obtaining a signature to a consent form should not be allowed to become an end in itself. The most important aspect of any consent procedure must always be the duty to explain to a patient or relative the nature and purpose of the proposed operation and to obtain a fully informed consent.'[2]

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[1] DOH 0014 0046; *'Consent Forms For Operations'*, D.S. 30.71

[2] DOH 0014 0046; *'Consent Forms For Operations'*, D.S. 30.71

7 In 1990 the DoH issued new guidance on consent:[3] HC(90) *'A Guide to Consent for Examination or Treatment'*.[4] In Chapter 1 it stated:

> 'A patient has the right under common law to give or withhold consent prior to examination or treatment … This is one of the basic principles of health care.'[5]

It went on:

> 'Patients are entitled to receive sufficient information in a way that they can understand about the proposed treatments, the possible alternatives and any substantial risks, so that they can make a balanced judgement. Patients must be allowed to decide whether they will agree to the treatment, and they may refuse treatment or withdraw consent to treatment at any time.'[6]

8 The 1990 Guidance stated further:

> 'Where a choice of treatment might reasonably be offered the health professional may always advise the patient of his/her recommendations together with reasons for selecting a particular course of action. Enough information must normally be given to ensure that they understand the nature, consequences and any substantial risks of the treatment proposed so that they are able to take a decision based on that information. Though it should be assumed that most patients will wish to be well informed, account should be taken of those who may find this distressing.'[7]

9 The Guidance also advised that the patient's ability to appreciate the significance of the information should be assessed,[8] in the case, for example, of patients who might be shocked, distressed or have difficulty in understanding English. It further stated that:

> 'A doctor will have to exercise his or her professional skill and judgement in deciding what risks the patient should be warned of and the terms in which the warning should be given. However, a doctor has a duty to warn patients of substantial or unusual risks inherent in any proposed treatment. This is especially so with surgery but may apply to other procedures including drug therapy and radiation treatment.'[9]

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[3] This appears to be the first guidance that addresses the position of the law on consent

[4] HOME 0004 0018 – 0034; *'A Guide to Consent or Treatment'*, HC(90)

[5] HOME 0004 0020; *'A Guide to Consent or Treatment'*, HC(90)

[6] HOME 0004 0020; *'A Guide to Consent or Treatment'*, HC(90)

[7] HOME 0004 0021; *'A Guide to Consent or Treatment'*, HC(90)

[8] HOME 0004 0021; *'A Guide to Consent or Treatment'*, HC(90)

[9] HOME 0004 0021; *'A Guide to Consent or Treatment'*, HC(90)

10 The 1990 Guidance stated that:[10]

> 'The standard of care required of the doctor concerned in all cases is laid down in Bolam v Friern Hospital Management Committee [1957] 1 WLR 582, namely, that he or she must act in accordance with a responsible body of relevant professional opinion.'[11]

11 It further stated:

> 'Guidance on the amount of information and warnings of risk to be given to patients can be found in the judgement of the House of Lords decision in Sidaway v Gov of Bethlem Royal Hospital [1985] AC 871.'[12]

12 The 1990 Guidance stated that consent may be implied or express. It then gave guidance on when written consent should be obtained:

> 'Written consent should be obtained for any procedure or treatment carrying any substantial risk or substantial side effect … written consent should always be obtained for general anaesthesia, surgery, certain forms of drug therapy …'[13]

It went on:

> 'Oral or written consent should be recorded in the patient's notes with relevant details of the health professional's explanation. Where written consent is obtained it should be incorporated into the notes.'[14]

13 As regards written consent, it stated:

> 'The main purpose of written consent is to provide documentary evidence that an explanation of the proposed procedure or treatment was given and that consent was sought and obtained.'[15]

14 The 1990 Guidance cautioned:

> 'Where a patient has not been given appropriate information then consent may not always have been obtained despite the signature on the form.'[16]

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[10] See further the analysis of the law on consent in the Interim Report: BRI Inquiry Interim Report, '*Removal and retention of human material',* p. 20–34 and at Annex B of the Interim Report, particularly at p. 68–9

[11] HOME 0004 0028; *'A Guide to Consent or Treatment'*, HC(90)

[12] HOME 0004 0021; *'A Guide to Consent or Treatment'*, HC(90)

[13] HOME 0004 0022; *'A Guide to Consent or Treatment'*, HC(90)

[14] HOME 0004 0022; *'A Guide to Consent or Treatment'*, HC(90)

[15] HOME 0004 0022; *'A Guide to Consent or Treatment'*, HC(90)

[16] HOME 0004 0022; *'A Guide to Consent or Treatment'*, HC(90)

15 The Guidance emphasised the importance of discussing treatment with the multidisciplinary team and other doctors. These discussions, it stated, should also be documented in the clinical case notes.[17]

16 In 1991 the DoH issued guidance entitled, *'Welfare of Children and Young People in Hospital'*[18] which stated:

> 'Districts and provider hospitals should ensure that good practices are followed on seeking consent to the treatment of children. A guide to consent for examination and treatment published by the NHS Management Executive in August 1990[19] will be of assistance here.'[20]

17 The 1991 Guidance gave advice on 'Parental Attendance and Involvement':[21]

> 'District and provider hospitals are advised to agree service specifications which:
>
> - 'recognise that parents and members of the immediate family are not visitors and encourage and assist them to be with their child *at all times* unless the interests of the child preclude this
> - 'enable parents to give continuous *love, care, comfort, and support to their child* and, especially, be together with their child at the most stressful times – e.g. during and after treatment, anaesthesia, investigations and x-rays
> - *'help parents* themselves to undertake many familiar tasks helpful to the care of their child (e.g. dressing and undressing) and, where appropriate, learn any clinical procedures which will enable them to care for their child at home after discharge
> - 'provide maximum help and advice to parents to enable them to play a part in the care of their children and *to continue the care* following the child's discharge from hospital
> - 'ensure that, exceptionally, when consideration is given to advising a parent on medical grounds *not to visit* a particular child, the decision is taken by the consultant in charge only after *full consultation* with other professional staff (the reason for the decisions will need to be recorded in the child's medical records)…'[22]

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[17] HOME 0004 0028; *'A Guide to Consent or Treatment'*, HC(90)

[18] HOME 0002 0001; *'Welfare of Children and Young People in Hospital'*, DOH 1991

[19] HOME 0004 0018 – 0034; *'A Guide to Consent or Treatment'*, HC(90)

[20] HOME 0002 0013; *'Welfare of Children and Young People in Hospital'*, DOH 1991

[21] HOME 0002 0024; *'Welfare of Children and Young People in Hospital'*, DOH 1991

[22] HOME 0002 0024; *'Welfare of Children and Young People in Hospital'*, DOH 1991 (emphasis in original)

18 On 28 July 1992 the NHS Management Executive (NHSME) issued Guideline HSG(92)32, entitled *'Patient Consent to Examination or Treatment'*.[23] It superseded the 1990 Guidance:

> 'Following discussion with representatives of the medical profession, the Department has revised the model consent forms … This should remove some of the misunderstandings that have arisen since HC(90)22 was introduced.'[24]

Guidance from professional and related bodies

The Medical Defence Union

19 In November 1992 the MDU published its guidance on consent entitled *'Consent to Treatment'*.[25] On 'Informed Consent', the MDU stated:

> 'A doctor … or other healthcare professional has a duty to explain to the patient in non-technical language the nature, purpose and material risks (vide infra) ["see below"] of the proposed procedure. *The patient must be capable of understanding the explanation given*; if he is incapable, whether from unsound mind or any other cause, informed consent cannot be obtained. If the proposed treatment is difficult to understand, it may be helpful for clinicians to use, for example, drawings, diagrams and models to supplement the verbal explanations. If necessary an interpreter should be present to ensure that the explanation is given in a language which the patient comprehends. The full explanation given to the patient is of paramount importance. The signing of a consent form is of secondary significance. Where the patient has been given insufficient information, the clinician may be found to have been in breach of his duty of care to the patient.'[26]

20 The MDU guidance advised that, when obtaining consent:

> 'The task should not be delegated routinely to a junior doctor, especially if a complicated or specialised procedure is contemplated. It is not appropriate to ask a student to obtain consent. It is important that the person who discusses the procedure with the patient should whenever possible be the person who will carry out the procedure. If that is not possible then consent should be obtained by someone who is appropriately qualified and familiar with all the details and risks of the proposed procedure, and any alternatives.'[27]

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[23] DOH 0014 0037 – 0044; *'Patient Consent to Examination or Treatment'*, HSG(92)32

[24] DOH 0014 0037; *'Patient Consent to Examination or Treatment'*, HSG(92)32

[25] DOH 0014 0001 – 0036; *'Consent to Treatment'*, MDU

[26] DOH 0014 0002; *'Consent to Treatment'*, MDU (emphasis in original)

[27] DOH 0014 0004; *'Consent to Treatment'*, MDU

21 As to when consent should be obtained, the MDU stated that:

> ‘Consent should be obtained preferably a short time before the proposed procedure … In the case of elective surgery, where no change in the basic condition requiring operative treatment is to be expected, there is no objection to obtaining the patient’s signed consent during the out-patient clinic. If the patient’s condition alters between the out-patient appointment and admission to hospital so there is some material change in the nature, purpose or risks of the procedure, then the patient’s consent should be obtained again; a further explanation should be given and a fresh consent form should be signed. Similarly, if a considerable time has elapsed between the out-patient appointment and admission, consent should be obtained again.’[28]

The General Medical Council

22 Sir Donald Irvine, President of the General Medical Council (GMC) from September 1995 to present, outlined the focus of the GMC’s guidance in the 1980s in his written evidence to the Inquiry:

> ‘In the early 1980s, the GMC saw its standard-setting role primarily in terms of character and conduct and hence of the standing and reputation of the profession and the doctor. As a result the guidance focused on questions of honesty, improper relationships and abuses of trust. Those issues were – and remain – important. However they virtually excluded standards of clinical practice and relationships with patients, both seen as vital today.
>
> ‘Until 1995, the guidance on standards was published as part of the description of the GMC’s conduct procedures.’[29]

23 Sir Donald went on:

> ‘The guidance was the product of the culture in which medical regulation was seen as a reactive means of coping with exceptional misconduct, rather than a means of promoting good practice across the whole profession.’[30]

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[28] DOH 0014 0003; *‘Consent to Treatment’*, MDU

[29] WIT 0051 0007 Sir Donald Irvine

[30] WIT 0051 0008 Sir Donald Irvine

24 Sir Donald explained the GMC's role in the following exchange:

> 'Q. I was exploring with you the nature of the way in which inadequate practice might be regulated by the one branch or other of the regulatory bodies, taking as a given that the GMC is really the end of the road, the long-stop. I have it right, have I? That is essentially how the GMC sees itself?
>
> 'A. Yes, although I qualify that: within the statutory framework that I have described, we have been undergoing a considerable change of outlook ourselves which began, again, in the early 1990s, and that was effectively to see how far within the framework, the statutory framework as it was, we could be as effective as possible.
>
> 'That change of view was occasioned by our understanding that couching advice to the profession in fairly negative terms, in terms of what doctors could not or should not do, seemed to be unsatisfactory, that there had to be a better way of doing this because one effect of that policy was to leave doctors feeling that, "Well, since I am clearly not bad, none of this advice applies to me".
>
> 'This recognition was coupled also with our understanding that the culture of medicine needed to take far greater account of patients, what patients thought about doctoring, what they expected of their doctors, and there seemed to be a gap, as it were, a mismatch here between the public and its confidence in the kind of advice given and the advice that we were actually giving.
>
> 'Thirdly, it was triggered by the issues of advertising, which do not seem central to performance, but nevertheless, the examination that we made at the time and the questioning about doctors' advertising led us in, I think it was 1991, really to put as central the whole question, for instance of information to patients, to discard much of the conventional thinking which was restrictive, and it was that kind of way of thinking which then encouraged us and led us to think that we ought to address our remarks more positively and more explicitly to the whole profession about their duties and responsibilities.
>
> 'The last point – it is very fundamental to the notion of self-regulation, but that is not an end in itself, only a means to getting the best care for the patient – was to make explicit that which had always been implicit in medicine, and that there is a contract between doctor and patient and that a registered practitioner, in accepting the privileges of being registered, which includes the ability to earn one's livelihood as a doctor, enters into certain obligations to the patient, to the public, as a result.
>
> 'It is that kind of thinking, Mr Langstaff, which was a million miles away from the very restrictive interpretation that we had traditionally placed on matters earlier.

> ‘It was in tune, lastly, with the more general move in medicine towards being explicit about good standards of practice wherever possible. The whole guidelines movement as you know was developing at that time, and I have given some background to that in Annex B to my evidence.’[31]

25 Sir Donald stated in his written evidence to the Inquiry:

> ‘The policy began to change in the mid 1980s, as The Blue Book[32] was expanded to include new advice on standards of patient care … This process of change culminated in the publication of *“Good Medical Practice”* (1995)[33] where, for the first time, the GMC defined systematically the principles of good practice expected of all doctors.’[34]

26 *‘Good Medical Practice’* (1995) advised doctors:

> ‘In providing care you must:
>
> - ‘recognise the limits of your professional competence;
> - ‘be willing to consult colleagues;
> - ‘be competent when making diagnoses and when giving or arranging treatment;
> - ‘keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatment prescribed;
> - ‘keep colleagues well informed when sharing the care of patients …’[35]

27 Sir Donald stated:

> ‘Throughout the 1980s and early 1990s the Council saw a clear distinction between areas governed by law – both common law and legislation – and questions of conduct and ethics. The GMC gave no guidance on matters which it believed were covered principally by law and would be dealt with in the courts. This is still the policy, but not every subject falls neatly into one category or the other.
>
> ‘This became increasingly clear in relation to consent. No advice on the issue was included in The Blue Book since consent was regarded as a complex legal issue falling outside the area in which the GMC was competent to give advice. However,

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[31] T48 p. 31–3 Sir Donald Irvine

[32] *‘General Medical Council’s Professional Conduct and Discipline: Fitness to Practise’* (published by the GMC)

[33] WIT 0051 0122 – 0132; *‘Good Medical Practice’*, GMC 1995

[34] WIT 0051 0008 Sir Donald Irvine

[35] WIT 0051 0124; *‘Good Medical Practice’*, GMC 1995

> neither The Blue Book nor *"Good Medical Practice"* attempted to provide a comprehensive guide to all matters which could raise a question of serious professional misconduct, and it therefore remained possible for the PCC [Professional Conduct Committee] to hear cases based on, or involving consent.
>
> 'During the late 1980s and 1990s the Professional Conduct Committee considered a number of such cases … in which the PCC emphasised the importance of doctors providing information about procedures and options open to their patients, obtaining consent and respecting patients' decisions.'[36]

28 The then Secretary of the British Medical Association (BMA), Dr Ernest Armstrong, stated in his written evidence to the Inquiry:

> 'In 1984, the BMA published a revised edition of its ethics handbook[37] which aimed to provide guidance for doctors on a range of issues. The issue of patient consent, including consent of minors is briefly covered, with little mention of parental consent. There was a clear expectation that doctors would not proceed without valid consent but the steps entailed in seeking that consent were not explored. The equivalent publication in 1993, *"Medical Ethics Today"* [38] featured over 30 pages of advice on the topic of consent generally and a separate chapter on aspects of treatment of children. In the interim period between these two publications, BMA ethical guidance tried pro-actively to encourage much greater recognition of the importance of patient/parent informed consent to treatment.'[39]

29 He went on:

> 'The BMA's ethical publications address the type of questions which doctors routinely raise with the Association at any given time. The absence of debate about some issues does not imply that they were regarded as unimportant but indicates that doctors are likely to have felt that they were part of a professional consensus, precluding the need for questions. … The relatively low level of emphasis given to issues of consent in the 1984 ethics handbook indicates that this was not an area viewed by doctors as ethically problematic …
>
> 'By 1993, it is very clear from the BMA's published advice that professional guidance was already moving distinctly in a rights-based direction.'[40]

30 As regards the discussion of risks associated with surgery, Dr Armstrong stated:

> 'The 1984 BMA advice typified much thinking at the beginning of the period in that the guidance contained next to no detail and left a great deal to clinical discretion.

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[36] WIT 0051 0076 Sir Donald Irvine

[37] WIT 0037 0143; *'The Handbook of Medical Ethics'*, BMA 1984

[38] WIT 0037 0149; *'Medical Ethics Today: Its Practice and Philosophy'*, BMA 1993

[39] WIT 0037 0018 Dr Armstrong

[40] WIT 0037 0019 Dr Armstrong

> It was generally assumed that doctors would come to their own decisions in each case about the manner in which consent was sought and the degree of information provided. The core statement in the extract from the 1984 handbook is that "the onus is always on the doctor carrying out the procedure to see that an *adequate* explanation is given" [emphasis added].[41] No indication is given in the guidance, however, about what would constitute adequacy or by whose standard (doctor's or patient's) adequacy should be judged, although it would normally be assumed that the medical standard would be the benchmark. There is a brief paragraph on the importance of clear communication and avoidance of misunderstanding but the necessity of discussing risks associated with treatment is entirely absent.'[42]

31 Dr Armstrong went on:

> '… the 1984 guidance makes clear that doctors should answer questions unambiguously but again leaves open how much information doctors should volunteer if no question is posed.'[43]

32 He stated that:

> 'The graver the decision and the riskier the procedure, the greater the need for well informed consent to be provided.'[44]

33 He added:

> 'The BMA expects doctors to base their recommendations for treatment on the most reliable evidence available about benefit and there is a clear expectation in the BMA's 1993 advice that doctors should not conceal any piece of information materially relevant to the patient's decision.'[45]

34 Dr Armstrong stated that the idea that a surgeon had an obligation to refer to specific factors such as outcome data 'was not an issue for discussion in 1984'.[46]

> 'A not uncommon argument during the period (although not one endorsed by the BMA) was that doctors had moral obligations to promote hope of recovery. In the 1993 version of its advice, the BMA noted that a past concern of doctors had been to avoid worrying patients and that historically this had led to a reluctance to tell them the full implications of an illness or the different options for treatment. While the Association assumed that this approach was increasingly being seen as outdated by 1993, it noted a continuing reluctance on the part of some doctors to discuss uncertainties in medicine. It is very likely that this idea about the duty for beneficence was interpreted by some members of the profession as a justification

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[41] WIT 0037 0144; *'The Handbook of Medical Ethics'*, BMA 1984

[42] WIT 0037 0020 Dr Armstrong

[43] WIT 0037 0021 Dr Armstrong

[44] WIT 0037 0021 Dr Armstrong

[45] WIT 0037 0021 Dr Armstrong

[46] WIT 0037 0021 Dr Armstrong

> for not discussing risk, despite the ever-increasing emphasis placed by courts and by professional guidance on informed consent. In addition at the beginning of the period in question [1984], it is possible that some doctors were discouraged from drawing comparisons with outcomes from other colleagues or other facilities because of a perception that this could potentially undermine patient confidence or risk improper disparagement of colleagues.'[47]

35 The BMA's *'Handbook of Medical Ethics'* (1984), referred to by Dr Armstrong, stated that:

> 'Consent is only valid when freely given by a patient who understands the nature and consequences of what is proposed.
>
> 'Assumed consent or consent obtained by undue influence is valueless … It is particularly important that consent should be free of any form of pressure or coercion … No influence should be exerted through any special relationship between a doctor and the person whose consent is sought.
>
> 'Doctors offer advice but it is the patient who decides whether or not to accept the advice. The necessary degree of understanding of what is proposed depends on the patient's education and intelligence and the seriousness and urgency of the condition being investigated or treated. The onus is always on the doctor carrying out the procedure to see that an adequate explanation is given.'[48]

36 The 1993 BMA guidance *'Medical Ethics Today: Its Practice and Philosophy'* gave the prerequisites for valid consent under the heading 'Consent to examination and treatment':

> 'In order for the consent of any person to be valid it must be based on competence, information and voluntariness. In our view, this can be broken down into several fundamental points:
>
> 'a) the ability to understand that there is a choice and that choices have consequences;
>
> 'b) a willingness to make a choice (including the choice that someone else choose the treatment);
>
> 'c) an understanding of the nature and purpose of the proposed procedure;
>
> 'd) an understanding of the proposed procedure's risks and side effects;

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[47] WIT 0037 0021 – 0022 Dr Armstrong

[48] WIT 0037 0144; *'The Handbook of Medical Ethics'*, BMA 1984

> ‘e) an understanding of the alternatives to the proposed procedure and the risks attached to them, and the consequences of no treatment;
>
> ‘f) freedom from pressure.’[49]

The Royal College of Surgeons of England

37 Sir Barry Jackson, the President of the Royal College of Surgeons of England (RCSE), gave the Inquiry his views on discussions with patients in the following exchange:

> ‘Q. If I can just turn then to another aspect of this particular document,[50] … the subject of how doctors explain risk to patients. It sets out the relationship between the consultant and the patient, the fact that areas of uncertainty and significant risk must be explored, the use of information leaflets and tapes, and then, at the bottom of that it says:
>
> ‘"The Colleges and specialist associations have an important role in the production of suitable information on a national basis but the surgeon must know and divulge local and personal figures."[51] For the success or otherwise of an operative procedure, presumably.
>
> ‘That is clear guidance from the College published in 1998. What would have been the standard in this area throughout the period of our Terms of Reference?
>
> ‘A. I do not think it would be so explicitly stated as it is stated here for surgery in general. I cannot speak for particular branches of surgery and specifically for cardiac surgery because I do not know, but it would certainly have not been in any way firm College guidelines that on a national basis surgeons should divulge local and personal figures relating to outcomes such as has been recommended in this document.
>
> ‘Q. Our understanding is certainly that there was no guidance to that effect because we are looking at a 1998 document that I think is clearer than any other on that subject, but are you able to help us on the practice that would nevertheless have been adopted at a local level?
>
> ‘A. I think it would have been uncommon, unless the patient had asked for that information. I imagine that that might differ from specialty to specialty within surgery because my understanding is that in the field of cardiac surgery, very high risk surgery, this information was not infrequently asked by relatives or by patients of the surgeon in question, whereas in other branches of surgery, it would have been extremely uncommon to have been asked that question.

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[49] WIT 0037 0158; *‘Medical Ethics Today: Its Practice and Philosophy’*, BMA 1993

[50] RCSE 0001 0009; *‘Response to the General Medical Council Determination on the Bristol Case’*, The Senate of Surgery of Great Britain and Ireland, Senate Paper 5, October 1998

[51] RCSE 0001 0009; *‘Response to the General Medical Council Determination on the Bristol Case’*, The Senate of Surgery of Great Britain and Ireland, Senate Paper 5, October 1998

'Certainly, from personal experience, not as a cardiac surgeon, I think I would have been asked specific questions regarding risks in general and certainly the risks in my own hands exceedingly – exceedingly – infrequently over my entire professional practice.

'Q. The Inquiry will, of course, hear from parents and also from the doctors concerned as to what their practice was, but it might be suggested that it would be unusual for a patient to be able to have the knowledge, as it were, to ask not merely about what the outcome or likely outcome was in broad terms, but to be able, to make a distinction to go behind a 30 per cent risk of mortality, to ask such further questions as, "Well, is that a national figure, is that a local figure, is that your personal figure?"

'That would accord with your experience, that patients did not really do that?

'A. Absolutely. I think it would have been most unusual for any patient to do that, and I would imagine, but others will be able to verify or refute my belief, that that would have been unusual in cardiac surgery, and specifically in paediatric cardiac surgery.

'Q. So this is an area where practice must have changed very recently and very rapidly?

'A. Well, I think that it does not happen now. I do not think patients by and large ask that information, other than, perhaps, in the field of cardiac surgery, largely, I suspect, as a result of the publicity that the circumstances in Bristol obtained.

'Q. What is being suggested in that guidance is that it is not merely surely a matter for the patient to ask, but for the doctor to volunteer this information?

'A. That is what is stated, correct.

'Q. But so far, does it follow from your earlier answer that that is not necessarily the practice, or is not common practice on the ground?

'A. I think that is probably not common practice, and as I have – I think I have not said specifically, but if I have, I am sorry to repeat it; if I have not, perhaps I could say that any College guideline that comes out, such as the one you have on the screen at the present moment, is a recommendation by the College to its fellows and others, but it is not mandatory upon our fellows and others to follow those guidelines or those recommendations.'[52]

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[52] T28 p. 117–120 Sir Barry Jackson

The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC)

38 The *'Code of Professional Conduct for the Nurse, Midwife and Health Visitor'*[53] issued by the UKCC in 1984 contained no guidance on obtaining consent or communication with patients.

39 In 1989, the UKCC published guidance entitled *'EXERCISING ACCOUNTABILITY – A framework to assist nurses, midwives and health visitors to consider ethical aspects of professional practice'.*[54] Under 'Consent and Truth', the guidance stated:

> 'For the purposes of this document "informed consent" means that the practitioner involved explains the intended test or procedure to the patient without bias and in as much detail (including detail of possible reactions, complications, side effects and social or personal ramifications) as the patient requires. In the case of an unquestioning patient the practitioner assesses and determines what information the patient needs so that the patient may make an informed decision. The practitioner should impart the information in a sensitive manner, recognising that it might cause distress. The patient must be given time to consider the information before being required to give the consent unless it is an emergency situation.'[55]

40 It continued:

> 'If the nurse, midwife or health visitor does not feel that sufficient information has been given in terms readily understandable to the patient so as to enable him to make a truly informed decision, it is for her to state this opinion and seek to have the situation remedied … Discussion of such matters between the health professionals concerned should not take place in the presence of patients.'[56]

41 It further stated that there will be occasions where a patient's:

> '… subsequent statements and questions to a nurse, midwife or health visitor indicate a failure to understand what is to be done, its risks and its ramifications. Where this proves to be the case it is necessary for that practitioner, in the patient's interest, to recall the relevant medical practitioner so that the deficiencies can be remedied without delay.'[57]

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[53] UBHT 0221 0013 – 0017; *'Code of Professional Conduct for the Nurse, Midwife and Health Visitor'*, UKCC 1984

[54] UBHT 0221 0001; '*EXERCISING ACCOUNTABILITY – A framework to assist nurses, midwives and health visitors to consider ethical aspects of professional practice'*, UKCC 1989

[55] UBHT 0221 0007; '*EXERCISING ACCOUNTABILITY –A framework to assist nurses, midwives and health visitors to consider ethical aspects of professional practice'*, UKCC 1989

[56] UBHT 0221 0007; '*EXERCISING ACCOUNTABILITY – A framework to assist nurses, midwives and health visitors to consider ethical aspects of professional practice'*, UKCC 1989

[57] UBHT 0221 0007; '*EXERCISING ACCOUNTABILITY – A framework to assist nurses, midwives and health visitors to consider ethical aspects of professional practice'*, UKCC 1989

The *'Patient's Charter'*

42 The *'Patient's Charter'* was introduced in 1992. The fifth right under the Charter entitled a patient to be given a clear explanation of any proposed treatment and any associated risk, and any alternative methods of treatment, before agreement on treatment is reached. To comply with this right the UBHT stated:

> 'Clinicians take great care to give explanations in all circumstances to the patient or a person having responsibility for the patient such as a parent. Furthermore some nursing "standards" include a requirement that a nurse also gives explanations. An example is in the Cardiac Surgery Unit where a trained nurse carries out a pre-operation talk to the patient and family and a visit is made to the Intensive Therapy Unit.'[58]

43 In the note of a meeting of the Patient Care Advisory Group of the UBHT, held on Monday 13 January 1992, it was recorded that:

> 'Dr Roylance explained that it was not always appropriate or possible to give patients a clear explanation of proposed treatment. It was agreed that the advice of the Medical Director would be sought on the most suitable method of obtaining patients'consent to treatment.'[59]

Expert evidence

44 Mr Leslie Hamilton, a consultant paediatric cardiac surgeon at Freeman Hospital, Newcastle, and one of the Inquiry's group of Experts, told the Inquiry:

> 'I think the move towards being much more explicit has been a more recent phenomenon and I would have put it in the 1990s. I have only been a consultant since 1991, so I can only speak from my own practice since then. It is only my perception that we felt we were protecting parents by not exposing them to all the worrying factors of what might happen, and that would have been the practice, I would have thought, in the 1980s.
>
> 'I think it is very important to state that every set of parents is different, and different parents will want different levels of information and different parents will take in different ideas during the consultation. I think there has been some work done, I think a figure of about 30 to 40 per cent of the information you give in a consultation is retained, because it is a very difficult and very traumatic time. So my

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[58] UBHT 0018 0345; the *'Patient's Charter'*, Patients Standard Care Committee Mar 1992–Sept 1993

[59] UBHT 0022 0343; note of meeting of Patient Care Advisory Group, UBHT, 13 January 1992

> own feeling is that the consent is a process; it is an ongoing process. I see that starting when I see the family in outpatients and I try in my practice to see them in outpatients in advance of the operation, when they were actually going on the waiting list. I see that as the actual point of consent.
>
> 'I think when they come into hospital the night before, I then do not go over all the details I have discussed in outpatients, because I think that is the last thing parents want to hear at a time of great anxiety.
>
> 'I would go even further. I think for me the final point of the consent process is actually after the operation. I like to see them again and make sure they have understood what I have actually done, how things have gone and what I would predict for the future, because, again, that is the last point at which I would see them because they would then go back to the care of the cardiologist. I do not think that is necessarily standard practice and I do not know if that is ideal practice.
>
> 'I think one of the difficulties we have in describing risks to parents is that we do not have a system of risk stratification for children's operations … It is a very individualised thing. The idea of going back to results and quoting a specific figure I think is not possible. I try and give the parents a ball-park figure of whether it is a high, medium or low risk operation. Most parents will want you to put a figure on it so I will try and do that, but as I have said, I emphasise statistics do not apply to individuals, they apply to populations.'[60]

45 Mr Hamilton went on:

> 'I certainly will give what I feel are the important parts of the consultation initially, depending on the diagnosis, and I think it is important to say that "Your child may die", because unless you say "die" or "death", parents do not want to hear that, so they will try and push that aside, so I think it is important to say that but then to try to quantify it and give some idea of the level of risk.
>
> 'But then I will mention the fact … that complications are relatively infrequent; it depends on the operation, but they can affect any part of the body. I will then give them the chance to ask questions and some parents will want to know every detail. They will ask specifically about brain damage, but I must admit, I do not go into specific detail unless they want me to. I try and be guided by them in their reaction to my conversation, as to how much they want.
>
> 'So this is a very difficult area. I do not think there is a clear answer, but I think things have changed dramatically since the 1980s and we are now much more explicit with parents.'[61]

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[60] T51 p. 128–130 Mr Hamilton

[61] T51 p. 131–2 Mr Hamilton

46 Professor de Leval and Mr Jaroslav Stark (former consultant in paediatric cardiothoracic surgery), both of Great Ormond Street Hospital for Sick Children, gave expert evidence to the Inquiry in a joint session. Professor de Leval said '... I do not think that in the 1980s we were giving the parents the information you expect today.'[62] On the issue of information to be given to parents and discussion with parents about the fact that a surgical procedure like the Arterial Switch was new, Mr Stark told the Inquiry:

> '… when you [Counsel to the Inquiry] say "when you discuss it with the parents", you actually are not asking the parents to make the decision, because I think, to some extent, the way you see the benefits, you are willingly or unwillingly influencing the parents. But the other way round, the parents sometimes influence you.
>
> 'I would like to give you an example. One of the very difficult conditions is pulmonary atresia, with major collaterals coming from the aorta.
>
> 'For this condition, although the outlook has improved, the usual scenario in the 1970s/80s was that we would do two, three, four palliations in the first three years. Eventually there was nothing to offer. So on those occasions when we told the parents this scenario and suggested, because the outlook is so bad, that perhaps we should not treat the child, of course very often the parents feel anything that could be done should be tried, and we did, and then the scenario was followed.
>
> 'Then, a few years later, the parents would write to me and say, "We are sorry we did not take your advice because the misery we have suffered during those three or four years was immense."
>
> 'So I think that there is always both sides that influence each other.'[63]

47 Speaking of the extent to which parents during the 1980s and 1990s would understand or be informed that their child was amongst the first to have a new (Switch) procedure, Professor de Leval told the Inquiry that:

> 'I think that the parents were informed that the procedure was new or that there was an alternative, but we were implying or proposing a new procedure, but I think all this was done in the context of a relationship of confidence between the families, the cardiologist first and the nursing staff, the surgeon, and I do not think that parents ever considered that they were probably the "victims" or "guinea pigs" or whatever you would call that. I think that they were, you know, as fully informed as we thought they should be, and we were totally open in what we were doing. The fact that we were telling them that it was a new procedure implied, without being necessarily specific in spelling it [out], that there was probably a higher risk in those days than now, because we have done more.

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[62] T50 p. 18 Professor de Leval

[63] T50 p. 21–2 Mr Stark

> 'But I think the relationship and the ambience where all those things were taking place was such that there was full confidence between parents and the institution.'[64]

48 Mr Stark, agreeing with Professor de Leval, said:

> 'I think this is a very important point, because I could give you an example of one operation which I thought could be done and it has not been done before, and when I talked to that family, I put it to them in those simple terms: "It has not been done before. I think it could work." The parents, and many other parents, in those days usually did not comprehend fully the anatomy of physiology, because … it is quite complex. Very often the answer was, "We know that you will do your best and we trust you". So we went ahead with the operation. That particular operation went well, but the feeling that the nurses, cardiologists, surgeons had the full trust of the parents probably made the explanation, even under such difficult conditions when we started new operations or where we knew the risk was still high, somewhat easier.'[65]

49 As for quoting risks, Mr Stark said:

> 'I think very often we would quote the parents actually [a] very broad idea, like saying the risk is less than 50:50. Only when the parents insisted, we put together our own experience, we put together the data from the literature, but it was not scientific; I completely agree. Unfortunately, we did not have the basis for that.'[66]

50 Professor de Leval indicated that:

> 'Nowadays, obviously, we are careful what we say, what we write and we try to choose our words, but I think that, frankly, when I was talking to parents in 1985 about risks, I did not know exactly what my results were and certainly not what the confidence interval was, so it was a clinical impression of what I had done; also a knowledge of what had been published and what I had heard at meetings. Some of the conditions, the number of cases I had done, we had done, was very small, rare conditions, and the risk quoted was the best I thought I could do in terms of assessing what the risk was, plus taking into consideration my own performance from previous cases … You tell the parents that three of the last four patients have died while all the others before had survived? We did not, but I am sure that when I was quoting a risk of an operation, having lost one or two patients from the same condition, I was more pessimistic. But this is no science. There was no confidence interval quoted.'[67]

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[64] T50 p. 26–7 Professor de Leval

[65] T50 p. 27–8 Mr Stark

[66] T50 p. 33 Mr Stark

[67] T50 p. 34 Professor de Leval

51 Mr Stark told the Inquiry that he tried to avoid quoting percentages because he thought they were meaningless to a number of parents. He said he tried to explain what the alternatives of not operating were to the parents and mentioned that 'even if the risk was 1 per cent … if that 1 per cent was their child, therefore it was 100 per cent.' He said: 'We did not have a better way to do it.'[68]

52 Dr Eric Silove, consultant paediatric cardiologist at Birmingham Children's Hospital and Senior Clinical Lecturer at the University of Birmingham and Dr Alan Houston, paediatric cardiologist at the Royal Hospital for Sick Children, Glasgow and Honorary Senior Lecturer at Glasgow University jointly gave expert evidence to the Inquiry.

53 They referred to the practice of holding 'joint meetings' between surgeons and cardiologists. Dr Houston told the Inquiry:

> 'But of course the surgeon will have looked at the angiogram with you [the cardiologist]. The surgeon is not going in to see if the coronaries are all right; he will have looked at the pictures and probably agreed with the physicians and the surgeons that they are all right. So he would be involved in that decision to operate as well, yes.'[69]

54 In relation to the collaboration between cardiologists and surgeons, the following exchange took place:

> 'Q. You talked of the determination being made as it were by the cardiologist in isolation or by the surgeon, that they would collaborate and look at these things together. Is that an essential prerequisite for the proper treatment of a patient, that the two of them collaborate and discuss?
>
> 'A. (Dr Houston): I would have said so, for all but the most relatively minor conditions, and I think in all centres, there are joint meetings of the cardiologist and cardiac surgeons. Perhaps for some simple things like tying a duct, you would not necessarily sit down and look at the information, or even an Atrial Septal Defect, but anything like this would be expected to be discussed at a combined meeting.
>
> 'A. (Dr Silove): I agree with that.'[70]

55 Dr Silove and Dr Houston told the Inquiry about prevailing practice (in their experience) during the period covered by the Inquiry's Terms of Reference regarding information given to and communication with parents about old, new and emerging surgical procedures. In the following exchange, they discussed general practice at the time concerning quoting risks:

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[68] T50 p. 36 Mr Stark

[69] T49 p. 64 Dr Houston

[70] T49 p. 66–7 Dr Houston and Dr Silove. See Chapter 3 for an explanation of clinical terms

‘A. (Dr Silove): I think it is very unlikely that cardiologists and surgeons at that time, sort of in the late 1980s, early 1990s, would have discussed the pros and cons in such depth with the parents. I think that today they would. In 1999 we know that there is a demand for a great deal of information, and some of that is good and some of it has major problems. But at that time – I cannot quite remember, but I suspect that one would have said to the parents, “We used to do an operation called the Atrial Switch”, say, “and our results for that were good but we know that children who had that operation, over a period of years, sometimes as early as the age of –”, I mean, I have talked about 20s and 30s, sometimes as early as 12 or 15, would die suddenly, would certainly get into big trouble as they got into their 20s, and would not have a normal life.

‘“We are now adopting the Arterial Switch operation; we have not done enough of these operations to be able to tell you just what the outlook is going to be; we expect that the long-term outlook will be very much better; we have a much better chance of having a live child when he or she is an adult, and we are not quite certain what the mortality rate is that we can expect at this stage, but we would expect it to be probably a little bit higher than the mortality rate for the Atrial Switch.”

‘That is what I think, I cannot remember, I think is the way we would probably have approached it. I do not know whether Dr Houston might recall how he would have approached it?

‘A. (Dr Houston): I think it perhaps would be very similar to that, but perhaps if you clearly believe what you are doing is the correct thing, you may put it a little more strongly than that … I think it is difficult to say exactly what words you would use, but you would clearly get over the concept that you thought the chances were much better by going for the Switch rather than the inflow correction, but briefly mention that that had been done in the past.

‘Q. (Mr Langstaff): Suppose that the parent says, or said to you at the time, “Well, what are the chances of my child coming through the operation, coming through this operation? How does that compare with the chances of my child coming through that operation?”

‘Q. (The Chairman): And we are talking about two kinds of chances. The chances immediately and the chances long-term, so perhaps in addition to Mr Langstaff’s question, you can address that as well, because Dr Houston, you used the word “chances”and of course it refers to two distinct time periods.

‘A. (Dr Houston): I cannot recollect anyone about that time asking me that directly. Perhaps it is different nowadays, but people often do not push for the exact details. I am very wary about giving percentage figures, because everyone is different. But I think at that time you would have said the risk of the Switch was up to 20 per cent mortality. The risk with inflow would probably be five or less. That would have been the sort of figures I would have thought of at the time, I think.

‘A. (Dr Silove): I think at the time that we moved over to the Arterial Switch, we would probably also have said that the experience of centres that are doing a lot of Arterial Switches is that the mortality is somewhere in the region of 10 per cent, whereas the mortality for the Atrial Switch operation is about half of that. But we feel that there are so many advantages to going for the Arterial Switch in the longer term, that is what we are advising.

‘Q. (Mr Langstaff): If I can just ask you both really to comment on this … we are here dealing with the risks and chances of survival or not, and using figures such as 10 per cent or 5 per cent.

‘To what extent would they be meaningful to a parent or patient when the reality is that the parent has no choice but to have a child with a congenital heart defect, the child has no choice, it is born that way and when the reality is, it is either death or survival, and percentages can be very false and take one away from the fact that in each case there is a real child?

‘A. (Dr Silove): Yes. I mean, the point you have made is a very real point. I think that what we are really saying is that if the mortality rate is less than 10 per cent, it is a reasonable risk, whereas if the mortality rate is 30 per cent, it is a very high risk. We really need to think twice about whether we would go in for an operation with a mortality rate of 30 per cent. ...

‘A. (Dr Houston): All I can think of is myself when we started, I had a figure of 20 per cent from general results that people are talking about for the procedure. It is less now, but that was the figure, 1 in 5, I tend to prefer that to percentage, somehow, and then less than 1 in 20 for an inflow correction ...

‘Q. (The Chairman): … would it have been part … of the habit or behaviour of cardiologists to say, “Well, we only do X, but if you go elsewhere, they do Y and as it happens, Y does have a greater chance of survival, albeit that there are problems later on down the road, as we understand them”, so that the parent can weigh that in the balance as well. Would that have been a habit?

‘A. (Dr Houston): I would have thought not, because you can talk about people not only in this country but elsewhere.

‘A. (Dr Silove): I agree with Dr Houston there. When you are dealing with a large population of patients, you have to be practical in the sense that you cannot really think of transferring everybody, if they wish to be transferred, to some other place, because you have to go through the logistics of organising that, and the place that you might want to transfer them to might not be able to take them.

‘Once you start trying to make those judgements in your own centre, it really becomes very difficult. You cannot just single out one or two conditions; you have to deal with every single condition that you see in the same way.

‘A. (Dr Houston): I do not know when we are talking about … We generally know who has good results now; would we have known them in the late 1980s?

‘A. (Dr Silove): You probably would only have known by sort of word of mouth at the meetings of our professional associations. ...

‘Q. (Mr Langstaff): We may not be talking here about good results, but alternative operations. That is certainly going to be known, is it not: who is still doing Mustards, who is still doing Sennings?

‘A. (Dr Houston): I think if parents had said, “I want a Mustard” or “I want a Senning done”, I think in most places it would have been discussed. No-one would refuse to do that for them but I think one might try to dissuade them and suggest the other alternative was the better, but if they wanted it, no-one would say “You are not getting this operation, you would have to go elsewhere.” I do not think so. Would that be correct?

‘A. (Dr Silove): I do not remember anyone saying that. ...

‘Q. (The Chairman): … One is really asking you as experts whether, in the late 1980s and early 1990s, it would have been perceived as part of your duty to tell the patient about other procedures elsewhere and the option of choosing X rather than Y.

‘A. (Dr Houston): I would have thought not. Not in detail. Again, to mention that previously there was an operation which had better immediate results but poorer long-term ones.

‘A. (Dr Silove): Let us take an extreme example. If I was in a centre where I knew that the mortality rate for a particular operation was, say, 50 per cent, and I knew that the same operation could be done with a mortality rate of, say, 10 per cent in one or two other centres in the country, I think I would tell the parents that. Supposing the mortality in my centre is 40 per cent, I would tell them that. If it is 30 per cent, I think I would still tell them that. But if it is 20 per cent, I am not so sure, because I do not know whether the mortality rate is going to stay at 20 per cent or come down to 10 per cent.’[71]

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[71] T49 p. 104–11 Dr Silove and Dr Houston. See Chapter 3 for an explanation of clinical terms

56 Dr Silove and Dr Houston discussed the practice of informing parents about the risk of morbidity and of quoting risks in the following exchange:

> 'A. (Dr Silove): … it is very interesting how surgeons and cardiologists over the years have always talked in terms of mortality rates, and any papers that you look at in the literature refer to mortality rates. There is very little actually written about the incidence of brain damage and kidney damage and liver damage and all sorts of other problems that occur.
>
> 'I think that for every percentage mortality rate that one gives, one has to give a percentage of perhaps a half a per cent for a risk of neurological damage. That is something which many of us, as cardiologists and cardiac surgeons, have tended not to do in discussing operations or proposed operations with parents.
>
> 'Q. (Mrs Howard): If that question, however, was asked specifically of you, how, in your practice, would you have answered that?
>
> 'A. (Dr Silove): I would say, with any operation, not only is there a risk of death, but there is a risk of other problems. I mean, that is something I always have said, but I have never gone on to specify the problems.
>
> 'If they are asking me, "Is there a risk of brain damage?" I would have said, "Yes, there is a risk of brain damage. I cannot quantify precisely what the risk is", largely because I do not think I knew what the risk was at that stage. I think it is only in the last five years or so that people have been writing a little bit more about the incidence of brain damage following cardiac surgery, at least, in the papers I read. I do not know what Dr Houston feels?
>
> 'A. (Dr Houston): For a long time, in fact for as long as I can remember as a consultant we have been writing down, "Parents interviewed, warned of risks", no matter how minor the thing is, risk of death, brain or kidney damage, but it certainly has not been my practice to quote a sort of figure for risk of brain or kidney damage. If they asked me, what would I say, it would depend on what the condition was they [the surgeons] were operating on, clearly.'[72]

57 Professor de Leval and Dr Silove in their expert evidence told the Inquiry that cardiologists and cardiac surgeons (and others) worked as a team when proposing the Switch procedure to parents:

> 'A. (Dr Silove): … the cardiologist would see the parents first, but the cardiologists and the surgeons will have discussed all of the ramifications in quite some detail before the cardiologist ever puts something to the parents.

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[72] T49 p. 146–7 Dr Silove and Dr Houston

> ‘I am sure it is the cardiologist who would be the first to suggest to the parents, “We have discussed this problem and we feel that the right way to go forward is to go for the Arterial Switch operation”. It then becomes a question of how it is dealt with in an individual institution, whether the parents see the surgeon or whether the cardiologist and the surgeon see the parents together, but the communication is terribly important …
>
> ‘It is a team consultation, it is a team decision and it is a team responsibility. I do not think the surgeon should take the flack for everything that goes wrong. I think the whole team is responsible for things going right or wrong.’
>
> ‘A. (Professor de Leval): I fully agree with that … every single patient operated on has been discussed once, twice or three times in great detail by at least two consultants, a surgeon and a cardiologist, but most of them by the junior staff, other consultants. If it is a difficult problem, we would repeat investigations. In the beginning we used to go back with the echocardiograms, repeat an angiogram, to find out where the coronary arteries were. Because the coronary artery was so crucial, sometimes we went ahead with a Switch and found different coronary arteries than expected and we had to back up to a Senning.
>
> ‘So all these decisions were team decisions in which we all took responsibilities. I think this is that type of attitude, corporate attitude that was communicated to the parents, which I think, allowed us to work in an atmosphere of trust and confidence. I think it is absolutely vital. I do not think the parents have ever seen me, as a surgeon, as a single individual within the hospital. I have been always part of a team, and they knew when I talked to them that it was after discussing with others, it was the decision, which had been taking place at the conference.’[73]

58 Dr Michael Scallan (consultant anaesthetist at the Royal Brompton Hospital) gave expert evidence to the Inquiry. Dr Scallan, commenting on Dr Stephen Pryn’s evidence, indicated that:

> ‘A. It is not normally the practice for an anaesthetist to give a specific risk figure for paediatric heart surgery. The surgeon will quote a figure and, as he said, that covers the whole procedure which anaesthesia is upon.
>
> ‘Q. Because the relative risk associated with anaesthesia is very small?
>
> ‘A. That is true, but like so many things, this is evolving and it is becoming increasingly obvious that the details of the anaesthetic and the risk will probably have to be explained to parents and patients in far more detail in the future. It is not inconceivable that at some future date there may be a separate anaesthetic consent form as distinct from the surgical consent form. We are not yet at that point.’[74]

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[73] T50 p. 28–30 Dr Silove and Professor de Leval. See Chapter 3 for an explanation of clinical terms

[74] T72 p. 177–8 Dr Scallan

UBH/T clinicians' evidence

59 Mr Janardan Dhasmana in his written evidence to the Inquiry stated:

> '… in the 70s and 80s, there was no concept of "Informed Consent". The "consent taking", as [it] was called at that time, ranged over a wide spectrum. At one end were the surgeons, who spent minimum time in explanations, recommended the operation and expected the patient/guardian to sign the consent form while at the other end considerable time and effort was devoted in explanations. Similarly the patients also ranged in two categories, one who did not wish to know too much and wanted to leave the details to surgeons, and others who did wish to enquire about details of the procedure.'[75]

60 Mr Dhasmana went on:

> 'The decision to operate on children was taken jointly with the attending paediatric cardiologists in all cases. In fact the child was initially admitted, investigated and treated by the paediatric team and then referred to surgery … All routine and most of the urgent cases were discussed in the joint meeting[76] attended by clinicians involved with the investigations and management of these children. The child's clinical condition, haemodynamic data and angiogram would be discussed at this meeting, which would also include risk assessment and their suitability for surgery. Clinician's opinion on the child's condition used to help in prioritising the admission for surgery and conveyed as such to the parents during our meeting.'[77]

61 Mr Dhasmana stated that he believed parents were informed of the risks of proposed surgery on at least three occasions in routine cases:

> 'a. By the cardiologist — after the diagnosis was established following the investigations ... when surgery was considered as the choice of treatment … Usually the cardiologist would have talked in detail about the pathology and pros and cons of the choice of treatment. I believe risk of surgery was mentioned during this discussion;[78]

> 'b. First meeting[79] with the surgeon — This used to take place in the outpatient department in most of the cases but on some occasions in the medical ward after the investigation and discussion in the joint meeting. …;[80]

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[75] WIT 0084 0116 Mr Dhasmana

[76] For a typical example of Joint Cardiac Meeting minutes, see UBHT 0188 0001

[77] WIT 0084 0121 Mr Dhasmana

[78] WIT 0084 0116 – 0117 Mr Dhasmana

[79] See below for details of what transpired at a 'first meeting'

[80] WIT 0084 0117 Mr Dhasmana

> 'c. On admission to the surgical ward — In routine cases children were admitted about 48 hours before operation and I used to see parents again before surgery and invite [them] for another discussion if they so wished. Since it was now our second meeting, it would have been run on the lines of a question and answer session and I would try to clarify if there was some doubt or misunderstanding in their mind. However I tended to be a bit more reassuring during this second meeting as I did not wish to increase their anxiety any more than was naturally present on the day before their child's operation.'[81]

62 As for emergency operations, Mr Dhasmana stated that the first contact with parents would be treated as a 'first meeting':

> '… the meeting would take place in the ward, usually introduced by the referring cardiologist or the accompanying ward nurse… I would stress the gravity of [the] situation and the reasons for recommending an emergency surgery. On a number of occasions I would have emphasised that even though the risk was high, i.e. 50:50 or even higher, their child may not survive without surgery. Examples are when babies were suffering from TAPVD, Truncus and some with complex and multiple problems, especially if they were already on ventilator and haemodynamically unstable.'[82]

63 Mr Dhasmana described what happened at a 'first meeting', with parents, which mostly took place in the outpatient department but on some occasions took place in the medical ward:

> '(i) I would introduce myself as a surgeon to whom the child was referred, examine the patient and start my preoperative discussion. The abnormality in the child's heart would be explained with the help of a diagram or sketches. These would come from either the cardiologist's notes/catheter report, or from my file of collection of various diagrams and sometimes in the form of hand drawn rough sketches. The surgical techniques would be explained in the same way with the help of sketches. It would have always been mentioned whether the procedure was open-heart surgery or a closed procedure and where it would be performed …
>
> '(ii) The risks, in particular the mortality, was mentioned in the form of percentage i.e. 20% or to simplify 2 out of 10 would not survive the operation. The morbidity or the possibility of postoperative complications would be mentioned during this discussion but figures would not have been mentioned, as these were not available at the time locally or from any other centre in the country. I have always mentioned that there was [the] possibility of injury to other organs of [the] body like lungs, kidneys and brain following the use of heart lung machine but these are becoming rarer with the continuing improvement in perfusion and surgical techniques. I would have also mentioned that these injuries would not be noticed until a few

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[81] WIT 0084 0119 Mr Dhasmana

[82] WIT 0084 0119 Mr Dhasmana. See Chapter 3 for an explanation of clinical terms

days after the surgery … Similarly the possibility of incidence of paraplegia after the surgery for Coarctation of Aorta was mentioned to parents of these children. The discussion on morbidity could go in more detail if parents asked further questions.

'(iii) I would have mentioned if there were possibilities of any further surgery in the future. For example, if the intended operation was a palliative procedure, i.e. shunt or PA banding, I would have mentioned the possible time frame for the definitive repair along with a brief description of that operation. Similarly, in cases of Tetralogy of Fallot, AV Canal and some other conditions where a VSD was also present, a possibility for repeat operation for residual VSD or further surgery on affected valve or scar related narrowing of Aorta and/or Pulmonary artery would also be mentioned.

'(iv) I would also state at this meeting that most children after surgery would require some form of medication for some time. This would be supervised by the cardiologists in the follow-up clinics and withdrawn, once the child has made full recovery from the operation. I also used to state that their children would be followed by the cardiologists for some time, maybe years. They would monitor the child's progress clinically and with investigations, such as a 2-D Echo examination, and refer the child back to me if any further intervention was required.

'(v) I tried to be as open and frank as possible during this meeting and as a result, on [a] number of occasions parents used to get upset especially with the mention of mortality and at times the accompanying nurse or counsellor would spend some time in trying to reassure the parent. I have also tried to reassure them on occasions with the statement, like, hopefully their child would come through this operation without too much trouble.

'(vi) I believe that this meeting was the best opportunity to discuss the risks associated with surgery. This gave them the time to ponder on various aspect[s] of the discussion and raise some further questions, which was not clear to them, with their GP and/or referring cardiologist. They could seek further clarification with me when the child was admitted for surgery. However, since it was our first meeting, the parents used to be very anxious and at times certain part[s] of the discussion could have been misunderstood as I found out on few occasions through their GP or the referring cardiologist's phone calls or letters. Similarly, there were [a] few occasions when parents had stormed off from the clinic or the ward after our first meeting, to return later after due consideration on their part.'[83]

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[83] WIT 0084 0117 – 0119 Mr Dhasmana. See Chapter 3 for an explanation of clinical terms

64 Mr Dhasmana told the Inquiry further that:

> 'Whenever I have mentioned, I think if I was seeing a child, then talking to the parents, I would in a way draw diagrams and I would really say what was wrong, and of course, then I would mention that there are two ways of dealing with it: one is if I am seeing the child at 7 or 8 months of age, and no VSD, then there is no use talking about the Switch there; that is a straightforward Senning.
>
> 'But of course in a child where both operations could be advised, there, especially a neonate, I would be talking of two ways of dealing: one is Senning, but that means waiting for 6 to 8 months from now, when this would be carried out. Unfortunately, the long-term outlook of Senning is not certain. Secondly, the Arterial Switch which I can repair right now, of course, it carries a high mortality, as compared to Senning, but with Senning, low mortality and long-term uncertainty, I think higher mortality at this time is quite acceptable, and I would strongly recommend that Arterial Switch is the better operation. That is how I put it.'[84]

65 On the role of non-clinicians, such as specialist nurses, family support services staff and junior staff, Mr Dhasmana stated that:

> 'There was no organised set up where these groups could routinely express their opinion. However the "Joint meeting" used to be attended by few nurses, cardiac technicians and the cardiac counsellor, but mostly as observer.'[85]

66 Mr James Wisheart, consultant cardiac surgeon, stated in his written evidence to the Inquiry:

> 'For decision-making about elective patients there were two meetings each week for virtually the whole of the period between 1984 and 1995. These were essentially meetings between the cardiologists, the cardiac surgeons and the cardiac radiologists but which frequently included the paediatric counsellor together with nurses and radiographers who worked in the catheterisation laboratory. From time to time an anaesthetist attended but this was not common. Where consultants were present, as far as possible, their juniors would attend also … Within these meetings patients were referred to Mr Dhasmana or me. The format of the meeting was that the paediatric cardiologist responsible for any given child would indicate to which surgeon the referral was being made. He would then present the case giving an account of the clinical history, the findings on examination, the ECG and chest X-ray, what the echocardiogram showed and what were the findings at cardiac catheterisation, angiography and any other special tests which had been done, such as a CT or an MRI scan. It would be normal for the echo to be shown to the whole meeting, as would the angiograms, plain X-rays, CT or MRI scan.'[86]

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[84] T87 p. 86–7 Mr Dhasmana. See Chapter 3 for an explanation of clinical terms

[85] WIT 0084 0121 Mr Dhasmana

[86] WIT 0120 0128 – 0129 Mr Wisheart

67 Dr Pryn stated:

> 'As an anaesthetist, I was not involved in pre-operative planning. This was no different from my experience in Oxford, although when I was in Southampton I would be involved in such discussions when cases planned for the next week were presented at a multi-disciplinary case conference.'[87]

68 Mr Wisheart stated that the nature of the discussion which followed would be determined by whether:

- '... the patient in question was quite straight forward and there was a broad body of accepted knowledge and practice concerning what should be done.
- 'the child had a straight forward condition about which there would be little disagreement as to what was appropriate, but in whom there were significant additional features of one sort or another. These additional features might require a discussion, modification of the usual strategy or even a more radical change in strategy.
- 'the patient had a condition and needed treatment which was more complex; there would then need to be a detailed discussion of the criteria on which selection for any given procedure was made.
- 'the child was one of a very small group with a rare condition needing uncommon and complex procedures; in some of these we might feel it wise that the patient should be discussed with colleagues at another centre, usually Great Ormond Street.

> 'In order to reach a decision there would then be a discussion which might primarily be between the referring cardiologist and the surgeon to whom the patient is referred but which would actively include all the others attending the meeting. The discussion was always open and contributions were always welcome from whatever source.'[88]

69 Mr Wisheart then set out the four possibilities arising from the meeting and discussion:

- '... that advice should be given to the parents that an operation should be undertaken and the parents would then be seen, either in the ward or in the outpatients.
- 'that further investigations should be carried out and the findings reviewed subsequently.

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[87] WIT 0341 0018 Dr Pryn

[88] WIT 0120 0129 Mr Wisheart

- ‘that a decision not to operate should be taken which might actually be one in principle for the long term or one to be reviewed after an interval.

- ‘advice might be sought from elsewhere.’[89]

70 As regards the involvement of other members of the team, Mr Wisheart stated:

> ‘While the cardiologist may well have suggested what type of surgical procedure would be appropriate for the child, at the end of the discussion the surgeon has to make a recommendation.’[90]

The role of junior staff

71 Mr Dhasmana stated that:

> ‘Traditionally the junior doctors used to get parents to sign the consent form soon after admission in the ward as a part of their clerking procedure in routine cases. I used to talk to junior doctors on the pathology and reparative techniques along with the risks involved during the ward rounds. Therefore most of junior doctors would have been aware of common routine conditions like ASD, VSD and Tetralogy, after they have spent few weeks in the cardiac unit. They also knew that parents have already talked to me in the clinic and have agreed for their child to have surgery. The new SHOs [senior house officers] were not supposed to get consent signed on their own. There were always few experienced doctors available in the unit to help the new SHO. In addition I always advised junior doctors in the unit, not to get consent signed if for some reason, I had not seen and talked to parents before or if they had questions regarding any aspect of surgery… I used to see parents in the ward before surgery and then have another discussion later on. I would get the consent signed at the end of this meeting, if it was not signed before. There was some change in the ward policy, around 1993 or 1994 when SHOs were asked not to get consent signed, but to leave it to the experienced Registrars or Consultants. In emergency situations I would get the consent signed after my meeting with parents in the ward.’[91]

72 In July 1993 Professor John Vann Jones wrote a letter to Mr Wisheart with a copy to Mr Dhasmana, stating:

> ‘My junior colleagues have complained to me today that they feel unhappy about consenting people for cardiac surgery and for writing up their pre-med. The reason

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[89] WIT 0120 0130 Mr Wisheart

[90] WIT 0120 0132 Mr Wisheart

[91] WIT 0084 0123 – 0124 Mr Dhasmana

> for this is they are distinctly unfamiliar with cardiac surgery and when it comes to consenting the patient they do not really know the procedures they are prescribing … they do feel that someone who is familiar with what the patient is about to undertake should be doing the consenting …'[92]

Calculating risks and informing parents about them

The approach of the clinicians in Bristol

Mr Dhasmana

73 Mr Dhasmana stated that:

> 'The national data, as received from the UK Cardiac Surgical Register (UKCSR) certainly influenced me in my discussions with parents. I believed that this data was an average for all centres in the country, some of which were lesser volume units like ourselves and may have been new to the procedure, and therefore should be achievable. As the data from the individual units were not available, this was the best guide I could have, during the early part of my career in mid to late eighties, when I had [a] smaller number of cases, where figures could not be predicted with any confidence. But the register was not helpful in … operation[s] like Arterial Switch, as the UKCSR categorises paediatric patients according to the pathology and not the type of operations. The Arterial Switch was performed in different group of patients and similarly the patients with Transposition of Great Arteries were treated by more than one technique in the country. Therefore the true mortality figures of the Arterial Switch procedures for a particular group of patients could not be known from the register.'[93]

74 Mr Dhasmana said he used the data relating to the BRI as a basis for discussion with parents for most procedures, with the exception of Arterial Switches, which only he carried out.[94]

75 Mr Dhasmana stated:

> 'I did take account of my record after 1990 when I had enough patients on my list to speak with any confidence on most of procedures. But this did not help me with Arterial Switches, which was started late (1988 in older children and the neonatal programme in 1992). In addition I was operating on average on 2 – 4 patients per year, not enough to speak with any confidence on my own figures, except in the

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[92] UBHT 0344 0013; letter from Professor Vann Jones to Mr Wisheart dated 5 July 1993

[93] WIT 0084 0119 – 0120 Mr Dhasmana. See Chapter 3 for an explanation of clinical terms

[94] WIT 0084 0120 Mr Dhasmana

> group of older children, where I developed enough experience by the end of 1992, to quote with confidence my own figure.'[95]

76 Mr Dhasmana told the Inquiry that he did not inform parents of the figures relating to his success or failure figures in a particular procedure unless he was asked:

> 'A. The first few patients I always quoted 50:50 may or may not make it. I even quoted 60 per cent, but my record is very good in Truncus after 1989; I had done 6, 7 or 8 without any deaths. I think in 1993/94 when I was talking to a parent about truncus, I would be giving a risk of about 30 per cent.
>
> 'Q. From that last answer, it appears you modify your assessment of risk given your own personal experience?
>
> 'A. That is right. If you have a series you will quote with confidence, you can quote. If you have no series, you have nothing else to fall back on except published literature, which you believe in.
>
> 'Q. I want to contrast the fact that your good experience causes you to reduce an estimate of risk made to a parent, as in, you say, your Truncus Arteriosus after 1989, but your bad experience, as in the neonatal Switch, did not cause you to increase your risk estimate to a parent, rather it made you go back to published literature and rely on the general medical risk in any particular centre.
>
> 'Why take a different approach depending on whether your results were good or bad?
>
> 'A. It was not a different approach. I find it difficult to explain nowadays with whatever information we have in the post-1995 era, what we should be talking to parents and what we should not be. I do believe that one has to put [in context], especially as a surgeon, in the era you were talking to parents, and what was happening. I did not think I was doing anything different than what was being done elsewhere. If any of those parents would really have asked me what was happening before, I would definitely have told them that had happened.
>
> 'Q. That relies on them asking you. You are the expert?
>
> 'A. Well, I am afraid at that time, that is what the practice was, and I was just following the practice.

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[95] WIT 0084 0121 Mr Dhasmana

> ‘Q. You did not have to follow anyone else’s practice; you had your own relationships with parents, did you not?
>
> ‘A. Well, you do not develop a relationship on the first day you are seeing them, really, do you?
>
> ‘Q. What, if anything, prevented you from saying, for instance, “Well, the risk in this operation is 25 per cent but what you ought to know is that the last five such cases that I have dealt with have been entirely successful.” That is one way of putting it, if that has been the case. One would have no problem with that, if 25 per cent reflected a general risk.
>
> ‘The converse: “The risk is 25 per cent but what you need to know is that sadly, for I think particular reasons, but sadly the last five I have operated on have all died.” Did you ever think of putting it that way?
>
> ‘A. Not at that time, no. I did not tell them my successes or failures, unless I was asked about it.
>
> ‘Q. Do you think you ought to have told them, rather than wait to be asked?
>
> ‘A. Now, I think what has happened after 1995, I think, yes, we should be now doing that, but thinking always changes with the passage of time. We have become wiser now.’[96]

77 Mr Dhasmana stated that:

> ‘My quotations for mortality figures changed over years keeping in pace with improvement nationally. To quote an example, in Tetralogy of Fallot a figure of 15% mentioned over mid to late eighties changed to under 10% after the year 1992–93. Similarly in cases of Complete AV canal, quotes for the mortality figures came down from 25–30% in late 80s to 20% in 90s.’[97]

78 As regards referral to another centre, particularly when the proposed surgical procedure was new, Mr Dhasmana stated that he followed what he understood to be the standard practice prevalent amongst his colleagues, together with knowledge from his training. He stated that his practice was to inform parents when new procedures or modifications to existing procedures were being proposed.[98]

> ‘In 1988 when I started the Arterial Switch programme, the parents of the first patient were informed and asked whether they would like to take their child to another centre like Birmingham … Similarly in 1992 when I started the neonatal

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[96] T87 p. 90–2 Mr Dhasmana. See Chapter 3 for an explanation of clinical terms

[97] WIT 0084 0123 Mr Dhasmana. See Chapter 3 for an explanation of clinical terms

[98] WIT 0084 0122 Mr Dhasmana

> Switch programme, the parents were informed that this was a new operation in the neonatal period and that I had performed this procedure in older children.'[99]

79 Mr Dhasmana further stated:

> 'I was not aware of any obligation that I should have quoted any comparative figure from other centres to parents during the preoperative discussion. During my training I had not witnessed this in any of the centres … I was aware that in most cardiac operations I was within UK figures or catching up … For Arterial switches no comparative data was available from other UK centres except from Birmingham until 1992 …'[100]
>
> '… I would have provided some information to parents if asked.'[101]

80 He referred in his written evidence to the Inquiry to a meeting with parents of a baby with Truncus who did ask about comparative information. He stated that he could only give figures from the UKCSR:

> 'I mentioned centres like GOS [Great Ormond Street Hospital] and Birmingham without any real data, as no figures were available from these or any other centres in the country.'[102]

81 As regards informing parents, during pre-operative discussions, about the current record relating to mortality and outcome in the Unit, Mr Dhasmana told the Inquiry:

> 'I used to tell them, in a way, that we were not doing this type of thing before; now we have started doing it. But I do not think I have really mentioned, except for the first few cases in the beginning, that this is what has happened in the past and I am not – you know, this is my results, no, not that way.'[103]

82 Discussing guidance on informed consent and on quoting risks, Mr Dhasmana said:

> 'There was no guidance at that time, and I did not know we were supposed to be saying that, because I had worked in a number of places and I heard nobody saying those things.'[104]

Mr Wisheart

83 Mr Wisheart described his approach in his written evidence to the Inquiry:

> 'My training, reading and personal views led me to explain to parents in detail what was involved in an operation and what estimate of risks were attached, and

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[99] WIT 0084 0122 Mr Dhasmana

[100] WIT 0084 0122 Mr Dhasmana

[101] WIT 0084 0123 Mr Dhasmana

[102] WIT 0084 0123 Mr Dhasmana

[103] T87 p. 84 Mr Dhasmana

[104] T87 p. 85 Mr Dhasmana

I devoted a substantial amount of time to this part of my work. This was the case throughout my time in Bristol from 1975 and initially I understood that my practices in this respect, were new in Bristol.'[105]

84 Mr Wisheart stated that he understood:

'... that the first written advice from the GMC on consent was published in 1999. Their booklet *"Good Medical Practice"* published in October, 1995, contained general advice only. The Senate of Surgery of Great Britain and Ireland gave advice on consent in October, 1997 in *"The Surgeon's Duty of Care"*.

'I believe that there was a booklet prepared by the Medical Protection Society on the subject of Consent, but it was only sent out on request or in relation to a relevant enquiry.'[106]

85 Mr Wisheart stated that as regards informing patients of the risks involved in surgery:

'During the period 1984–1995 I provided information on the risks associated with surgery in the following manner, in outline:

- 'I provided an explanation of the abnormality that was present in the heart.
- 'I explained what would be the consequences of that abnormality if left untreated.
- 'I indicated what treatment was available for this abnormality.
- 'I indicated what I believed was the treatment of choice, and gave that as my advice. I would have indicated what I hoped would be achieved by following that course and whether there were any major predictable limitation. I would then have given them an indication of what risk of mortality was associated with this advised operation. I would normally do this by saying either:

'(i) that the risk of this operation is X%, by which I mean that if 100 children had the operation 100–X would come through but X might die at or following the operation.

'Or

'(ii) I might simply say that if 100 children had this operation I would expect so many to come through (quoting a number) but that the remainder (quoting the residual number) would not come through, or would die at, or following the operation.

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[105] WIT 0120 0368 Mr Wisheart

[106] WIT 0120 0368 Mr Wisheart

> ‘Occasionally, I would have discussed alternative methods of treatment.
>
> ‘Save for coarctation surgery … it was not part of my routine to indicate the risk of surviving with a permanent complication or injury, which for practical purposes means a central nervous system injury. It is my belief that such explanations were not generally given until recent years …
>
> - ‘This explanation, in nearly all cases was given by myself and in many cases would have been in the presence of a nurse, a counsellor or a junior doctor.
> - ‘I always invited parents to ask questions and discuss the issues.
>
> ‘For completeness, consent for cardiac catheterisation was obtained by the cardiologist and consent for general anaesthesia by the anaesthetist.’[107]

86 Mr Wisheart told the Inquiry that he took account of data relating to his own practice, in so far as they were relevant to the patient whom he was treating at the time.[108] In his written evidence to the Inquiry he stated:

> ‘The risk involved in a procedure, is the risk in the here and now; that is to say in this Institution, by this surgeon, in the present era. It is not sufficient to quote the results of another surgeon or an eminent centre elsewhere, such as the Mayo Clinic. There will normally be figures for the Institution and for the surgeon which can be the basis of information provided to the patient or to the patient’s parents. However, the difficulty is that for many operations, the numbers involved in the Institution’s own experience will be so small as to make those figures unreliable, or unhelpful. Reference must then be made to larger registers and other sources of information.
>
> ‘It is also important to note that the risk given for any given child is not just the risk for a set procedure, taken from some list or document, it is the risk of that procedure taking account of all the relevant details and circumstances of that child. Thus for example;
>
> ‘1) If the child has additional abnormalities, or
>
> ‘2) If the child’s condition is unstable at the time of the operation, or
>
> ‘3) If the operation is of an emergency nature,
>
> ‘any of these factors will add to the risk of the operation. Therefore the risk to be given has to be tailored to the needs and the circumstances of the individual child.

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[107] WIT 0120 0357 – 0358 Mr Wisheart. See Chapter 3 for an explanation of clinical terms

[108] T92 p. 57 Mr Wisheart

> ‘Finally it would be quite wrong to depict a surgeon as a doctor who simply carries out procedures, the results of which can be measured, or that the understanding between a surgeon and his patient is simply that the surgeon will carry out a tightly defined procedure.’[109]

87 Mr Wisheart told the Inquiry further:

> ‘The indication of the level of risk that I would give to parents about a particular child would be based on the information I had about that child and would be tailored for that individual child. So in this context if the child under consideration to the best of our knowledge had an AVSD with either nothing more or only something that would have changed things relatively marginally, then that would have been quite different from a situation where a child had an atrioventricular Septal Defect and let us say I knew that the child had left ventricular outflow tract obstruction or if I knew the child had severe but not inoperable pulmonary vascular disease. So you cannot just say AVSD, press a button and get a number. The individual child has his own characteristics or her own characteristics and one therefore does one’s best to tailor what one says to those individual characteristics because I think it would clearly be inappropriate to ignore those differences that I have just indicated to you if you knew them.
>
> ‘So when I looked back on my experience, I think you said at this point I have operated on 13 patients in this particular series from 1990,[110] and that would be correct, so I can say to you that just 9 of those 13 were free of a significant abnormality. Therefore if the child in front of me now appears to be free of any significant additional abnormality or risk factor, then the immediate relevance of the previous 13 patients has to be carefully considered, and it is not just a matter of transferring the number or whatever it may be from that experience to this child.’[111]

88 Mr Wisheart stated in his written evidence to the Inquiry that information on the child’s condition was:

> ‘… the essential and the fundamentally most important information in assessing the risk of that child having any particular procedure. The risk can be predicted to be influenced by such factors as –
>
> ‘i. Additional abnormalities.
>
> ‘ii. The child’s condition at the time of the operation; eg. is he or she ventilator dependent?
>
> ‘iii. Is it an emergency operation?

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[109] WIT 0120 0360 – 0361 Mr Wisheart

[110] AVSD series. See Chapter 3 for an explanation of clinical terms

[111] T92 p. 58–9 Mr Wisheart

> ‘iv. The presence of Pulmonary Vascular Disease, which has not achieved a level of severity that would contra-indicate the operation altogether.
>
> ‘v. In the early part of the era mainly young age and low weight would have been considered important incremental risk factors.
>
> ‘This group of factors, without doubt influences the risk. Some factors will do so to a marginal extent and others to a highly significant extent. The difficulty is that there is no general accepted basis for assessing in a precise or quantitative manner, the degree to which any of these factors would increase the risk. It is only possible therefore to do so in a qualitative or, even possibly, an arbitrary manner. Once a risk factor is identified then one can begin the work of attempting to neutralise or minimise the effect of a risk factor and thus reducing the risk of the operation.
>
> ‘It was my practice always to consider factors such as these when making an estimate of the risk, even though there was no basis for doing so in a precise manner.’[112]

89 Mr Wisheart stated that, as a consequence, the BRI’s and his own personal record were the basis for any quotation of risks to parents:

> ‘These should be taken together as they are the real foundation for advice to parents about the risks of any particular procedure. In 1999 it might be thought that such data would have been constantly updated and freely available to surgeons throughout the period under review by the Inquiry. However, this should probably not always be assumed to be correct. I depended on my own log and on the material in the annual statistical summaries. In my experience the main limitation of local data was that for many of the procedures, the numbers locally may be very small. Indeed these numbers may be too small to be considered in isolation.’[113]

90 Asked by Leading Counsel to the Inquiry about the extent to which risk stratification could affect the way he described the degree of risk to a parent, Mr Wisheart replied:

> ‘… risk stratification are the factors that may exist within each of those categories altering the risk above or below the figure given and that is the core of the problem in all of this issue.
>
> ‘Because I can describe the presence of the abnormalities, I can give a qualitative indication of their severity but I cannot put a figure on it and therefore I cannot do a calculation and say “In this group of patients the risk is half normal, double normal, treble normal”, I cannot do that. All I can say is that the effect of all of these observed additional factors put together seems to be important and may double or whatever the risk. But there is no basis for being precise about it. That really is the

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[112] WIT 0120 0363 – 0364 Mr Wisheart. See Chapter 3 for an explanation of clinical terms

[113] WIT 0120 0362 – 0363 Mr Wisheart

central difficulty. Otherwise I think one would be able to communicate it much more clearly.'[114]

91 Referring to the figures and the quoting of risks at other centres, Mr Wisheart stated:

- 'In general, this information about individual centres was not known, therefore it would not have been possible to refer to risks at other institutions.
- 'There may have been some procedures, for which there may have been information (although not necessarily precise information) about higher or lower risks at some other institutions.
- 'I am not aware of any professional or ethics guidance or requirement to refer to risks at other institutions during the period under review by the Inquiry.'[115]

92 Mr Wisheart described the use of national and international data and published papers. As for national data, he stated:

> 'Throughout the period 1984–1995 there has been national data in the form of the United Kingdom Cardiac Surgical Register (UKCSR). It has strengths and weaknesses, which have been outlined elsewhere in the evidence provided to this Inquiry. For the surgery of any condition, it provides an aggregated figure for the whole country or a national average. It does not provide the range of results from the Institutions or surgeons across the country, nor does it provide risk-stratified data. Nevertheless, where the unit's or my own surgical figures for the procedure in question are very small, I would also consider and give appropriate weight to the reported experience across the UK.'[116]

93 Regarding international data, Mr Wisheart stated:

> 'During the period 1984–1995 data from registers in other countries or from international registers was very limited. The only data which I can recall came from two groupings of surgeons in North America, namely the Congenital Heart Surgeons of North America and the Paediatric Cardiac Care Consortium. The information they made available up to 1995 was very limited. The latter group has published the results of their work for 1984–1995.'[117]

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[114] T92 p. 109–110 Mr Wisheart
[115] WIT 0120 0367 Mr Wisheart
[116] WIT 0120 0361 Mr Wisheart
[117] WIT 0120 0362 Mr Wisheart

94 As for published papers, Mr Wisheart stated:

> 'Often these papers came from centres of excellence and usually only papers are published which give the best results. They are therefore not representative, and are of limited use, and do not often contribute to the assessment of the risk in a particular operation. Over the years I can only remember a very few occasions when I relied on reports in published papers, to make an estimate of the risks of an operation.'[118]

95 Commenting on the views of other members of the team, inclusive of specialist nurses and family support services, Mr Wisheart stated:

> 'In general the opinion being expressed to the parents by me as a surgeon, was indeed the opinion which had previously been reached by the team. That is to say the cardiologists, the radiologists, the surgeon and any others who may have been in attendance at the clinical meeting. In the case of an emergency operation, generally it is the opinion of the cardiologist on call and myself as the surgeon on call, who will have conferred together. The advice being offered is virtually never the unilateral advice of the surgeon.'[119]

96 Mr Wisheart concluded:

> 'I always sought to make my estimate of risk as accurate as possible, but also sought to avoid optimism. I believe that my estimates of risk were adequate in that they were as precise and accurate as possible.
>
> 'However, I wish to make two points:-
>
> 'i) The accuracy, precision or statistical reliability of any figure given to a patient or a patient's family, will always be questionable. Such a figure is at best an approximation and its validity would virtually always be open to debate. The importance of this consideration is underlined by the very large number of different procedures which are carried out in paediatric cardiac surgery, each type of procedure being carried out in very small numbers.
>
> 'ii) For the patient or parent such a statement is always inadequate, because in the event for that patient, the risk will either be zero per cent or 100 per cent.'[120]

97 Mr Wisheart described where and when discussions with the parents took place:

> 'For elective operations I believe that the explanation should be given at a reasonable time interval before the operations so that the parents would have time to absorb and come to terms with, whatever has been said in the explanation. They

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[118] WIT 0120 0362 Mr Wisheart

[119] WIT 0120 0364 Mr Wisheart

[120] WIT 0120 0370 – 0371 Mr Wisheart

> also would have an opportunity on mature reflection, to think of any other questions that they might wish to ask. I usually met with the child and the family in the outpatient clinic. In a minority of instances, usually where the decision was a difficult one, more than one consultation would be needed to reach a conclusion.
>
> 'It would be my practice to see the parents again on the ward when the patient is admitted for surgery. On that occasion I would offer to repeat the explanation or to answer any questions which they would ask.
>
> 'Inevitably in the course of complex medical treatment, such as paediatric cardiac surgery, unforeseen findings may be encountered. It is not practical to obtain further consent from the parents during the course of the operation. In these circumstances the surgeon has no alternative but to take whatever action he believes protects the best interest of the patient.'[121]

98 As regards the use of written information or leaflets to inform parents, Mr Wisheart stated:

> 'These were rarely used in my practice beyond occasionally using a pre-existing diagram to explain the abnormality in the heart.'[122]

99 Mr Wisheart stated further that:

- 'I am not aware of any guidance as to how one should quote for risk, in the sense of the process of … making the best estimation of risk. I believe I did understand how to quote for risk, in the sense of how to talk with a patient or parents.
- 'In quoting for risk I took into account the procedure being advised, the detailed circumstances of the patient, the experience of the surgeon and the institution, and where appropriate, the national or internationally available data.'[123]

100 In his written evidence to the Inquiry, Mr Wisheart described his practice relating to the discussion of morbidity:

> 'From the early 80s the risk of paraplegia following Coarctation surgery in children was something which I explicitly stated to parents. This risk was of the order of 1 in 200 to 1 in 300. Indication of the risk undoubtedly caused distress and anxiety until the operation was over.'[124]

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[121] WIT 0120 0359 Mr Wisheart

[122] WIT 0120 0365 Mr Wisheart

[123] WIT 0120 0369 Mr Wisheart

[124] WIT 0120 0373 Mr Wisheart. See Chapter 3 for an explanation of clinical terms

101 Mr Wisheart also said:

> ‘It was not part of my routine to mention the possibility of Central Nervous System injury as a risk of other operations.
>
> - ‘If I were asked about this, I would have responded by indicating that there was a risk, but that it was very small.
> - ‘My view was that the risk of *surviving* with *severe* neurological damage was very small.
>
> ‘In the latter part of the period there was discussion in the field of cardiac surgery generally, including paediatric cardiac surgery, about the need to indicate the possibility of Central Nervous System Injury. I do not believe that it ever became common practice in the UK to do so during or before 1995.’[125]

102 Mr Wisheart stated further that:

> ‘Recoverable complications would only be discussed if I was asked about them.’[126]

103 Mr Wisheart described his practice relating to discussing with parents the likelihood of future surgery or continuing care being needed:

> ‘Where the risk of future surgery was predictable I told the parents about it in the discussion. For example, I would say that:
>
> ‘a) A patient having a palliative procedure would normally require a corrective procedure later.
>
> ‘b) If Coarctation surgery was carried out very early in life (the first 3 months), then the possibility of a recurrence of the Coarctation was greater than if carried out later. This might lead to the need for further surgery (or in the latter part of the period under review, to the need for non-surgical intervention).
>
> ‘c) The use of any prosthetic or bio-prosthetic material (other than a simple patch), early in life, meant that as the child grew that prosthesis or bio-prosthesis would be inadequate in size and therefore would need to be surgically replaced.
>
> ‘d) In some operations, of which Atrio-Ventricular Septal Defect (AVSD) corrections are an example, the surgery was complex and the risks of needing some later surgical treatment were greater than after most other procedures. Following AVSD correction further repair or replacement of the mitral valve might be needed or a permanent pacemaker might be required in the event of complete heart-block.

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[125] WIT 0120 0373 Mr Wisheart (emphasis in original)

[126] WIT 0120 0375 Mr Wisheart

'e) The likelihood of protracted drug regimes being needed was relatively uncommon, but might be predictable as a possibility in a small number of cases. I doubt that this would have been routinely discussed before surgery.'[127]

104 As regards any discussion with parents as to alternative methods of treatment, Mr Wisheart stated:

- 'Sometimes there would be a choice between correction or initial palliation and part of our advice would be to indicate which was more appropriate for the child. The advice would be determined by consideration of the details of the abnormality and the operations involved.
- 'Sometimes it would be agreed that an operation was needed but that there would be no urgency as to this procedure and therefore there could be a discussion about its timing.
- 'The view would have been held with increasing conviction throughout the period under review, that usually, and for most conditions, anatomical correction relatively early in life gave the best chances for future length and quality of life. Therefore alternatives to anatomical correction were in principle undesirable.
- 'With increasing importance as time progressed through the period under review, for some abnormalities there was a choice between surgical and non-surgical intervention. Usually these two options would have been discussed by the cardiologists, surgeons and radiologists at the clinical meeting and if the patient was referred for surgery, it was because the clinicians had agreed that surgery offered the better prospect for the patient. If non-surgical intervention were mentioned in that discussion, it would usually have been indicated that we regarded it as a less favourable course of action.
- 'If at a clinical meeting the clinicians had decided that non-surgical intervention was the course of choice, then the cardiologists would have explained that to the parents and the patient would not have been referred to the surgeon.'[128]

105 As regards non-intervention, Mr Wisheart stated:

- 'If the conclusion reached at the clinical meeting by the clinicians was that surgical intervention was not appropriate, then that patient or that patient's parents would not normally see the surgeon. The advice would have been conveyed to them by the cardiologist.
- 'The possibility of non-intervention is referred to in the discussion with every patient, when the outcome of the condition if it is left untreated is discussed.

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[127] WIT 0120 0374 Mr Wisheart. See Chapter 3 for an explanation of clinical terms

[128] WIT 0120 0375 – 0376 Mr Wisheart

- 'If the decision to advise surgery was genuinely borderline (ie there was a fine balance between the risks and benefits), and the patient was referred to the surgeon, then the real option would have been discussed. This was an uncommon situation and the patients would have been in two groups:

> 'a) those with a trivial abnormality, in whom the prospects of a long and fit life untreated were good, but the prospects following surgery would have been better in our opinion. Such benefits are relatively marginal and a long way into the future. The two options would have been discussed and surgery could only be considered if its risks were very low. The patient or the patient's parents then decide.
>
> 'b) Those in whom the condition was extremely complex, and a proposal to operate may have been on the borderlines of what was possible. Again that would have been discussed, with a rehearsal of the main factors on either side of the decisions.'[129]

Dr Martin

106 Dr Robin Martin discussed reference to data from other centres, its uses when referring to other centres and the relevant considerations for referring to Bristol, in the following exchange:

> 'Q. … if you had said to the parent, who perhaps is the best judge of the child's interests "You may stay here in Bristol where it is good and it is local and where we have only done three operations of this sort on children at this age and they have all died, or we can, if you wish, send you to Birmingham where there is a risk, we cannot deny the risk but there appears on what we know about the figures to be a better chance of survival"; how do you suppose a parent would react from your experience to a choice put in those terms?
>
> 'A. That predisposes I had that information. As I have already said, I did not have information from other units. The only crude data I would have would be that from the Surgeons' Registry, the Society of Cardiothoracic Surgeons' Registry which gave very broad data for different groups, but it was not operation specific. We had really no comparable data to be sure about based on that. So whether I should refer patients to another hospital because Joe Bloggs had said their results when I met him at a meeting were good, I do not think that is a basis for making the referral. I would really have liked to see more data than that.
>
> 'Q. I think you jumped the question.
>
> 'A. Have I? Right.

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[129] WIT 0120 0376 – 0377 Mr Wisheart

‘Q. You have answered the question which I had not yet asked, which is: why did you not? The question I was asking: suppose the parent were presented with the option in something like those terms, what would you, from your experience, expect the parent to do? We will come in a moment to whether you could have put it in those terms because you may not have had the information. Suppose you had put it in those terms to a parent, what would the parent do you think have said?

‘A. It is very hypothetical. As I already said, that presumes you have the knowledge to put it in those terms.

‘Q. If you had the knowledge to put it in those terms and you said it, what would you expect most parents would say to you?

‘A. I think if you put it in those terms without any riders, I would expect probably the parents to say “I will go to a different centre”, most likely.

‘Q. You suspect that because, if those terms are appropriate on that hypothesis, I appreciate, there is really no answer, is there, to the suggestion that the child is probably better cared for in a centre which has an apparently better track record and has a much greater experience of the operation?

‘A. That predisposes you know that information.

‘Q. But on that hypothesis, that must be right, must it not?

‘A. If you tell me so. I think it is very difficult to judge, but there are many reasons why you might favour a referral to your own centre, which is the sort of line you are taking. There is the geographical ideas we have already discussed. The patients you are talking about may be only a relatively small proportion of your overall work so you build up a working relationship with your surgical colleagues. You certainly come to rely on their experience and expertise and listen to their advice. Any patient that is being assessed for surgery, it is not something I am saying this is what has to be done, it is something you discuss as a group and — I am not sure whether you have seen yet, but the joint conference data notes that would be done for most patients mean that opinions are canvassed from different areas, so my cardiological colleagues, my surgical colleagues all would have input into that decision-making process.

‘So deciding what treatment is right for that particular patient is a complex one; it is a complex interaction between many individuals of a team.

> ‘Q. As part of that answer you have said to me that the building up of a relationship with the surgeon in your centre is a matter of importance?
>
> ‘A. You inevitably build up a working relationship with colleagues and to an important degree you do listen to other people’s advice, you know, within your unit. So building up a relationship per se is not the “be all and end all”, but it is an important part of how cardiologists, cardiac surgeons work, they work as a team.
>
> ‘Q. Do you think it would prejudice the relationship of any cardiologist at Bristol with the surgeons at Bristol to have said “In this case we are going to refer this child to another surgeon for an operation which can be done here, but we think it can be done better there”?
>
> ‘A. It is very difficult to say. I think you would have to ask other colleagues, you know, particularly the surgical colleagues, whether they would have done.
>
> ‘I think there would have been a danger it could do so.’[130]

Dr Joffe

107 Dr Hyam Joffe discussed the role of the cardiologists, in informing parents, particularly as regards new procedures, in the following exchange:

> ‘Q. You said a moment ago that once the decision [to operate] had been taken, that the cardiologists – I forget your phrase –
>
> ‘A. Supported the service.
>
> ‘Q. — fully, I think, was the impression you were giving?
>
> ‘A. Yes.
>
> ‘Q. Does that mean that the cardiologists, in talking to parents about the operation, gave perhaps a more enthusiastic description of the operation and what it might achieve than they individually would have given had the decision as it were been theirs alone and had they not been part of the collective that decided to conduct the Arterial Switch?
>
> ‘A. I do not believe so. I think, with any new procedure, one has to be as open as possible, with parents. I do not believe actually we mentioned to anybody that this operation had never been done in this unit before, but the view would certainly have been given that this is a new operation, generally; that the results are not quite as good or not as good as the results of immediate post-operative surgery using the Senning procedure, but that the belief is, among the cardiac fraternity, paediatric,

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[130] T76 p. 136–9 Dr Martin

around the world and in this country, that the long-term benefits would be better. So, of the two operations available, we would recommend the Arterial Switch.

‘Q. Why was it, do you think, that it was not mentioned by anyone that this was the first or the second such operation being done in the unit?

‘A. I think at the time I do not believe that any unit would have taken a different approach, personally.

‘Q. That is not quite the same – that is not quite an answer.

‘A. I was going to come on to say that either one started a new procedure or one did not. I believe that it is a very difficult question to deal with, but I do not believe we would have necessarily started that operation if the advice had been given to parents in such a way that they knew we had no experience at all in neonates and would most likely not have wanted to do the operation.

‘At the same time, we would have told them that the surgeons had a fair amount of experience with the non-neonatal Switch, and that in that procedure the surgeon doing the operation has been achieving results that are more or less equivalent to those in other units in the country. And that that same surgeon would be tackling the neonatal Switch.

‘Q. So what you are saying in effect is that if you told the parents the whole truth, the whole facts about the operation, they probably would have said “No, I will not have the operation”, and to avoid that as a result, you did not volunteer all the facts?

‘A. Not all the facts, no, but I think we would have indicated, certainly, that this was a new operation and that if asked, I think we would have informed the parents that in fact, at that point for case number 1, we had not done one previously. There always has to be a case number 1.

‘Q. How many parents, in your experience, say to you, “Doctor, this is the operation you are recommending; tell me, have you ever done one before?”

‘A. I agree with you entirely, today that is exactly what I would say, that we have not done one before. In the current climate of 1992, which was more defensive, that was the view of, I believe, most of my colleagues around the country and that was the one we followed. I think it is inappropriate today, in retrospect, I would agree with you.’[131]

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[131] T90 p. 135–7 Dr Joffe. See Chapter 3 for an explanation of clinical terms

108 As regards informing parents generally, Dr Joffe told the Inquiry:

> '… I think the understanding of the lay public (and that includes parents as well as other patients) has evolved, has changed, has opened up, has become more desirous of knowing the full facts and I believe now (and I am using my usual kind of non-direct approach, if you like) [it is] probably best to give the full facts but put them in perspective as far as one can and somehow retain the sense of hope in the patient.
>
> 'But I still believe there is an element of judgement and selectivity involved and that there are some patients or parents … where I think I might have been a little tardy about telling them absolutely everything in a stark fashion because of my judgement, not that they would not want their child to be operated upon, but because it might – destroy is too strong a word, but might be too tough for them to cope with at that time.
>
> 'I would rather, under those circumstances, perhaps break up the information into what I believed at the time they would cope with, with a view to seeing them again once or twice before an operation and try and convey additional risks thereafter; it is a very difficult subject. I believe it comes with experience of being with people and unfortunately I have had to be part of the process, not only of informing people of the total picture but also of being present at bereavement situations and inevitably there will be a difference of opinion about how that should be handled. But I think one does one's best in one's own perception of the requirement.'[132]

109 Asked by the Chairman whether seeking to retain 'some sense of hope'[133] in the patient was misleading or unhelpful, Dr Joffe replied:

> 'It is a balance. I think the primary or the overriding risks I think should be stated and I do not think that under any circumstances one should shy away from that.
>
> 'By that I mean that if an operation has a risk of 1 in 3 or 1 in 4, and quite frankly at that time I do not think there is a difference in a parent's mind about what 33 mortality rate is versus 35 mortality rate, it is a real mortality rate, their child could die is the point and I think that is as far as one needs to go, frankly, at that stage but one cannot hold back on that, that is reality.
>
> 'But in terms of some of the less common complications, I believe that can be introduced in a gentler way in the case of cerebral haemorrhage or as Dr Houston mentioned, renal failure and other sorts of complications that would be far rarer.'[134]

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[132] T91 p. 35–6 Dr Joffe

[133] T91 p. 36 Dr Joffe

[134] T91 p. 36–7 Dr Joffe

110 Dr Joffe was asked about training in communication skills, in the following exchange:

> ‘Q. Did you have any training in communication skills?
>
> ‘A. No, not at all.
>
> ‘Q. You have picked up the skills that you have by practice?
>
> ‘A. Yes, correct.’[135]

Dr Jordan

111 Dr Stephen Jordan discussed the issue of giving estimates of the risks involved in an operation to parents, in the following exchange:

> ‘A. … from my own point of view I find this whole business of emphasis on giving parents an exact figure for the mortality for an operation rather strange and it did not seem to relate to the real world in which I worked at the time. It may well be the situation in 1999 is entirely different, but I was much more prone to use terms like “This is a major operation, there are going to be considerable risks, but on the other hand ... “ and you know, describe what the advantages are.
>
> ‘In other words it was not my practice unasked to say to the parents “I am going to tell you what the statistics are with regard to the chance of your child surviving this operation”.
>
> ‘Q. In terms of statistics from other centres, I think we have already discussed this a couple of times, there was not any reliable published comparative data showing the comparison between Bristol or any other centre and other individual centres?
>
> ‘A. The statistics on this occasion would consist of what either we heard formally at meetings of people presenting results or what was discussed over coffee at the same sort of meetings with clinicians there.
>
> ‘Q. There might be papers published by centres who were anxious to broadcast to the relevant professional community?
>
> ‘A. Papers usually are sort of given as presentations first. You would probably hear of it more quickly by going to something like a British Cardiac meeting or surgeons going to one of the Cardiac Surgical meetings.
>
> ‘Q. Typically centres would be more anxious to write papers and give lectures and presentations on their successes as opposed to their failures?
>
> ‘A. That is true, yes.’[136]

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[135] T91 p. 38 Dr Joffe

[136] T79 p. 173–4 Dr Jordan

112 The issue of informing the parents before a neonatal Switch procedure was discussed by Dr Jordan in the following exchange:

> ‘A. My best recollection of what I said in effect was that, rather similar to starting off what I would have said about a normal neonatal Arterial Switch operation, the severity of the condition and obviously it is important that the parents realise once you are starting to talk about an operation with important risks that you are also talking about an operation on a child who otherwise is not going to survive. That is the first thing that is said.
>
> ‘The second thing is to say that there are actually two ways of dealing with this condition. We will be discussing with the surgeon, this is if I had not already discussed it with the surgeon, that “There is one operation which can be left for some time and in our hands has very good immediate results, but the operation which would actually correct the condition is a much more major operation and it would have to be done fairly soon while your baby is still very small.”
>
> ‘Q. What would be said about the relative risks of mortality in that Arterial Switch procedure?
>
> ‘A. As I have said before, I was not one to write figures on a piece of paper, I know the surgeons did on occasions, but I would have used terms like “major risk”and so on.
>
> ‘Again, had I been pushed I would have said at that time “I think that the risks of doing a neonatal Arterial Switch operation in our hospital with this surgeon with his previous experience in a relatively uncomplicated transposition are going to be similar to the risks that would have occurred in the older patients with the more complicated form of anatomy”.’[137]

Dr Masey

113 Dr Sally Masey stated:

> ‘It has always been my practice to see patients prior to surgery, as far as is possible. Consequently I would visit a child having cardiac surgery the evening before surgery and discuss with the parents, and child if old enough, the anaesthetic plan. I would give them the opportunity to ask questions although I was not involved in obtaining consent for surgery.’[138]

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[137] T79 p. 181–2 Dr Jordan. See Chapter 3 for an explanation of clinical terms

[138] WIT 0270 0005 Dr Masey

Dr Pryn

114 As regards discussing risks associated with surgery with parents, Dr Pryn stated:

> 'I always visited the patients on the afternoon or evening prior to surgery. I attempted to coincide my visit with the child's parents or guardians, although this was not always possible. I did not see it as my role, nor did I have the experience, to re-assess the patient's cardiac condition, with a view to determining whether the proposed operation was still indicated, nor whether this was the optimum time for the surgical intervention. This I assumed to be performed by the cardiac surgeons in conjunction with the paediatric cardiologists … I developed an anaesthetic care plan in my mind and explained to the parents the basics of my plan for pre-operative starvation, pre-medication, anaesthetic induction, invasive monitoring and intensive care. I always invited questions from parents or guardians. I did not specifically cover issues of operative risk, although if asked directly I covered it in general terms and referred the parents to their surgical consultant for further discussion. The approach I have always taken to pre-operative visits is encompassed by the standards subsequently published by the Royal College of Anaesthetists (RCA Guidance for Purchasers 1994). There were no information booklets on anaesthesia for parents, similar to that produced by AAGBI (Anaesthesia and Anaesthetists – Information for Patients and their Relatives), available within the BRI. Consequently no literature was provided for the parents concerning anaesthesia.'[139]

115 Dr Pryn stated in his written evidence to the Inquiry that he would explain operative risks to parents in 'general terms'. He discussed this further in the following exchange:

> 'A. I would say: "Your child is extremely unwell. His is a high-risk procedure. You are aware of that", or "Your child is relatively well at the moment. We do lots of these procedures. It is relatively low risk", that sort of general terms, but I would not put figures on it.
>
> 'Q. What about risks associated with anaesthetics? Is there any necessity to explain any of those?
>
> 'A. I thought that that was all incorporated within the overall surgical risk, because the risk associated with an anaesthetic is relatively small in most patients compared with the operative risk.
>
> 'Q. So there was no need to treat that separately at further length?
>
> 'A. I did not feel at the time.

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[139] WIT 0341 0016 – 0017 Dr Pryn

‘Q. At the time?

‘A. I did not feel so, so I did not.

‘Q. Presumably one of the reasons why you might refer a patient, or parent rather, back to the surgeon for further surgical discussion of risk would be if you picked up the fact that they did not appear to be adequately informed about the dangers of the operation that lay ahead.

‘Would that be correct?

‘A. That is true, but Mr Wisheart and Mr Dhasmana were extremely conscientious of documenting in the notes, in their clinic appointment that they had spoken to the parents about risk, and they often would write down the risk that they quoted to the parents. So I knew pretty much what had been told to the parents already.

‘Q. And, knowing what had been told to the parents, were there any occasions when you felt concerned about the adequacy of that explanation that had been apparently offered by the surgeons?

‘A. No.

‘Q. What about parents’ perception of the advice that had been given to them? Were there times when, having looked at the notes, you thought an adequate, proper, reasonable explanation of risk had been given, but it did not appear to have filtered through on to the consciousness of the parents?

‘A. I cannot remember any instances when I thought that the parents were not adequately prepared for a very risky procedure.

‘Q. So overall this was an area that did not cause either concern or a need to refer back patients or parents to the surgeons for further discussion?

‘A. Not often, no, and, in fact, the night before surgery is not a good time to have detailed discussions of risks anyway, so I probably did not court those discussions.’[140]

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[140] T72 p. 73–5 Dr Pryn

116 Dr Pryn expanded on the incorporation of any risk from anaesthesia into the risks of surgery in the following exchange:

> ‘A. I assumed that when parents are told about the risk of the procedure, that risk incorporates all the risks: anaesthesia, surgery, intensive care.
>
> ‘Q. Is that integration of risk a normal assumption for you, or do [you] separate the risk in any other situation, and therefore discuss with parents risk of anaesthesia as a separate issue?
>
> ‘A. I think it is normal to group them together. I think the one time you would not group it would be, say, for a cardiac catheter study, where the risk of the procedure is relatively small, the main risk is that of anaesthesia, but for a complex surgical operation, the main risk will be surgery.’[141]

Nurses

Sister Woodcraft

117 Joyce Woodcraft, Senior Sister, BRHSC ICU 1985–1994, indicated in her written evidence to the Inquiry that, whilst nurses did not generally play an active role in obtaining consent from parents, they were present during discussions between the clinicians and parents.

118 She stated:

> ‘In relation to Mr Dhasmana and Mr Wisheart, I have sat in with them many times whilst they explained to parents and family members the operation required. In my professional opinion they explained carefully and showed a great deal of empathy with the family. They drew diagrams to explain the surgery to the families. They were always careful to fully explain the risks involved.’[142]

Sister Disley

119 On the role of nurses in the discussions about consent and the risks of surgery, Sister Disley, Ward Sister, BRI, told the Inquiry:

> ‘Q. You say that you had no role in discussing with families what the risks and benefits of the operation were. Whose role was it?
>
> ‘A. The surgeon’s.
>
> ‘Q. Anyone else?
>
> ‘A. Possibly the cardiologists must have been involved.

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[141] T72 p. 175 Dr Pryn

[142] WIT 0121 0009 Ms Woodcraft

‘Q. The cardiologist, would he normally be involved?

‘A. Yes, they would. They would see the children in the initial stages.

‘Q. For adults, the cardiologist would be in the same building as the surgeons?

‘A. Yes.

‘Q. Was there any difficulty in having these discussions in the case of children when the cardiologists were based elsewhere? Did the cardiologists come down to the BRI to take part in this discussion?

‘A. This particular discussion, I would have imagined would have taken place at the Children’s Hospital before the children were admitted for surgery.

‘Q. Do you remember witnessing the risk discussion, if I can put it like that, between the surgeon and the cardiologist and parents of a child at the BRI?

‘A. No. No.

‘Q. So when you say that you attended discussions in supporting role —

‘A. I think what I am referring to is discussions that probably happened maybe one or two days pre-operatively. I think they were discussions to just clarify issues that had been discussed several times before with the parents about the risks and benefits.

‘Clearly, the day before surgery is not the day to be identifying those risks and benefits. That is the stage to which I am referring.

‘Q. Would your role at this stage have been to provide essentially reassurance to the parents, to the patients?

‘A. I think so. I think parents were probably very anxious and had questions to ask afterwards. It was useful if you had been there to explain.

‘Q. Let us take parents of a child. The child is going to have surgery tomorrow or the next day. What kind of questions would the parent ask of you, as the Sister, as opposed to the cardiologist or the consultant surgeon?

‘A. I think they would be asking things about the pattern of the post-operative recovery, how long the child might be on a ventilator, how long they might have chest drains, where they could eat, at what stage they might be expected to wake up, that sort of thing.

‘Q. Would they ever ask you about the surgeon himself? Would they ever say, “Is X good?”

‘A. I do not recall anybody asking me that.

‘Q. Would you provide reassurance by saying things like, “Your child is in good hands with Mr X”?

‘A. I might have done. It is very difficult to remember.

‘Q. Is that the sort of reassurance that you might well have provided?

‘A. I think the reassurance that I am talking about refers to their post-operative recovery in the intensive care, explaining that route that the child would go down.

‘Q. Do you ever remember attending one of these discussions and hearing a risk or a benefit quoted to a patient, or a parent of a patient, that you disagreed with?

‘A. I do recall such an occasion, but it was actually after the child had had surgery.

‘Q. What was the occasion?

‘A. It was an occasion where the child was — I cannot even recall the surgery he had. He had made slower than expected progress, and was beginning to fit, if I can recall.

‘Q. What was said that you disagreed with?

‘A. I cannot recall the details of the discussion, but I felt that it seemed optimistic.

‘Q. The chances of survival being quoted? What was being quoted that was optimistic?

‘A. The recovery that the child would make.

‘Q. What did you do when you heard this being quoted that you thought was optimistic? How did you react?

‘A. At the time, I did not do anything — at the time, no, I did not do anything.

‘Q. When was this incident that you recall?

‘A. It must have been 1995.

‘Q. Who was the clinician who was giving what you thought was an optimistic prognosis?

‘A. Mr Wisheart.

‘Q. If you had a similar experience tomorrow at work with a patient and a clinician, would you react differently now?

‘A. Yes, I think there are occasions perhaps when we are discussing the care of long-term patients, and — yes, I would.

‘Q. Who would you go and talk to? Would you go to Fiona Thomas or Rachel Ferris or a clinician?

‘A. I would probably talk about it with a clinician.

‘Q. The one who had given the advice?

‘A. Yes.

‘Q. Can we go to WIT 85/35, please? This is again Dr Bolsin’s comments on your statement. He has given a comment on this particular paragraph. He said he would be surprised if a senior ward manager of long-standing, which I think is a reference to you, did not enquire of the surgeons whether the figures being quoted to relatives were correct or not.

‘First of all, is that something that you did before 1995, to enquire of the surgeons in that way?

‘A. As I have said earlier, these discussions, talking about figures being quoted, were undertaken pre-operatively, and not commonly undertaken in the ward for the first time.

‘I did not question them.

‘Q. As far as you were aware, were you alone in not questioning them, or was that common practice among ward sisters?

‘A. I do not know.

‘Q. Do you know of anyone who did enquire of the surgeons whether the figures quoted were correct or incorrect?

‘A. No, I do not.’[143]

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[143] T32 p. 118–123 Ms Disley

Counsellors

Reverend Robert Yeomans

120 In his written evidence to the Inquiry, the Reverend Robert Yeomans, advisor to the UBHT in spiritual and religious matters from 1993, stated that:

> 'I felt on those few occasions when I sat in with surgeons' discussions with parents that they stressed the seriousness of what was happening and did not gloss over it. I recall risks being discussed. They were discussed in the form of percentages. I cannot recall anything about the figures. The information was given with sensitivity. I recall the use of diagrams and sometimes parents would show me these. I usually felt that parents were told as much as they could know and understand. Some parents were unable to cope with the explanations because of other practical pressures, being emotionally drained, or a deep wish to have things "put right" without needing to understand. Some people took in every word and talked it over. Some people seemed to understand but could seemingly recall nothing. None of this is particular to cardiac parents but these are aspects of human nature. Sometimes the parents wanted clarification, or perhaps wanted something repeated, and I would try to give them the courage to go back to ask for further information, which they usually did.'[144]

Mrs Vegoda and Miss Stratton

121 In his written evidence to the Inquiry, Dr Joffe stated:

> 'During the early 1980s, it became apparent that, after the detailed initial discussion with parents at the time of diagnosis about the implications of the child's condition, and the plan of action to be followed, Dr Jordan and I found it increasingly difficult to spend sufficient time with parents to allay their anxieties. This was aggravated by the paucity of junior medical support in the BCH and the demands of the many peripheral clinics. Consequently, I approached Mrs Jean Pratten, Secretary of the Bristol and South West Children's Heart Circle, to seek financial support for a post of Counsellor in Paediatric Cardiology, who could act as a liaison between the cardiologists and parents. The Heart Circle decided to back this initiative and Mrs Helen Vegoda was appointed in late 1987 to one of the first such posts in the UK. She commenced duties in January 1988. A few years later because of parents' concerns about surgery and the split site, there was a need in the BRI ITU for a similar post but with a medical background. The Heart Circle also supported this post and Ms Helen Stratton was appointed in about 1991.'[145]

122 Dr Joffe stated further that both Helen Vegoda and Helen Stratton were involved in providing bereavement support. Bereavement support was developed in the BRHSC by Helen Vegoda who established a regular monthly meeting for those parents who wished to receive ongoing support.[146]

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[144] WIT 0274 0016 Reverend Yeomans

[145] WIT 0097 0014 Dr Joffe

[146] WIT 0097 0014 – 0015 Dr Joffe

123 Mrs Helen Vegoda described her role:

> 'I understood it was quite a complex role, because it involved the emotional and psychological support and counselling to families. It involved giving information – … not medical information but other supportive information. It involved being there as a very general support at times of stress. It involved what I would have called "orientation", helping parents to know what facilities were around in the Children's Hospital in Bristol. It had a liaison element to it in terms of the community, and there were certainly other aspects, but I think at that time those were probably, possibly, the main ones.'[147]

124 Mrs Vegoda explained what she did by way of counselling and providing support:

> '… I think there is a continuum from counselling through to support, and it does not stop at a particular point.
>
> 'What I was very careful not to do was to, what I would say, counsel in terms of medical information because I did not have that background. The counselling that I gave, the emotional support I would give, was, for example, there were certain particularly key points for parents that were emotionally extremely stressful and, for example, the diagnosis or a child going for a catheterisation or surgery, or at other points like that, and quite a bit of my counselling and support would be to try and be around at those key points and to give parents space to allow them, or maybe facilitate their emotional response at those times, to be there to listen to them.'[148]

125 In her written evidence to the Inquiry, she stated:

> 'I became involved with the children and their families when they were admitted to the hospitals … I provided emotional and other support at key times during the child's admission, for example, being available to parents accompanying the child to theatre or the catheter lab and supporting them whilst they awaited the child's return. Some of my support was to liaise with parents' employers to obtain leave of absence, give information about voluntary organisations such as the Heart Circle and the Downs [*sic*] Heart Group, and help make preparations for discharge by contacting other agencies, e.g. Social Services, GPs and Health Visitors. Having attempted to establish a working relationship with the families, my involvement with them varied from very intense to minimal, depending on the needs of the family.'[149]

126 Mrs Vegoda stated that occasionally she sat in with cardiologists and surgeons when a diagnosis was made or when details of surgery were given to parents.[150]

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[147] T47 p. 85–6 Mrs Vegoda

[148] T47 p. 92–3 Mrs Vegoda

[149] WIT 0192 0002 – 0003 Mrs Vegoda

[150] WIT 0192 0003 Mrs Vegoda

127 She told the Inquiry how she decided which occasions it was appropriate for her to sit in with parents at the discussions with clinicians:

> 'What I did was, I made a point of going down to the outpatients clinics at the BCH, and I think they were on Wednesdays. That would be when the pre-operative discussion took place with the parents.
>
> 'The nursing staff knew that I went down, and what would happen was that either I met there parents whom I had met previously, who I knew were going to be there … and I knew that they were going to talk to the surgeons, so that I might have prearranged to accompany them, if that is what they wanted. So that was one set of parents.
>
> 'Others, the nursing staff might have involved me and actually said to me, "There is a family in this afternoon who are going to be talking to one of the surgeons; it is quite a complex operation, I am just telling you that." If I did not know that family, I might go and introduce myself and offer to be around. But it was the parents' choice. If they did not wish me to be there, and obviously I cleared this with the surgeons and the cardiologists, then I would not sit in.'[151]

128 Mrs Vegoda stated that:

> '… I would usually try to ascertain whether a parent understood what any treatment or surgery entailed following the meeting with the cardiologists or surgeons. If it was apparent that a parent needed clarification of the information, I would ask the consultant/Registrar or one of the nurses to meet with the parents again to explain the procedures. I would never explain the medical aspect of any procedure to a parent, as I was not qualified to do so. I could provide the details of the process and place of treatment only… If parents were still concerned about procedures I would encourage them to go back to the cardiologist or arrange a meeting for them.'[152]

129 Mrs Vegoda told the Inquiry how she was able to judge whether parents had properly understood the details of what the clinicians had told them:

> '… it is a combination of what I heard myself, and as time went on, I became more familiar with some of the language that was used, and also, very much checking out with parents. I mean, if, for example, I was ever there when there was a diagnosis or surgery was explained or a procedure was explained, I did always ask the parents, or I hope I always asked the parents, you know, "Did you understand what was being said? Is there anything you are confused about or you want to go back over, or you want repeated?"

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[151] T47 p. 149–150 Mrs Vegoda

[152] WIT 0192 0003 Mrs Vegoda

> ‘To an extent, because I did not have the background of everything myself, I suppose there might have been instances where the parents said they did understand and possibly they did not. But I think with time, possibly I was getting more information as well.’[153]

130 Mrs Vegoda described her role in bereavement counselling:

> ‘Part of my role included emotional support, counselling and practical help to parents at the time of, or following a child’s death. My contact with bereaved parents was open ended, and in some instances continued for several years.
>
> ‘At the time of death my support could include staying with the parents until they were ready to go home, accompanying the parents to register the child’s death, meeting them if they returned to the hospital to see their child in the Chapel, and liaise with and be present at meetings with the Surgeon or Cardiologist …
>
> ‘I sent out regular cards to parents on the anniversary of their child’s death and birth and instigated and organised an annual Remembrance Service for Cardiac families for three years …’[154]

131 Miss Stratton described her role in her written evidence to the Inquiry:

> ‘My understanding of the role was to bring together the BCH paediatric/cardiac activities with those of the BRI. The aim was to ensure the smooth transition for parents and children from the BCH to the BRI. This would include corresponding with the child’s health visitor and/or GP. I also had to ensure that parents had accommodation and had practical information on the child’s admission to the BRI and their forthcoming stay. This would include advice on transport and the envisaged length of stay… I would work in a very practical way with the parents … My understanding was that I was there to support the parents so that when the child was in surgery or in intensive care the liaison nurse could spend time explaining for example why the child was on a ventilator and what the lines were for, and the reason for sedation. The nurses caring for the child often did not have the time to spend with the parents and explain at length what was happening.’[155]

132 Miss Stratton explained how she approached parents:

> ‘At the beginning of every month I would get a theatre list with all the adult and children’s names on it along with the referring GP. I would write to the parents and introduce myself and say that they may have met Helen Vegoda at the BCH and that my role was to provide support and care while they were at the BRI, in conjunction with Helen Vegoda … I also rang the Health Visitor to notify her of the admission

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[153] T47 p. 94 Mrs Vegoda
[154] WIT 0192 0005 – 0006 Mrs Vegoda
[155] WIT 0256 0002 Miss Stratton

> and to let her have my number. Sometimes the Health Visitor would inform me of any social aspects of the family that I would relay to Sarah Appleton the social worker.'[156]

133 Miss Stratton stated:

> 'I had come across a book at GOS called *"Heart Children"*… which had concise and easy to understand explanations of the commonest cardiac conditions with diagrams. It was written for parents and it was very good. They were not cheap so I had a master copy to show to the parents and if they wanted to buy a copy I would sell them one and give the money back to the Heart Circle.'[157]

134 As regards bereavement, she stated:

> 'Where a child died, I would notify the health visitor and would tell them how the parents had reacted and their plans for returning home. This then allowed the Health Visitor to go and see them. I would tell the Health Visitor as much as I was able to so that the Health Visitor could meet the parents and already have an idea of what had happened while the parents and the baby were at the BRI.'[158]

135 She told the Inquiry that:

> '… I kept a red book with patients' names and addresses, the name of the health visitor, how often I had spoken to the health visitor, the name of the GP and other information like whether I had referred the family to the Social Worker. It was really a record that I could see: had I contacted the health visitor, when did I last contact them, had the parents received any support from the social worker and had they received any financial support from the Heart Circle …
>
> 'It had the date of the operation, the date the child was extubated and taken off the ventilator, the date they were moved through to the nursery, the date that they went home and the date they died …'[159]

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[156] WIT 0256 0008 Miss Stratton

[157] WIT 0256 0007 Miss Stratton

[158] WIT 0256 0008 Miss Stratton

[159] T46 p. 161 Miss Stratton

Parents' evidence on communication with clinicians and the process of obtaining their consent to surgery

The Inquiry's Experts

136 Dr Houston told the Inquiry about the difficulty that parents under stress have in remembering information and the fact that any information given to them could be perceived differently from what was meant:

> '… there are two people in any communication situation, there is not just the doctor, there is also the parent and usually we are talking to them when they are very emotionally upset. Sometimes when you speak to them subsequently their perception of what was said is not what was said, and I think there is no doubt about that.
>
> 'I can certainly recollect a parent coming back and asking her "What were you told about this?", and I said, "Who on earth told you that?", looked up the notes and it was myself and I have a pretty standard way of putting things, so people do perceive things differently. I was very interested in this ... people come back and say "Yes, I was told that this would be done when the child was 7, 6, 8" and I do not believe anyone actually said that. Sometimes they may say "When would it be?" and we might say, "We have to wait and see", and whether they might have said at that time "About 8?", and someone might have said "It might be the case I am not even sure of that", but people do come with this idea of set times when things would be done …
>
> 'They have this perception, and again how things are put by different people are taken up differently.
>
> 'I am sure we all offer to see them again and go over it again if they want, but patients do not very often come back and ask, I think they do not like perhaps to ask us and it is only when we say "Do you want me to go over it again?" some will say, "No it is all right"and some will say "Yes, could you".'[160]

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[160] T91 p. 40–2 Dr Houston

Parents

137 Justine Eastwood, mother of Oliver, told the Inquiry of her experience of communicating with clinicians in the following exchange:

> ‘A. ... I had got to know Mr Dhasmana over a long period of time. I knew that I understood the way he spoke and things he was saying. Mr Moore and Dr Mather,[161] perhaps it is because I did not know them so well, I do not know. They perhaps used more technical terms with me. I did have a particularly difficult conversation with them, which I think is what we are talking about.
>
> ‘Perhaps they were not quite so approachable. Maybe that is the word I am looking for. Maybe I did not feel confident enough to ask the right questions with them, whereas I always felt very confident asking Mr Dhasmana.
>
> ‘Q. There were occasions, were there, when some staff appeared to show a lack of sensitivity in their relationships with you? There was one doctor who made a comment that you took exception to, asking if Oliver was Down’s syndrome?
>
> ‘A. Yes. We were actually in the ward for a very short period of time. Dr Hayes had actually asked the therapist to speak to me, because Oliver was unable to suck, because we were trying to introduce the bottle to him. She felt a speech therapist would be useful. It was actually the speech therapist who made this comment, because she had been given a few notes on Oliver, and I believe it was a Junior Registrar who had actually told her that Oliver was a Down’s syndrome child, so she did say to me, “When did you realise that Oliver was a Down’s child?”and I said “Just now”. It was a little bit of a shock. So it was a mistake by somebody which, you know —
>
> ‘Q. It was upsetting?
>
> ‘A. Very upsetting. I do have to say, he did come and apologise profusely later in the evening, but very upsetting, yes.
>
> ‘Q. From what you are describing, the communication skills varied from doctor to doctor?
>
> ‘A. Exactly, yes. We dealt with so many people, this is the trouble. I would not say there was probably one person in that hospital who did not know Oliver or his case, so we were dealing with an awful lot of people down the line, really.
>
> ‘Q. You make the point in your statement of the honesty of Mr Dhasmana in the sense that he refused to exaggerate the chances of Oliver’s survival.
>
> ‘A. Right.

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[161] Cardiologist at the BRHSC

> ‘Q. Did you find that unsettling, or helpful, or helpful only in retrospect, or what?
>
> ‘A. We just felt he was being honest. He was not putting us under any false illusions. We knew that Oliver was extremely unique with his problems, he had heart problems and also problems with his trachea, and unfortunately — I mean, there was hope, but nobody ever, particularly Mr Dhasmana, never built our hopes up, which is how we wanted it. There was no getting away from the fact that we were dealing with a very difficult situation.
>
> ‘Q. We have heard Mr Dhasmana described to us as “brusque” or “abrupt” at telling someone bad news. From your dealings with him over some time, do you think he might be perceived in that way?
>
> ‘A. Might be. In the very first pages of my diary, I did actually write he came across as a negative man. Maybe that could be looked at as brusque. I would not say so, though. It was perhaps his manner. I never thought of him in that way. Everyone comes across in a different way. We had the opportunity to get to know him over a year, and I certainly would not put him down as a brusque uncaring man.
>
> ‘Q. What made him seem negative?
>
> ‘A. Because he never built our hopes up. If anything, he went the other way. I would say he was just honest. He did not build our hopes up, perhaps, in the way we wanted him to, because things were looking so grim, but he was just that way.’[162]

138 Justine Eastwood told the Inquiry her views on whether parents who had just been told that their child had a heart defect were given sufficient information:

> ‘I think everybody initially is bemused and confused by it all. My experience is, there were many books around. There were plenty of people to try to explain things to you if you did not understand it, but again, from what I saw, if you did not understand it, people came back and told you again and again, until you perhaps did understand. You were not left with one conversation and then they walk away and let you get on and hopefully muddle it through. It was not like that.
>
> ‘If my memory serves me correctly, I vaguely remember there was actually a little booklet that had been made by parents and professionals for parents, and I believe it was something like that that we actually first read. So it was very basic, but it just gave us some sort of insight into heart problems.’[163]

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[162] T95 p. 75–7 Justine Eastwood

[163] T95 p. 69–70 Justine Eastwood

139 Karen Welby, mother of Jade, described the approach of Mr Wisheart in 1984:

> 'Because I was very, very upset, taking Jade off to theatre and I wanted to have — I wanted to think she was going to come out and everything was going to be fine, but he was not going to let me believe that for one minute. He wanted me to understand she was possibly going to die on the operating table. I did not want to accept it, so I thought he was very cruel to tell somebody who was almost hysterical that their daughter was probably going to die. Obviously later on I realised that that is what he should have said to me, that is what I needed to know; I did not need to be given any false hope, and I appreciated that from then on, that he was very, very honest and that whenever he said to me that things were looking good, then I could breathe a sigh of relief, and think "Mr Wisheart says she is going to be okay".'[164]

140 Karen Welby described the difficulties of understanding what was happening:

> '… I found it very difficult to understand everything that was going on anyway. I was only young myself [20 years old] and I was in such a state of shock …'[165]

141 She continued:

> 'Probably after her operation I started to get a better understanding of what was going on. I remember that she was shaking and in quite a state before her operation, and nobody seemed to be telling me the truth about what was happening then. They were making excuses of her being upset because she had had X-rays done. When I went back later, she was still that way and I thought, "This is not right. Nobody is telling me quite what is going on here." I did actually demand to see a doctor, to have that explained to me. They explained that the drug they had her on to keep the valve open, they were not quite sure of the amount they were giving her, they thought might be upsetting her, but they thought if they reduced it again, her valve might shut off.'[166]

142 Sheila Forsythe, mother of Andrew, told the Inquiry of her experience in 1986:

> 'I asked the questions and I found that everybody answered them to the depth that in fact I was asking the question to. If the staff could not actually answer the question because they had not the time to explain it, they would actually come back and answer the question to my level of understanding later, and I used to tell parents, when they came into the BRI, that they must ask the questions and keep asking the questions until they were satisfied to the level of information that they required. There was never any problem so far as we were concerned.'[167]

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[164] T95 p. 78 Karen Welby

[165] T95 p. 73 Karen Welby

[166] T95 p. 73 Karen Welby

[167] T95 p. 74 Sheila Forsythe

143 Michelle Cummings, mother of Charlotte, referred to the factors that can affect parents' perceptions of any information that they are given:

> 'I think the difficulty as well is that it has to be recognised that there are some people, and perhaps all of us at different times, during the time our children were in hospital, you reach the point where you actually cannot take the news that you are being given. You physically and mentally cannot take any more and you shut off. That is a problem, because that, then, opens the opportunity for later down the road to actually come back and say, "Actually, I was not told that", when in fact you were told it; it was just that you have mentally, for preservation purposes, shut off. I think that is a very real problem.'[168]

144 Diana Hill, mother of Jessica and James, told the Inquiry of the conflicting information she was given in 1989 by Dr Joffe on the one hand and Mr Dhasmana on the other. Diana Hill first saw Dr Joffe when Jessica's heart condition was diagnosed:

> '… he explained to me she had a VSD. He said what it was, he said basically it was a hole in the heart but it seemed to be that there was no concern from him about this.'[169]

> 'The one thing I do remember is that he did not relay any concern, it just seemed that it was a VSD, a hole he hoped would close up and that is all it seemed like. I mean I cannot remember him saying anything about pulmonary hypertension to me.'[170]

145 Diana Hill said that nothing was said to her at all about Jessica's attendance for echocardiography and the appearance of the pulmonary artery and turbulent flow:[171]

> 'Nothing was said to me at all. The only thing I can remember was Dr Joffe saying to me that he wanted to wait for the hole to close.'[172]

146 She continued:

> 'He said he wanted to do a catheter just to see how bad I think the VSD was. I remember him going over the catheter procedure because he said to me "There is always a chance that a baby can die having this procedure". That is what put me off having the whole thing done because I thought "Gosh, I am going to lose my baby having this done". It seemed quite a big thing compared to the reasons. I thought there was nothing wrong with her, it seemed like there was nothing wrong with her and they were doing this catheter and she could die having this catheter. That is what he explained.'[173]

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[168] T95 p. 80–1 Michelle Cummings

[169] T83 p. 5 Diana Hill

[170] T83 p. 6 Diana Hill

[171] MR 1761 0053; letter from Dr Joffe to Dr Vulliamy (Paediatric Registrar)

[172] T83 p. 9 Diana Hill

[173] T83 p. 9–10 Diana Hill

> ‘I was worried that she was going to die having that catheter because he did tell me sometimes that can happen, yes, it made me worried.’[174]

147 Diana Hill then described her initial meeting and communication with Helen Vegoda:

> ‘I think she was trying to help me but I am surprised she did not feel that I did not want her there because I did — I was saying it in a way, I did not just tell her to go away because I thought that was not the nice thing to do, but she must have known I just did not want her there, I did not. She would say things that were helpful that were making me worse. I just remember at the time in the hospital I really wished she had not been there. After the hospital, when I saw her after she was helpful.’[175]

148 Diana Hill told the Inquiry of her recollection of a meeting after the catheterisation:

> ‘… I remember them putting on some X-rays on a screen in the room. Nobody ever said to me she had a bad condition of pulmonary hypertension, nobody ever explained to me because if they had I would have then been prepared for it, they had not, it was just still the same as what I knew before, she had a VSD and that seemed to be what she had and that was it.
>
> ‘… I just assumed from what Dr Joffe had said that he was waiting for her hole to close and was waiting for her lungs to develop. If this did not happen, he said possibly she may need an operation in the future. The future — I came to the conclusion she would probably have an operation when she was 1, 2, but he did not say anything was really wrong with her, he never said she was going to die or anything. I actually thought I had a well baby, although she might need an operation later.’[176]

149 Diana Hill then described her meeting with Mr Dhasmana:

> ‘He introduced himself, said “Hello”, we sat down, I sat down with my mother and he just said to us, he said “There is nothing I can do for her” and he said it quite matter-of-fact and it just was something I was not expecting to hear at all. I thought I was going there to hear him say she would have an operation in a year’s time but he just said “There is nothing I can do for her”, he said she was inoperable.’[177]

150 She continued:

> ‘When I saw Mr Dhasmana, after he said there was nothing he could do for her, she is inoperable … he just saw how shocked we were. He was shocked at the fact we did not know. It was written all over his face.

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[174] T83 p. 11 Diana Hill
[175] T83 p. 12–13 Diana Hill
[176] T83 p. 13–14 Diana Hill
[177] T83 p. 15 Diana Hill

> ‘He then said “Because of her age, 7 months” – which at this time she was not 7 months, she was about 8 and a half months, but he kept saying she was 7 months – he felt he had to give her the chance of operating. He said as time was going on her pulmonary hypertension — he was the first person to tell me about her pulmonary hypertension, I had never heard about it before. He drew diagrams and he explained to me what was happening and as time was going on he would not be able to perform the surgery. He said to me if another month elapsed he would not be able to do the surgery. So he told me to come in on 16th August and he would perform the operation on the 18th.
>
> ‘There was no choice. He then proceeded to say that he was going on holiday that day and [Mr] Wisheart would be doing the post-operative care. As soon as he said this I thought, “No, she is not going to have proper continuity of care”. I told him this. I said, “I do not want Mr Wisheart doing the post-operative care, I want to have the same surgeon”. Everything was telling me, signs were telling me I did not want her to have it done now here. All of a sudden I had this well baby and then suddenly she was going to die, it was like she was just going to die.’[178]
>
> ‘… he said, and I remember these words like yesterday: “The surgeons get the worst job of telling the patients”.’[179]

151 Diana Hill stated that she (and her mother) did not like Mr Dhasmana’s bedside manner, which they both thought was ‘extremely arrogant’.[180]

152 In his notes Mr Dhasmana recorded that ‘High risk explained. Mother broke down.’[181]

153 Diana Hill told the Inquiry of her feelings:

> ‘It was a shock. I just wanted the floor to open and take me away. I had a well baby crawling around on the floor at this time.
>
> ‘He then had to test her heart, he had to check her chest, check her heart and do all those things. I could not cope. I was in a terrible state, my mother was in a terrible state, we were all in a terrible state, none of us knew, none of us knew that she was this bad.’[182]

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[178] T83 p. 16–17 Diana Hill

[179] T83 p. 17 Diana Hill

[180] WIT 0263 0007 Diana Hill

[181] MR 1761 0020; medical records of Jessica Hill

[182] T83 p. 17–18 Diana Hill

154 Diana Hill's mother had a meeting with Mr Dhasmana the next day. Diana Hill told the Inquiry that the reason was:

> '… because Mr Dhasmana wanted us to make a decision there and then to have the operation. I felt I could not make that decision because part of me was telling me I wanted to take her to America to have this operation because she was the most precious thing, I would have done anything for her. It just did not feel right for her to be having it done there. I cannot explain what it was, I think it was just the shock that I had not been told before, that is what made me feel like that and I thought "No, I am not going to decide today, I want to think about what else I can do".
>
> 'So my mother rang him the next day because she was quite upset how Dhasmana — he was quite arrogant and blunt, his whole manner, his body language you know was quite blunt and arrogant. So she rang him up the next day asking if there was anywhere else we could take her. He said "No, Bristol is the best place"and then he said "I do not have to operate, you know".
>
> 'He was very matter-of-fact with everything. He did not relay any sort of compassion. I mean I was in shock, my mother was in shock. It is like, there was no sort of compassion from him at all, it was just very matter-of-fact, "This is what I am doing" — it almost felt you were lucky to be having this operation, I was lucky to be having this operation on that day.'[183]

155 Diana Hill recalled the discussion she had with Dr Joffe after the meeting with Mr Dhasmana:

> 'I had a discussion with Joffe about two days later and I remember it because I remember feeling really, really anxious about the whole thing and he then gave me 70/80[184] per cent chance that Jessica would be okay. This was a different statistic to what I had from Mr Dhasmana. Mr Dhasmana had given me 50/50 per cent that she would live so I knew it was like she could die. But Dr Joffe was giving me a 70/80 per cent chance she would live. Even then when I spoke to him it was as if she was going to live with this operation. It seemed like he was not concerned at all.'[185]

She continued:

> '… I remember him painting a picture to me that it was going to be quite — that it was like she was not going to die. I remember him saying to me there was a 70/80 per cent chance she was going to be okay because automatically I thought — it made me feel better actually when he said that because I thought perhaps she is going to be alive. I wanted somebody to tell me she was going to live and he was doing that.'[186]

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[183] T83 p. 18–19 Diana Hill

[184] MR 1761 0037; this figure is quoted in a letter from Dr Joffe

[185] T83 p. 19–20 Diana Hill

[186] T83 p. 20–1 Diana Hill

156 Diana Hill described her anxiety at the passage of time:

> 'Things worried me like, I know she was getting older, it was getting worse and I just remember fixing this month in my head, Dhasmana saying she was 7 months and in actual fact she was not 7 months, she was 8 and a half, so by that time she was getting older anyway and then it was another month later she had the operation, so by the time she had the operation she was 9 and a half months. Surely if she is inoperable she is not going to live because "inoperable" means she cannot live.'[187]

157 She indicated that:

> '… I did not want her to have it done here but the fact is I did not have much time to take her anywhere else although I wanted to.'[188]

She added:

> 'People were explaining to me what was going to happen, you know, there is no doubt about that. But you could just tell from some people, some of the medical staff[189] were telling me "You could pull out if you want to". It almost felt as if she was not going to live.'[190]

Further:

> 'It was very difficult because I had a baby who was very well. She was by this time — well, she was standing up, she was babbling, she was crawling. I did not have an ill baby on my hands so it was very hard to watch this well baby that they were saying was inoperable who was going to die, who was ill. I could not believe it.'[191]

158 In her written evidence to the Inquiry Diana Hill expressed the view that:

> 'I think that Dr Joffe did not tell me how serious Jessica's condition was, and that Mr Dhasmana covered up for him.'[192]

159 Helen Rickard, mother of Samantha, told the Inquiry of her and her husband's experience after Samantha's catheterisation:

> 'Andy and I obviously waited at the hospital for Samantha to come back out of the theatre … Dr Jordan came back up to the ward with Samantha, where we were waiting. We both looked at him expecting him to be forthcoming with some kind of information about what they had done, what they had found. That did not happen.

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[187] T83 p. 21–2 Diana Hill

[188] T83 p. 22 Diana Hill

[189] WIT 0263 0009 – 0010; Diana Hill mentions a House Officer, Helen Vegoda, a nurse she believes is called L Syonng and Dr Bolsin

[190] T83 p. 23 Diana Hill

[191] T83 p. 24 Diana Hill

[192] WIT 0263 0014 Diana Hill

> Dr Jordan was not willing to talk to us. He said that he would need to discuss the findings with his colleagues and we would be contacted after that.
>
> 'I asked to see Samantha's medical records at that point and I was told no, that would not be possible. We were basically just left there with no information again.'[193]

160 Kathleen Tilley's daughter, Lauren, underwent a Switch operation performed by Mr Dhasmana in February 1988. Lauren died on the operating table.

161 The problem with Lauren's heart was discovered within hours of her birth. In her written evidence to the Inquiry, Kathleen Tilley described meeting Dr Jordan in the ICU at the BRHSC:

> 'He told us that they were unsure what the problem was but she was having difficulty breathing and there was obviously a heart condition. He told us that they would need to take her down to do a cardiac catheter and a scan. He explained exactly what they would do and that was to cut Lauren and then feed a tube through so that they could actually find out exactly what the position was.
>
> 'I had no complaints about the way we were treated at Bristol nor have I any complaints about the procedures or the explanations that we were given.'[194]

162 As regards being told about the diagnosis of Lauren's problem, she stated that Dr Jordan:

> '... told us that Lauren had a condition which was known as the Transposition of the Greater [*sic*] Arteries and also had a hole in her heart. He said that they would operate immediately. He explained to Glyn [her husband] and myself exactly what the condition was and what they were going to do … I was devastated and although I accept that Dr Jordan did his utmost to explain the operation in detail to us so that we knew what was going on, it was not until I returned home a week later and I spoke to a family friend who was a nurse, that I fully understood the implications of the condition that Lauren had. I place no blame on Dr Jordan for my lack of understanding and can only put it down to my emotional distress.'[195]

163 As regards the timing of Lauren's operation, Kathleen Tilley stated:

> '… at one of the regular monthly check ups at Dr Jordan's clinic at the Royal Gwent Hospital in Newport he told me that he thought that it was time she needed the operation. Both at the time and in hindsight I was surprised at the decision that was taken. I had no idea why the decision was taken to operate at that meeting. No explanation was given. It is true that Dr Jordan said that she had not put on any

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[193] T52 p. 122 Helen Rickard

[194] WIT 0230 0003 Kathleen Tilley

[195] WIT 0230 0004 Kathleen Tilley. See Chapter 3 for an explanation of clinical terms

> significant amount of weight since she was born. However, that was nothing new. She was not distressed, and her breathing was as good as it had been throughout the period and I am therefore at a loss to understand the reason for the sudden rush. I use the word "rush" because almost immediately after being told that she should have the operation we received a letter from the Bristol Children's Hospital giving us a date for the operation for 29th February 1988.'[196]

164 Kathleen Tilley met Mr Dhasmana two days before Lauren's Switch operation. She stated that:

> 'He introduced himself and confirmed that he would be operating on Lauren. He then went on to explain what procedure he was going to undertake.
>
> 'Mr Dhasmana said that this was an operation which had not been performed for very long and that he himself had not done it many times. He said the chances of success were 75%. I must admit that when he said that he had not done it very often both Glyn and I were very perturbed. Glyn then asked him about the operation and questioned him about what he had said. Mr Dhasmana replied that it was not a common operation but that despite that and despite the fact that he himself had not done this particular operation very often, it was in his opinion the best thing for Lauren.
>
> 'As a result of that answer neither of us questioned him any further about his ability to undertake the operation or the chances of Lauren's survival. The conversation took at least half an hour but at no time during the conversation was it made known to us that there was any other choice. We were not offered any other explanation nor were we told at this or any other time that there were other centres and other surgeons with far higher success rates. So far as Glyn and I were concerned, at the time, we trusted the surgeon in front of us and we accepted the information which he gave as we had no reason, at that time, to doubt it.'[197]

165 She said later in her statement:

> 'Lauren was operated on in 1988 and I accept that she was one of the very first to be dealt with by Mr Dhasmana. I therefore accept that there may have been no trend at that stage and that insofar as Lauren is concerned it might not be appropriate to complain about the failure to disclose the actual morbidity rate. However, as a mother and a member of the public, I do have serious concerns about the management of the hospital, from at least 1990 onwards because they should have made sure that the significant losses of childrens lives was investigated. The fact that they did not do so means that they failed both in their duty to the individual children as well as their duty to the general public which the hospital served.'[198]

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[196] WIT 0230 0007 – 0008 Kathleen Tilley

[197] WIT 0230 0008 – 0009 Kathleen Tilley; Mr Dhasmana's response to this is at WIT 0230 0036 – 0037

[198] WIT 0230 0014 Kathleen Tilley

166 John Williams' daughter, Melanie, had a successful Switch operation in September 1988. A few weeks after her birth in September 1983, Dr Jordan had diagnosed that Melanie had TGA, amongst other cardiac problems, and, according to Mr Williams, he had 'explained that due to her age and all of her complications, it would be impossible to correct all the problems with one operation …'[199]

167 Mr Wisheart performed the first operation on Melanie. John Williams stated that:

> 'We were very impressed by Mr Wisheart, whose conduct towards us had given us every confidence in him. His advice had been very positive but at the same time realistic. We also fully understood that this was only a temporary solution and that further surgery would be needed at a later age.'[200]

168 He stated that when he saw Mr Wisheart in April 1987:

> '… he [Mr Wisheart] went through Melanie's problems with us and talked about the possible surgical options. He explained that he felt the best option was the Switch operation, because he felt that this would give Melanie the best long-term chance.'[201]

169 According to John Williams:

> '… there was never the least suggestion that we might have considered going elsewhere other than to the Bristol hospitals, partly because of the adverse publicity surrounding other centres, but more importantly because we were very happy with what had been achieved so far and the way in which it had all been done.'[202]

170 He described the advice and information given to him:

> 'We met with Mr Wisheart on the 3rd September, and he reiterated to us that the operation was by no means straightforward. Nevertheless he said that her overall prospects would be good if she came through the operation. He also said that it was going to be a long difficult operation, and that he intended to undertake it jointly with Mr Dhasmana. We met with Mr Dhasmana and his way of expressing things came over as a little more pessimistic, not so as to suggest that he viewed the situation differently from Mr Wisheart but reflecting the different temperaments of the two Surgeons. Also he had not seen Melanie before, and he also mentioned that scar tissue from the previous operations could possibly give rise to problems.
> We also met with the Anaesthetist prior to the operation.

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[199] WIT 0140 0002 John Williams
[200] WIT 0140 0002 John Williams
[201] WIT 0140 0003 John Williams
[202] WIT 0140 0004 John Williams

> ‘The operation that was to be undertaken was a “Switch” as the main arteries were the wrong way round. We were told that this was a new and relatively difficult technique, and we understood that the Surgeons had not done many of these operations before. Mr Wisheart had set out to us three possible courses of action, of which the Switch operation gave the best long-term prospects, and he gave quite a clear recommendation that this was the best option to take. The other options would have meant, in layman’s terms, that the “wrong” side of the heart would still have been carrying out the wrong function, but the hope would be that the heart would redevelop to cope. These might be safer on a short-term view, but in the longer term, the Switch, if successful, would be a better solution. I understood that there was a relatively high degree of risk, and as far as I can recall I think it was put to us as a 25% risk, but we accepted that as a risk worth taking in the circumstances. This was certainly the choice that Mr Wisheart encouraged us to take, and I was glad that he gave us a firm and positive lead in taking the decision.
>
> ‘We were happy as to the procedure for giving our formal consent to the operation. We had been given a great deal of medical detail, and that we had been given a proper and balanced assessment of the very real risks involved in the operation, and of which we had been made aware long before it came to the point of signing the Consent Forms.’[203]

171 Christine Ellis’ son, Richard, had a non-neonatal Switch operation in June 1991. It was performed successfully by Mr Dhasmana. Mrs Ellis described meeting Dr Jordan and being given the diagnosis:

> ‘… I saw a female doctor in Doctor Jordan’s team along with my husband. She told us that Richard required a balloon catheter operation to enlarge a hole in his heart in order to allow better mixture of his blood. She told us that a balloon catheter procedure was the prelude to a Switch operation. When the Switch operation took place would depend upon the progress that Richard made following the balloon catheter procedure. She indicated that Richard was seriously ill. She may have discussed the risk factor of a balloon catheter procedure, but I cannot remember that happening.
>
> ‘The balloon catheter operation took place without incident …
>
> ‘I do not think anyone gave a prognosis or discussed the risk factor of this particular procedure.
>
> ‘There were no discussions on standards of care or success rate, but the procedure was discussed in detail.
>
> ‘There was no discussion about whether a referral to another centre was required.’[204]

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[203] WIT 0140 0005 – 0006 John Williams

[204] WIT 0023 0003 – 0004 Christine Ellis

172 Christine Ellis stated that she met Mr Dhasmana on the day before Richard's operation and that Mr Dhasmana 'dealt with the detail of the planned surgery.'[205] As regards the information and quotation of risks which she was given before consenting to the operation, she stated that:

> 'Mr Dhasmana came over as friendly caring and concerned. That particularly struck me about him. I was left in no doubt that he wanted to do his best for my husband and I and Richard.
>
> 'Mr Dhasmana explained the surgery that was going to be carried out the following day. He drew diagrams for us to illustrate what was going to happen. He drew a diagram showing a normal heart. He drew a diagram showing the current problem with Richard's heart. He drew a diagram showing us what he was going to do to put that right. He could see that we had not taken on board exactly what was to happen the first time and he went through that all again until he was sure we understood what was to happen.
>
> 'Mr Dhasmana told my husband and I that the operation would take about eight hours and it is my recollection that he gave a sixty-forty chance of success.
>
> 'Mr Dhasmana said that if the operation did not take place then the balloon catheter would not last forever and as Richard got bigger he would be at risk. It was better for surgery to take place earlier rather than later.
>
> 'I was in no doubt that the operation had to take place whatever the risk.
>
> 'I remember the whole discussion as being unhurried, kind and friendly and I felt very comfortable.
>
> 'I was quite aware that any surgery would have risks under general anaesthetic.
>
> 'I had no discussions with the anaesthetist Doctor Masey prior to the operation as far as I can recall.
>
> 'There was no suggestion that either this operation or the balloon catheter operation should have been done elsewhere than at the Children's Hospital in the first instance and the BRI in the second instance.
>
> 'I do not recall whether the percentage success rate explained by Mr Dhasmana was the hospital's success rate, his success rate or the general success rate.
>
> 'I and my husband had no difficulty in giving consent to the operation and we did.

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[205] WIT 0023 0006 Christine Ellis

> ‘I cannot recall the likelihood of future surgery or protracted drug regimes being discussed or side effects or other complications or alternative treatment methods.’[206]

173 Julie Johnson’s son, Max, underwent a Switch operation in June 1994 which was performed by Mr Dhasmana. Max died a few days later.

174 Julie Johnson stated in her written evidence to the Inquiry that she remembered meeting Dr Alison Hayes in December 1993 who performed a cardiac catheterisation and an echocardiogram on Max so as to obtain a clearer picture of his heart. Mrs Johnson stated:

> ‘Dr Hayes told us that Max’s main arteries were switched round from their normal position. Both outlets came from the right ventricle of his heart. Dr Hayes told us that he also had a Coarctation of the Aorta, and that the aortic arch was severely underdeveloped. In addition, there was a hole between the bottom two chambers of Max’s heart. Dr Hayes stated that, normally, this was a serious defect in itself but, since Max had no blood supply into the bottom left chamber, the hole was helping to keep him alive at this stage.’[207]

175 Julie Johnson stated that Dr Hayes then introduced her and her husband to Mr Dhasmana who informed them that:

> ‘… Max needed open-heart surgery, but that, due to his size and age, it would be better to give him closed-heart surgery first, as soon as possible. He would then need one more operation, which would take place around his first birthday, when he would be older and stronger. This would increase his chances of surviving open-heart surgery. Mr Dhasmana told us that the closed-heart surgery would involve reconstructing Max’s aortic arch, resection of his coarctation, and putting banding on his pulmonary artery. These procedures would, basically, “patch him up” until he was older.’[208]

176 Julie Johnson described what she was told about the risks involved in the surgery:

> ‘Dr Hayes said that there was about a 33% risk to Max’s life from the closed-heart surgery. She then stated that the risks of open-heart surgery would be a bit higher — I did not ask her to quantify this latter risk as a percentage, as I did not really want to know at this stage. I then asked Mr Dhasmana if there was any possibility of brain damage occurring as a result of this surgery. He said, “No, he will either live or die on the operating table”. I did not realise or believe that there was a risk to Max’s life post-operatively, in the Intensive Care Unit (ICU). I was not offered a choice of different types of surgery, or of another hospital or consultant surgeon.

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[206] WIT 0023 0006 – 0008 Christine Ellis

[207] WIT 0178 0004 Julie Johnson. See Chapter 3 for an explanation of clinical terms

[208] WIT 0178 0005 Julie Johnson

> I asked if I had any alternative, but they said that Max would die without surgery. We agreed to allow surgery to take place.'[209]

177 Following tests in March 1994, Julie Johnson stated that she and her husband were informed by Dr Hayes that Max was suitable for the Arterial Switch operation.[210]

178 In April 1994 Steve and Julie Johnson met both Dr Hayes and Mr Dhasmana to discuss the Switch operation. Julie Johnson stated that:

> '… we initially saw Dr Hayes. She said that the surgery held serious risks for Max's heart, due to the fact that he had never used the left side of it. She said that it might take Max up to a fortnight to recover from surgery. I asked Dr Hayes if there was any alternative course of action, but she said that Max was getting sluggish, and needed surgery. We then spoke to Mr Dhasmana, and again asked him if Max would sustain any other injury, such as brain damage. He replied that the risk was all in the surgery, and that Max would either "live or die on the operating table". He also said that brain damage was "virtually unheard of". Mr Dhasmana did not quantify any risks as a percentage.'[211]

179 The day before Max's Switch operation, Julie Johnson met Mr Dhasmana to discuss the operation. Her recollection of events is that:

> 'He drew me a rough sketch of what he intended to do the following day, and said that, if the surgery was successful, Max would lead a near-normal life afterwards. I mentioned that Dr Hayes had said that it could be up to two weeks before we would know if the surgery had been successful, since Max's left side was turning to muscle. He said that she was being quite pessimistic; they had seen far more of this type of case in the BRI than in the BCH. He also said that he was quietly confident, and would be able to know if the surgery had worked in just three to four days. He added that Max had done well these past months despite his heart problems, that he was a strong baby, and that I owed it to him to give him a chance of a normal life. I felt more confident than before after this meeting.'[212]

180 Timothy Davies' son, Richard, underwent a neonatal Switch operation performed by Mr Dhasmana on 28 May 1992. Richard died on 8 June.

181 Dr Jordan diagnosed that Richard had cardiac problems within hours of his birth. Timothy Davies stated that he remembered rushing back to the hospital to meet Dr Jordan:

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[209] WIT 0178 0005 Julie Johnson; Mr Dhasmana's response to this is at WIT 0178 0026 – 0027

[210] WIT 0178 0008 Julie Johnson

[211] WIT 0178 0008 Julie Johnson; Mr Dhasmana's reponse to this is at WIT 0178 0027

[212] WIT 0178 0010 Julie Johnson

> ‘He told me that they had already performed one operation on Richard. He said that they had put a balloon in to keep the airways open. While I was trying to take this in, Dr Jordan made it clear that this operation had to be performed, and that is why it was carried out so quickly. Dr Jordan then went on to say that Richard’s arteries were the wrong way round in the heart. He produced a diagram[213]… on a piece of paper headed “Transposition of the Great Arteries”. I did not take any notice of the writing on this piece of paper and Dr Jordan did not draw my attention to any of it. What he did do was point to the picture of the heart on the left, showing the normal position, and explained that Richard’s heart was like the one on the right. He said that, basically, the blood was being pumped the wrong way, and that Richard needed a further operation.’[214]

182 As regards any information and advice and the process of consent, Timothy Davies stated that:

> ‘Dr Jordan stated that, normally, they could leave babies in Richard’s condition for between 6 months to a year. However, he then said something like, “We have decided that due to the severity of his condition we need to operate within the next 4 days.” Having said that there had to [be] the operation within the next four days Dr Jordan said that he had a Consent form with him for the operation to go ahead.
>
> ‘Having received no advice as to why I was at the hospital until Dr Jordan came in to see me, I found myself taken aback by what he was saying. I felt numb. I wanted to ask questions, but I thought “He is a Surgeon[215] and you can trust your child’s life into his hands”. I therefore just signed the Consent form. I had not read any of the information given on the sheet describing Transposition of the Great Arteries or taken in anything from the Consent form. I was too numb to take it all in. All I thought was that it had to be dealt with quickly. I was not given any time to think about matters, but just did what I thought was the right thing and signed the form. I cannot think that Dr Jordan was with us for longer than 10 minutes. As soon as I had signed the form, Dr Jordan left the room and Julie and I were left alone again.’[216]

183 Timothy Davies stated in his written evidence to the Inquiry that he did not meet with Mr Dhasmana or any other doctor before the operation to discuss what was going to happen:

> ‘The only persons we saw were the nursing staff. At no point can I recall any Doctor or Consultant coming to see me to explain what was going to happen.’[217]

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[213] WIT 0160 0016 – 0017 Timothy Davies

[214] WIT 0160 0006 Timothy Davies. See Chapter 3 for an explanation of clinical terms

[215] Dr Jordan was in fact a consultant cardiologist and not a surgeon

[216] WIT 0160 0006 – 0007 Timothy Davies

[217] WIT 0160 0009 Timothy Davies

184 On the day of the operation, Timothy Davies accompanied Richard to the BRI by ambulance:

> ‘On the way to the Bristol Royal Infirmary, the nurse said to me that we were very lucky; Mr Dhasmana was one of the best. She said that he had done a 36-hour operation a few days ago. I asked if the person had lived, and she said yes. I remember thinking that he must be a brilliant surgeon. This was the first time I had heard Mr Dhasmana’s name.
>
> ‘I met with an anaesthetist at the Bristol Royal Infirmary. I believe she was Su Underwood. She told me that it was time for Richard to have his first batch of injections. She said “he’ll see you later”. I remember feeling very distressed at this point, and said something to the effect that “he isn’t going to come back”. The anaesthetist said “yes he will — he’ll be fine”.’[218]

185 Timothy Davies stated that he met Mr Dhasmana for the first time two days after the operation, while he was in the ICU:

> ‘Later that morning, at about 5.30 am, a man came in. He came up and said good morning. He said the operation had gone well, and then went off into what seemed to be the nursery section of the room. I followed him in there, and asked him who he was. He said he had performed the operation. I asked him if he was Mr Dhasmana. He said that he was.’[219]

186 As regards his feelings about signing the consent form for the operation, Timothy Davies stated:

> ‘… I blame myself for killing Richard, because I signed the consent form. I keep asking whether I did the right thing; I just cannot get this out of my mind. I know that, had I not consented to the operation, Richard would not have lived anyway, but did I do the right thing in signing that form? I keep asking if I should have asked questions and found out more. What would have been the position if I had done so?’.[220]

187 Douglas Bwye’s son, Jason, underwent a neonatal Switch operation performed by Mr Dhasmana in July 1992 but died during the operation. In his written evidence to the Inquiry, Douglas Bwye recalled the events immediately preceding his signing the consent form:

> ‘… Mr Dhasmana explained once again the operation that he was to perform. He said the success rate was 80% and not the 70% from the previous doctor. In addition, however, he did not make it sound as straightforward. He informed us that not only did he have to deal with the greater arteries but that there were also

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[218] WIT 0160 0009 Timothy Davies

[219] WIT 0160 0011 Timothy Davies; Mr Dhasmana’s response to this is at WIT 0160 0019 – 0020

[220] WIT 0160 0015 Timothy Davies

> other smaller ones which had to be swapped which he said were more complicated. Although he was giving us a higher percentage of success rate I did not feel that he was as confident of the outcome of the operation as the previous doctor. Mr Dhasmana was not with us very long although I accept that may well have been because of what he told us and there were few questions which I had to ask. I confirm that I signed the consent form although I cannot recall whether I read it or not. Mr Dhasmana said that Jason would need further surgery when he was older because of the growing process and although I was disappointed at that at least I had the consolation of thinking that Jason would be stronger and more able to cope with any further procedure.'[221]

188 About seven days previously Douglas Bwye stated that had met another doctor in the hospital whose name he did not know:

> '… a doctor sat down with us and drew a diagram for us of the condition which Jason had. He explained that it was not a condition that they were unused to and that although there was a risk which he placed at 30%, there was an operation that they could do. I then asked him what happened in the 30% of cases where they were unsuccessful. He did not reply to that question but told me to focus on the fact that other than the heart defect which Jason had, he was well. I left that and did not pursue it again.'[222]

189 As regards the process of being informed, Douglas Bwye stated that everything happened 'so quickly that it was almost like a blur.'[223] He added:

> '… such was the confidence that both Janine and I had in the surgeons, that we felt it was wrong to interfere with them by asking [too] many questions. I am not saying that they refused to answer questions I am just saying that we did not feel that it was our place to ask questions which we may have thought of.'[224]

190 Douglas Bwye told the Inquiry in the following exchange that he could not remember events happening even though they were recorded in Jason's medical records:

> 'Q. When did anyone next speak to you about Jason?
>
> 'A. It is a difficult question to answer, that, because it was not necessarily one person coming back and telling me what the situation was. It was sort of on-going all the time. I was asking questions all the time. At the end of the day, I just realised that he was not right and that he was in an incubator, and I was just sort of thinking, "Well, they know what they are doing, so ..."

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[221] WIT 0002 0005 Douglas Bwye
[222] WIT 0002 0003 Douglas Bwye
[223] WIT 0002 0006 Douglas Bwye
[224] WIT 0002 0006 Douglas Bwye

> ‘Q. Would you like to have a look …[at MR 0403 0035] This is a note … from the Special Care Baby Unit. It reads: “Parents visited and seen by Dr Bradford who explained that baby possibly had pneumonia and that oxygen and antibiotics were necessary at present.”[225]
>
> ‘Do you remember seeing a Dr Bradford?
>
> ‘A. No.
>
> ‘Q. Do you remember an explanation being given to you as to what might be wrong with Jason?
>
> ‘A. I cannot remember the explanation that was given to me of what they thought was wrong at that time, but shortly after, I was told that it was not what they thought it was and that the oxygen was not in fact helping. They kept upping the level of oxygen up to 100 per cent, I think, and it still was not really having any effect.’[226]

191 Douglas Bwye was asked:

> ‘Q. There is a drawing which is in the medical records. I am going to ask you to look at it. It is [MR] 0403 0101… What I do not know … is whether the diagram we see here is one which you saw and if so, whether it was done at this earlier occasion, just after the septostomy, or whether it was done later on when you spoke to Mr Dhasmana in respect of getting consent for the bigger operation later on.
>
> ‘Can you help?
>
> ‘A. That drawing on there I do not think was done immediately after the septostomy, because in the room at the time I can remember the doctor grabbing a piece of paper to do it on, and as far as I could see, it was scrap paper. I do not remember seeing any of the writing on it, no.
>
> ‘Q. So that was probably something which was done later on?
>
> ‘A. Yes.’[227]

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[225] MR 0403 0035; medical records of Jason Bwye

[226] T6 p. 3–4 Douglas Bwye

[227] T6 p. 13 Douglas Bwye

192 Douglas Bwye returned to the diagram in the following exchange:

> ‘Q. Can we go back to the little picture that was drawn which I said I would come back to at a later stage?
>
> ‘This picture: was that one drawn by Mr Dhasmana?
>
> ‘A. I do not remember that being drawn.
>
> ‘Q. You do not?
>
> ‘A. I do not even recognise it, only because I have seen another picture drawn by someone else that was similar, but I do not actually recognise that.
>
> ‘Q. It is obviously not a picture drawn for Mr Dhasmana’s or any doctor’s benefit, because they would know the anatomy, so it must have been done for you or your wife at some stage?
>
> ‘A. Yes.
>
> ‘Q. It is in Jason’s records so we assume – we may be wrong – that is to do with Jason and something that one of the doctors, whoever it was, may have said to you?
>
> ‘A. Yes.
>
> ‘Q. Did more than one person, so far as you can remember, draw diagrams to explain to you what was involved?
>
> ‘A. I can only remember one person drawing a diagram.
>
> ‘Q. You cannot recall this diagram as being the one that was then drawn, because that was done on a piece of paper which was pulled across towards you?
>
> ‘A. That is right.
>
> ‘Q. So whoever it was who drew this, if it had anything to do with Jason – I appreciate it is in his records, it may be a mistake – but if it is anything to do with Jason, you cannot recall it being done?
>
> ‘A. No.’[228]

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[228] T6 p. 30–2 Douglas Bwye

193 As regards quoting risks, Douglas Bwye told the Inquiry:

> ‘He [Mr Dhasmana] volunteered the 80 per cent success without me asking, because I had already asked previously, when the balloon septostomy was done, and I had been told 70 per cent, so I was not asking him, because as far as I was concerned, I already knew. He volunteered that to me. ...
>
> ‘The reason I remember that so well is because as soon as he said a 30 per cent chance of failure, I said, “Well, can you tell me why those 30 per cent fail?” But he did not tell me why. He just said “The main thing for you to do is to focus on the fact that other than that, Jason is well.” So it looks good, basically. …
>
> ‘I cannot remember the exact words. He just said – I think he said something like, “All being well, we would expect 20 per cent chance of failure, but ...” We did not really sort of understand why there was a difference in what he said, but it just did not seem to matter at the time. We just thought, “Just do it”, basically.’[229]

194 It is recorded in the medical records that the nature of the operation was explained and 25 per cent[230] failure rate quoted to the parents. The following exchange then took place:

> ‘Q. Are you sure that it was 20 per cent that he mentioned, as opposed to 25 per cent?
>
> ‘A. I am positive.
>
> ‘Q. Because you have had difficulties, I think, recollecting precise words, precise conversations, precise identities throughout the brief period we have already been discussing?
>
> ‘A. Yes.
>
> ‘Q. But you are convinced that it was 20 per cent?
>
> ‘A. Yes.
>
> ‘Q. And it was that way round: 20 per cent risk of failure as opposed to 80 per cent chance of success?
>
> ‘A. Yes.

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[229] T6 p. 27–8 Douglas Bwye

[230] MR 0403 0068; medical records of Jason Bwye

‘Q. The reason I ask if you are sure is, if we can go to MR 0403 0068, this is Mr Dhasmana’s own entry, 27th July 1992.

‘”Seen [that relates to you rather than Jason] for arterial switch repair tomorrow. Nature and risks (25 per cent) explained to parents, agree. Consent”[231] and a tick.

‘So he has made a note at or about the day that he saw you that he had said 25 per cent?

‘A. Yes.

‘Q. If he said 20 per cent, he might — it might be suggested on his behalf, why should he write 25 per cent? Again, I just ask you: it may be, perhaps that he may have said, “Well, the risk is 20 per cent, it could be more, it could be 20 to 30 per cent, something like that”, which would, if you are going to pick one figure, you pick a figure in the middle and you pick 25 per cent. Did it come out like that at all, do you think?

‘A. All I can say to that is two things. Firstly, in view of the fact that first we were told 70, then he told me 80, it does not surprise me that the final thing that was written was 75.

‘Q. But he did not know you had been told 70. You did not tell him?

‘A. No. What I mean is, if one can tell me one thing and one can tell me the other, it does not surprise me what gets written down is something else. In view of the type of person that I have learned Mr Dhasmana is, that does not surprise me, that he would write down something that had not been said.

‘Q. In any event, you are certain that he said 20 per cent to you?

‘A. Yes.

‘Q. Why was it that you agreed to the operation?

‘A. Because we wanted Jason to live.

‘Q. If he quoted 50 per cent or 60 per cent, you would still have given consent, would you?

‘A. Yes.’[232]

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[231] MR 0403 0068; medical records of Jason Bwye

[232] T6 p. 28–30 Douglas Bwye; Mr Dhasmana’s response to Douglas Bwye’s evidence is at WIT 0002 0013 – 0014

195 Clare Steel's son, Jonathan, underwent a Switch operation performed by Mr Dhasmana in March 1993 which was successful.

196 Clare Steel was trained as a nurse and health visitor. In her written evidence to the Inquiry she described how she was told of Jonathan's diagnosis and the need to refer him to the BRI:

> 'Dr Martin diagnosed that Jonathan had a condition known as Transposition of the Great Arteries …
>
> 'Dr Martin recommended that Jonathan should be immediately transferred to Bristol for this treatment. He explained that Jonathan's cardiac condition was very serious but he nevertheless gave me confidence. In hindsight, I feel Dr Martin was not entirely straight with us. He must by then have known of the poor success rate for these operations at the BRI. He must have known that this rate was significantly below the national average. He did not tell us about this and I was left feeling confident that my husband and I were making the correct informed decision in allowing our son to go to the BRI for the surgery described by Dr Martin. He could have referred Jonathan to Birmingham but there was no discussion of this and I believe that Dr French [referring consultant paediatrician at Taunton and Somerset Hospital] was ignorant of the problems at the BRI.
>
> '... I feel that my husband and I were let down by the staff at Bristol who were the only people who could have known of the poor success rate of infant cardiac surgery at the BRI. I include Dr Martin specifically in this criticism as well as Mr Dhasmana.'[233]

197 She continued:

> 'I do not think that the nursing staff or Junior Doctors who we saw most of the time were aware of the failing success rate for infant cardiac surgery at the BRI. This was probably due to the split sites. I suspect that Dr Martin knew of the situation as he was a Consultant Cardiologist and should have been aware.'[234]

198 Clare Steel recalled her meeting with Mr Dhasmana before the operation and the discussion of the nature of the operation and the attendant risks:

> 'Mr Dhasmana explained to Norman and myself that Jonathan's condition was very serious and that it was a major operation. He told us that during the course of the operation, the heart would have to be stopped and then re-started. He said that he wanted us to understand the risk of death and of brain damage. He did not in so many words say that the risk of brain damage would stem from any delay or difficulty in re-starting the heart but Norman and I understood this in any event.

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[233] WIT 0510 0003 – 0004 Clare Steel

[234] WIT 0510 0005 Clare Steel

> He told us that 8 out of every 10 babies undergoing the operation did well. He told us that he did not know how long Jonathan would be in intensive care following the operation – it could be 2 or 3 weeks. He also said that until recently the operation used to be performed at 8–9 months but experience now showed that the lifelong result was likely to be better if the surgery was carried out at 10 days due to the possible enlargement of the heart associated with any delay…
>
> 'Norman and I understood that Jonathan would die or remain very sick without the surgery described by Mr Dhasmana. We were therefore bound to conclude that the surgery should proceed. We were given confidence in the knowledge that it was now known that the operation was better performed at 10 days and not 8–9 months. Although Mr Dhasmana told us that 8 out of 10 children undergoing surgery did well, we were not informed that the record at the BRI was far worse. If we had been told of the poor success rate at Bristol, our consent to the surgery being performed there by Mr Dhasmana would not have been given. Jonathan could have been transferred to Birmingham or London following his septostomy. In hindsight, we would have expected him to have informed us of his own poor success rate in performing this type of cardiac operation upon infants. We would have expected him to have informed us of the option to have the surgery performed elsewhere such as Birmingham. Because we were not so informed, there was no discussion at all about the option of other centres. As far as we were aware, Bristol was a specialist centre for such cardiac surgery and we assumed that the 8 out of 10 success rate applied to Bristol given the context of the conversation. Had we known the true success rate at Bristol we would certainly have opted to have Jonathan transferred elsewhere.'[235]

199 Janet Edwards' daughter, Sophie, underwent a neonatal Switch operation performed by Mr Dhasmana in April 1993 but died during the operation.

200 Sophie's cardiac problem was recognised at birth and she was transferred to Bristol with her mother immediately. Janet Edwards stated that although at the time she was dazed[236] and distressed,[237] she remembered meeting Dr Jordan:

> 'At some stage Dr Jordan came to see me and told me that they were going to take Sophie down to what he described as the Echo Room. The purpose of that was to have a better look at her heart. He also said that whilst she was there they may have to undertake some surgical procedure. He may have said exactly what they were going to do but I was too upset to take it in [and] due to my condition it was all above me at that stage.'[238]

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[235] WIT 0510 0007 – 0009 Clare Steel

[236] WIT 0005 0001 Janet Edwards

[237] WIT 0005 0002 Janet Edwards

[238] WIT 0005 0002 Janet Edwards

She said that later:

> ‘Dr Jordan came to see me at 5.00 pm, and told me what they had done. He brought me some Polaroid pictures of Sophie. They were not very good but I was glad to have them and I was glad to see him as he gave me a reasonable amount of information. He was charming and polite and I was grateful. … During one of my meetings with Dr Jordan, after they had undertaken the surgical procedure on Sophie, he confirmed to me that she was going to need surgery. I cannot recall exactly what he said.’[239]

201 Janet Edwards described meeting Mr Dhasmana before the operation and the information and the quotation of risks which he gave her:

> ‘Mr Dhasmana came to see me at about lunchtime on Friday. He explained the operation which Sophie required. He called it a Switch Operation and he drew a diagram. He went on to tell me that this was an operation which had recently been invented and that it was now thought that the best time to undertake the operation was in the first month of life. He said that Sophie’s chance of not surviving was 1 in 5 and I discussed with him my concerns about resuscitation and brain damage… I asked him whether this was the only operation she would have to undergo. He did say to me that some children when they are about five have to have a further operation because the scar tissue does not expand. He pointed out to me that the little boy in the bed next door in the Baby Unit was recovering from a Switch Operation and was doing well. He seemed positive and confident; he gave me hope and I never thought that Sophie would not pull through. I thought that he was a god and that he was going to make things right.
>
> ‘I accepted everything Mr Dhasmana said and I would not have dreamed of questioning him unless he had said something which made me think twice in view of my medical training.[240] I had the utmost faith in him in view of his position and never once doubted anything that he told me.
>
> ‘On the Sunday morning we were with Sophie when Mr Dhasmana arrived to see Ken. I cannot recall whether Mr Dhasmana had previously told me the time for the operation but he confirmed that it was to be Tuesday.
>
> ‘I cannot remember specifically what Mr Dhasmana said as I was not feeling well. I do remember that Mr Dhasmana mentioned an 80% success rate. I think I recall him doing a further drawing to assist Ken in understanding what he was going to do and I do definitely remember him explaining once again about the possibility of a further operation when Sophie was about five years old.’[241]

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[239] WIT 0005 0002 – 0003 Janet Edwards

[240] Janet Edwards is a community nurse

[241] WIT 0005 0003 – 0004 Janet Edwards. In response, Mr Dhasmana said he would have given a mortality figure of ‘around 30%’, WIT 0005 0011

202 As regards signing the consent form, Janet Edwards stated:

> '… I had become aware of a small problem with the Consent Form. I had assumed that Ken would be going to Bristol but he had decided not to. I think that he wanted to stay near to Sarah and myself. In any event, the Consent Form had to be faxed to Barnstaple and was then signed by Ken and returned.'[242]

203 Stephen Willis' son, Daniel, underwent a Switch operation performed by Mr Dhasmana in May 1993. Daniel died on the operating table.

204 As regards the referral of Daniel to Bristol, Stephen Willis stated in his written evidence to the Inquiry:

> 'I recall specifically enquiring of Dr Richardson [consultant paediatrician] why Bristol and I was told that Bristol was the nearest. There was more to the conversation but that was the only specific reason that I can recall being given for the transfer to Bristol. At no time were we given any other information as to the level of care that we were to expect at Bristol or the possibility of referral to any other Centres.'[243]

205 At the BRI, Dr Joffe confirmed that Daniel had TGA. Stephen Willis stated that he and Michaela Willis then met Mr Dhasmana:

> '… Mr Dhasmana came onto the Ward. He explained to us that the cardiac catheter had gone well but confirmed that Daniel would, nevertheless, need an immediate operation. We were left in no doubt that the operation should be performed as soon as possible. He then went on to explain that there were two operations that Daniel could have. One was known as sennings and the other operation was the switch operation. Mr Dhasmana could say nothing good about the sennings and was extremely positive about the switch.
>
> 'Insofar as the sennings operation is concerned he stated that it was one that has been done for a long time and that there were drawbacks with it. He said that Daniel's quality of life would not be as good … and that Daniel would require further surgery probably in his teens. I think he did give a success rate for the sennings operation but I cannot recall with any certainty what that was. In contrast Mr Dhasmana was very upbeat about the switch operation. He said that it would be a total repair and that Daniel's quality of life would be fine after the operation. My abiding memory of his comparison between the two operations was that with the sennings Daniel would always be short of breath would not really be able to play sport very well whereas with the switch operation he should have a reasonably normal life.

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[242] WIT 0005 0005 Janet Edwards

[243] WIT 0285 0002 – 0003 Stephen Willis

> ‘I do recall that Mr Dhasmana was not forthcoming with the success rates … I specifically asked for the success rate of the switch operation and was told unequivocally 80–85%. I did not ask Mr Dhasmana whether that was his personal success rate but as he had given me the success rate I assumed that as he was undertaking the operation then it was his. On the basis that I had specifically asked him what were Daniel’s chances the response that I received of 80–85% meant to me that it was Daniel’s chances of success were 80–85%.
>
> ‘It should be said that Mr Dhasmana explained by diagram how each of the operations would be performed and that we were under no doubt what he was going to do.
>
> ‘After the explanation by Mr Dhasmana we were left in no doubt that we had little or no alternative but to opt for the switch operation. The positive nature with which he had dealt with the operation itself and Daniel’s chances as opposed to the very downbeat way he dealt with the sennings left us with no choice … I asked him once again to confirm, which he did, that the success rate that he had given me for Daniel’s chances of survival was accurate. He repeated the figures again to me. I then specifically asked him whether this was the best place for Daniel to be or whether there was somewhere else that the operation should be performed. Mr Dhasmana’s reply was in words to the effect that Daniel would be fine. I took this to mean that Daniel would be no better off anywhere else.’[244]

206 Mr Dhasmana was asked by Counsel to the Inquiry on what he based his assessment of risk in the case of Daniel Willis:

> ‘A. I have a huge problem with the neonatal Switch in a way to know, really, how can I quote my own statistics, because I have not got any running series of success. So there, I was going mostly on the basis of published literature and the American paper which I quoted before, which was going on the medium sized centre, what they would expect, and knowing about the term which is not really accepted, earlier experience, I am using the term here.
>
> ‘Q. So the position would be for someone like the Willises that they were getting a perception of the risks in the literature but not the risks in your particular unit?
>
> ‘A. That is correct.
>
> ‘Q. Was that not effectively misleading, do you think?
>
> ‘A. I did not think at that time — we are talking of 1992/93, there was no guideline, and almost all surgeons were quoting, whenever they were starting a new operation, what they were expecting from published literature.’[245]

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[244] WIT 0285 0005 – 0007 Stephen Willis

[245] T87 p. 89–90 Mr Dhasmana

207 Stephen Willis described an event in relation to signing the consent form:

> '… whilst I was away … I believe Michaela saw a Doctor and signed the Consent Form. Michaela amended the Consent Form by adding the words "based on the information given to me by Dr Dhasmana". After the transfer to the BRI we were informed that the Consent Form had been lost and I was required to sign a further Consent Form. I believe that the Consent Form signed by my wife has subsequently reappeared.'[246]

208 Stephen Willis recalled that after Daniel's operation:

> 'Mr Dhasmana was wearing his operating gown which was green and blood was splashed all over his chest and left shoulder. He was obviously distressed, there were tears in his eyes and he said that Daniel was dead. I can specifically recall him saying that the operation had been a success but he could not get his heart to beat again and he did not know why he could not save Daniel.'[247]

209 Stephen Willis stated that:

> 'We believed that Daniel had received the very best of care, in the best place and that our son was one of the unlucky 15%. We believed that we had taken the decision that we had in his best interest and it was no fault of anybody else that he died. It was for those reasons that we felt that his death could not be avoided and we did not feel that immediate feeling of devastation usually experienced when loosing [*sic*] someone very close and we accepted it as inevitable.'[248]

> 'Although we accepted at the time and still do that there was a risk to Daniel in the operation it is true to say that had he gone to Birmingham, Southampton or to Great Ormond Street his chances of survival in 1993 would, in my view, have been greatly enhanced. Secondly, I would like to highlight the excellent standard of care that Daniel received at the Bristol Children's Hospital. This was, as I have pointed out in my statement, in total contrast to the situation to be found at the Bristol Royal Infirmary.'[249]

> 'If my wife and I had received the true statistical information or a true reply to my second question I can say without any fear at all that we would have insisted that Daniel be operated on at the Centre where he had most chance … Taking into account either of the criteria which I requested Bristol was not that place.'[250]

210 Erica Pottage's son, Thomas, had a Switch operation performed by Mr Dhasmana in July 1993. Thomas died on the operating table.

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[246] WIT 0285 0008 Stephen Willis
[247] WIT 0285 0011 Stephen Willis
[248] WIT 0285 0012 Stephen Willis
[249] WIT 0285 0014 Stephen Willis
[250] WIT 0285 0015 Stephen Willis

211 Dr Joffe diagnosed Thomas as having TGA. Erica Pottage stated that Dr Joffe informed her that Mr Dhasmana would carry out the necessary operation. She stated that Dr Joffe explained that:

> 'Mr Dhasmana would decide whether to perform the switch operation (he explained what this would entail and the fact that it had to be carried out within the first two weeks of birth) or another operation at 18 months which he described as "extra plumbing" which would require further surgery as Thomas grew older. Dr Joffe said that the switch operation was quite new (2 to 3 years) but they had been very pleased with the success rate.'[251]

212 Erica Pottage described her meeting with Mr Dhasmana:

> 'We went to see Mr Dhasmana who drew pictures of Thomas's heart problem and explained the operation to us. At this point I asked "What are the chances of Thomas's survival?" Mr Dhasmana said "We do not like to quote statistics. It is a serious operation and Thomas is a small baby." Mr Dhasmana said "Only one child has had to return for further surgery following a Switch operation". My husband and I believed Thomas was in the best possible hands. We signed the consent form on this basis. Had Mr Dhasmana told us the truth about the statistics, we would not have given our consent. We feel that Mr Dhasmana should have referred us to another Hospital where Thomas had a greater chance of survival.'[252]

213 She said:

> 'I do not believe that we were told the whole truth regarding Thomas' chances of survival. I felt we were given little background information about the operation. My husband and I were not told about the lack of success of the operation in Bristol. We were not told where the best chance of a successful operation was.
>
> 'The doctors and consultants were the experts and we looked to them to advise us truthfully about Thomas' chances of success and whether, if Thomas went to another children's unit, he would have a higher chance of success. We were not told that, apart from Thomas's heart problem he was a healthy baby. We thought we had given our son the best possible chance of survival based on the information we were given at the Bristol Hospitals and we took some comfort from that when Thomas died. Now we find that this was not the case and I feel that we have been "cheated".'[253]

214 Malcolm Curnow's daughter, Verity, underwent a shunt operation which was performed by Mr Dhasmana on 12 September 1990. Verity died on 16 September 1990.

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[251] WIT 0260 0002 Erica Pottage. See Chapter 3 for an explanation of clinical terms

[252] WIT 0260 0003 Erica Pottage; Mr Dhasmana's response to this evidence is at WIT 0260 0007 – 0008

[253] WIT 0260 0004 Erica Pottage

215 Malcolm Curnow, in his witness statement, stated that:

> ‘While I was concerned about Verity, Mr Dhasmana’s views on the risks of the operation were very reassuring, and I was confident of a favourable outcome.’[254]

216 Malcolm Curnow stated that when he met Dr Jordan and was given the diagnosis, the explanation of the condition was minimal. Malcolm Curnow stated Dr Jordan recommended that since Verity appeared to be coping well they should take her home and ‘feed her up’.[255] Malcolm Curnow stated that subsequently:

> ‘Mr Dhasmana explained that it [the operation] was a simple procedure.’[256]

217 In his oral evidence, Malcolm Curnow’s attention was drawn to a letter dated 23 February 1990 written by his GP (Dr Stephen Straughan) to Dr Jordan which read:

> ‘This baby is now seven weeks of age, diagnosed by yourselves as having pulmonary atresia with VSD, with I understand a very small or non-existent pulmonary artery which makes immediate surgery impossible. She has been reviewed in Exeter by Dr McNinch. The parents, who are extremely sensible, understand the situation well and are coping admirably. Verity is gaining weight.
>
> ‘They have requested for genuine reasons that they are followed up in your clinic in Bristol rather than being seen in Exeter and if it were possible to arrange this, I would be most grateful.
>
> ‘I am sure this stems from the positive and helpful way the family were treated during their stay in Bristol when Verity was a week old.
>
> ‘They remain optimistic, but do realise the precarious position that Verity is in.’[257]

218 Asked whether the letter was a fair reflection of what he was feeling at the time, Malcolm Curnow told the Inquiry:

> ‘A. We were certainly aware that Verity, as I said, was not going to be normal for the rest of her life. We knew that surgical intervention was certainly a possibility.
>
> ‘We did not know whether it was a probability or not, and we understood the situation to be precarious as it is said there, in view of the fact that the next 9 months were very much in the hands of the Gods. … We did not know whether a shunt operation was going to be required or whether it was not. Our concern was to keep Verity well, which we were doing, but we knew that the future was uncertain and that was our understanding of the situation.

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[254] WIT 0004 0006 Malcolm Curnow

[255] WIT 0004 0003 Malcolm Curnow

[256] WIT 0004 0005 Malcolm Curnow; Mr Dhasmana’s response to this is at WIT 0004 0015

[257] MR 2374 0102; medical records of Verity Curnow. See Chapter 3 for an explanation of clinical terms

> ‘Q. So your use of “precarious” by the GP, if it were interpreted to give the impression that you knew that Verity was on a knife-edge between survival and death, that would be wrong?
>
> ‘A. That would be wrong.’[258]

219 After the death of Verity, Dr Jordan wrote a letter to Malcolm and Jane Curnow, which read in part:

> ‘As you know, we felt that although the prospects looked generally poor, we should make the attempt as I and all my colleagues felt that her outlook without some attempt at operation was extremely poor and we could be fairly certain that she would not have managed to survive another 6 or 12 months without some sort of intervention.’[259]

220 Responding to the suggestion that the words ‘As you know, we felt that…’[260] meant that Dr Jordan knew that Verity’s chances of survival without an operation were limited, Malcolm Curnow insisted that he and his wife had not been told so. Malcolm Curnow told the Inquiry that his understanding was that without an operation, Verity would be able to live up until her teens.[261]

221 Michelle Cummings’ daughter, Charlotte, underwent a Sennings operation performed by Mr Wisheart in June 1988. Charlotte died in March 1989.

222 Michelle Cummings stated in her written evidence to the Inquiry that Dr Jordan informed her of the heart defect and the diagnosis:

> ‘He told me that Charlotte had transposition of the great arteries a large hole in the lower chambers which cut through the bicuspid and tricuspid valves and narrowing of the aortic artery.
>
> ‘Doctor Jordan told me that he felt that something could be done to put things right, but that would involve two operations before she was one year old.’[262]

223 Dr Jordan referred Charlotte to the care of Mr Wisheart, whom Robert and Michelle Cummings already knew. Michelle Cummings stated that:

> ‘Robert [Mr Cummings] and I were confident in Mr Wisheart because Robert had been under Mr Wisheart’s care for many years in connection with his congenital heart defects.

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[258] T3 p. 19 Malcolm Curnow
[259] T3 p. 42 Malcolm Curnow and MR 2374 0084; medical records of Verity Curnow
[260] T3 p. 43 Malcolm Curnow
[261] T3 p. 43 Malcolm Curnow
[262] WIT 0123 0008 Michelle Cummings. See Chapter 3 for an explanation of clinical terms

> ‘I asked for a meeting with Mr Wisheart and saw him that afternoon. I remember being very nervous. I well recall Mr Wisheart coming across as being calm, soft spoken, patient and extremely kind. He went over again what Doctor Jordan had already told me several times, until he was sure I understood exactly what Charlotte’s condition entailed. I recall him drawing diagrams to illustrate the problem. He explained why the aorta had to be corrected before the main operation could take place. He said that he feared that as Charlotte got older, the aorta would constrict, making her problems worse.
>
> ‘Mr Wisheart said that Charlotte’s case was very unusual. He said that he had experienced all the problems that Charlotte had in one form or another in different patients, but never all of them together in one patient.
>
> ‘I recall Mr Wisheart saying to me that Charlotte would most likely not reach her second birthday if there was no surgical intervention and even then provided she did not deteriorate before surgical intervention could take place.’[263]

224 Michelle Cummings described the meeting she had with Mr Wisheart (in February 1988):

> ‘Mr Wisheart described the operation that he was going to perform for Charlotte. I was pleased about the meeting because it gave me an opportunity to ask Mr Wisheart about the availability of a switch operation. I had heard that a switch operation was available in America. I asked Mr Wisheart if this was possible for Charlotte. Mr Wisheart said that these operations were only at that time being performed in London. He said that at that time London had only done four such operations on children and hadn’t had great results. Mr Wisheart went on to say that in America the procedure was still in its early stages. Some seven procedures had been carried out on children in America and again, not with great results. I remember offering that I would pay for the switch operation if it would help Charlotte. Mr Wisheart was quite forthright in saying that he felt that the risk wasn’t worth taking. He also said that even if the operation was available, the nature of Charlotte’s defects were such as to exclude her as a candidate for such a procedure. He explained that a switch procedure was to put the arteries back the right way round, but that procedure would be too much for Charlotte because of her condition. I was happy to accept Mr Wisheart’s explanation. I remember that he was kind, but candid in the matter.
>
> ‘Mr Wisheart went on to explain the operation that he was going to carry out for Charlotte. It was to be a Sennings Procedure. He explained that Charlotte’s heart had the wrong chamber acting as the pumping chamber, which in Charlotte, was opposite to where it should have been. Mr Wisheart said he couldn’t change that. He had to get the blood and oxygen going the right way round. He said he would do that by carving little canals and making little bridges to allow that to

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[263] WIT 0123 0009 – 0010 Michelle Cummings

happen. He explained he also had to graft a wall in the lower chambers where the hole in the heart was (AVSD) and try and patch the valves because Charlotte had leaking valves.

‘I remember Mr Wisheart taking a great deal of time with me drawing diagrams and explaining the problems and procedures and indeed going over them several times.

‘Mr Wisheart explained how the operation would go. He said that the first stage was to cool the body down to enable it to be put on by-pass. I think he said it took three hours to slow down the body and to open up and clamp preparatory for the heart being put on by-pass. I remember him saying that that procedure was done by a separate team.

‘Mr Wisheart explained that there could be problems. He explained that not all patients were compatible with heart by-pass and that there was some risk attached to that, but that they would only know whether or not Charlotte was incompatible when she was put on the by-pass.

‘Mr Wisheart explained that there was a risk of brain damage because of the length of the operation and the amount of the anaesthetic required.

‘Mr Wisheart said that once the heart had been stopped and Charlotte put on by-pass, there was only a certain amount of time allowed within which the surgery could be carried out before she had to be taken off the by-pass. I do not remember how long Mr Wisheart said that period was.

‘Mr Wisheart said that there could also be problems taking Charlotte off the by-pass. Charlotte would have to be warmed up after the surgery and then taken off the by-pass and that could be a problem time.

‘Mr Wisheart was very specific about brain damage risk associated with by-pass and anaesthetics. He said that compared with past times anaesthetics were very much better and the risk very much less, but nonetheless there was still risk.

‘I remember asking Mr Wisheart what backup plan he had if he opened Charlotte up and realised that the planned operation couldn’t be done.

‘Mr Wisheart said that there was always a risk of opening up a patient to find that the situation was worse than that anticipated. He said that couldn’t always be planned for and that one would have to address and assess each situation as the need arose.

‘Mr Wisheart said there was a risk of Charlotte dying on the operating table if the problems were greater in fact when she was opened up, than had been anticipated.

> ‘Mr Wisheart warned that it was possible that Charlotte would end up on a pacemaker for the rest of her life, or might be paralysed for the rest of her life.
>
> ‘Mr Wisheart warned that after the operation there was another problem, namely with ventilation in that not all paediatric patients are compatible with ventilation and that there were difficulties sometimes associated with taking a paediatric patient off ventilation because paediatric patients could become ventilation dependent.
>
> ‘I remember asking Mr Wisheart whether in his opinion Charlotte would live to grow up. Mr Wisheart said he couldn’t tell me that. I remember him saying “One hopes that by doing this operation she will live a normal healthy life.” He said he couldn’t say for sure that that would happen. He said that he would do everything that he could for Charlotte and would do his best for her.
>
> ‘Mr Wisheart said that the success rate of the operational ie (Sennings) procedure was 75%. I think that was the figure, but I might be wrong.
>
> ‘I remember I discussed with Mr Wisheart the Mustard Procedure and reasons why that was not appropriate. I forget the detail of that. I didn’t make a note.
>
> ‘I remember Mr Wisheart saying there was a risk that the channels that he created would narrow, in which case a further operation would be indicated and that further operation was not always very successful.’[264]

225 As regards giving her consent for the operation, Michelle Cummings stated:

> ‘On the morning of the 13th June 1988 before Charlotte went down to the operating theatre for surgery Mr Wisheart saw my husband and I to sign the consent form … in February he [Mr Wisheart] had gone into great detail as to the operation to be performed and its associated risks and prognosis. On at least one occasion since then I had gone through the whole thing again in detail with Mr Wisheart and indeed we had gone through the whole thing again after Charlotte’s actual admission to the BRI for the surgery, consequently I signed the consent form with full knowledge of everything which was involved.’[265]

226 In a letter dated 31 October 1998, she said:

> ‘James Wisheart was particularly meticulous in planning the operations. All the avenues were explored and every consideration was taken into account and most importantly that it was the best choice for the child and that we as parents were informed every step of the way. Never were we mislead [*sic*] or misinformed.

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[264] WIT 0123 0014 – 0018 Michelle Cummings. See Chapter 3 for an explanation of clinical terms

[265] WIT 0123 0019 Michelle Cummings

> 'The statistic given for success did not mean the survival of the child, but for the success rate of the operational procedure being performed. We were never led to believe that this was an indication of our daughter's survival rate. Mr Wisheart went to great pains to point out that even if the operational procedure was a success there was no guarantee Charlotte herself would be able to cope.'[266]

227 Carol Kift, mother of Steven, stated in her written evidence to the Inquiry that Steven went to the BRHSC under the care of Mr Wisheart on 26 August 1986 and was operated on the next day for Coarctation of the Aorta at the BRI. She stated that she and her husband were in shock and her memory of what happened just before the operation was 'rather hazy'.[267] But she stated:

> '… I certainly don't remember Mr Wisheart explaining anything about the operation or its risks. The staff kept their distance from us as if they did not have the time to be involved with individual patients. We just consoled ourselves with the fact that Harefield had recommended the operation.'[268]

228 Carol Kift said that she was alarmed when the operation seemed to be taking hours longer than planned:

> '… Mr Wisheart came out of the operating theatre to meet us. He told us that the surgery was still going on because they had discovered complications with Steven's arteries during the course of the surgery. This rather confused us because no abnormality in the arteries had been revealed by the scan. He gave no further explanation but went back into the operating theatre. Although Mr Wisheart had not been rude, we felt that his manner left quite a lot to be desired.
>
> '… Neither Mr Wisheart nor any of the other staff explained what effect, if any, the problems with Steven's arteries would have. However, our main concern at that point was Steven's size. When he had gone in for surgery he was normal size, but by the time he had got to intensive care the next day he seemed much bigger. It was as if he had suddenly grown. I commented on this to the nurse and she told me that Steven's kidneys had failed, and that he had not been to the toilet since the operation. No one had seen fit to tell us this until we asked.'[269]

229 Carol Kift stated that, 'Our major criticism of the BRHSC is that we received so little explanation and guidance about Steven's care … Mr Wisheart, in particular, seemed to talk at us rather than to us.'[270]

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[266] WIT 0123 0035 Michelle Cummings

[267] WIT 0461 0003 Carol Kift

[268] WIT 0461 0003 – 0004 Carol Kift

[269] WIT 0461 0004 Carol Kift

[270] WIT 0461 0006 Carol Kift; Mr Wisheart's response to this evidence is at WIT 0461 0011 – 0012

230 Amanda Boyland, mother of James, stated that in 1990:

> 'Five hours after our arrival at the Children's Hospital, Mr Wisheart came to the families room to speak to us. He confirmed that James had a hole in the heart, but he also said that James had a narrowing of the aorta, which had constricted, in other words it had closed up. Mr Wisheart then left the room, but came back and said that James had horseshoe kidneys which were at the front of the abdomen instead of at the back. He said that this was not a problem, it wouldn't affect James in any way.
>
> 'Mr Wisheart then told us that he would operate on James's heart in the morning to widen the aorta. Mr Wisheart came over as a real gentleman, he was very quiet and he smiled a lot. I trusted him completely. He drew diagrams to explain things so that I would understand what he was telling me. At the time I thought I had understood, but I didn't realise how ill James was. I didn't realise at that time that he could die.'[271]

231 As regards the consent form, she stated:

> 'The next morning, 9th May 1990, the hospital phoned me in the late morning. They said that they needed me to go back to the Children's Hospital to sign a consent form for the operation … The nurses asked us to wait in the families room. It was then that my mother-in-law arrived. An anaesthetist came to the families room to see us. He explained the anaesthetic procedure to us. My mother then informed him that there was a family history of hyperpoxy, an allergic reaction to anaesthetic. He explained that due to this he would use a neutral anaesthetic. I was then asked to sign the consent form for James's operation, which I did.'[272]

232 Amanda Boyland stated that, after the operation, Mr Wisheart came to see her:

> 'He told us that … during the operation he had done what he had wanted to, and that the operation had gone well. He said that it was slightly more complicated than expected, as the narrowing of the aorta was lower than had been first thought. He had put a band on the aorta to keep it open to increase the blood flow to the heart and to keep the aorta from narrowing further in the future. Mr Wisheart said that he had not repaired the hole in James's heart, but they had had a closer look at it during the operation and discovered that the hole went through all four chambers of the heart. We were told that Mr Wisheart would remove the band and repair the hole at a later date, before James reached the age of 5. We [were] also told that the next 24 hours would be crucial for James.'[273]

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[271] WIT 0232 0003 Amanda Boyland

[272] WIT 0232 0004 Amanda Boyland

[273] WIT 0232 0005 Amanda Boyland

233 Amanda Boyland referred to an incident after the operation:

> 'In the afternoon, James suddenly took a turn for the worse. At the time Dr Martin, Dr Jordan and Mr Wisheart were with James as they were doing their ward rounds. They asked us to leave, so once again we went to wait in the families room. Mr Wisheart came to tell us that James's kidneys were failing. My mother asked him to put James on a dialysis machine. Nursing staff brought the dialysis machine to the ITU. I cannot recall the exact time that it was brought to the ward. We do not know if James was attached to it. The doctors and nursing staff were huddled together. I heard one of them say that it was only brought to keep the family happy.'[274]

234 Amanda Boyland described a subsequent consultation with Mr Wisheart, at which he explained the next operation:

> 'My parents and I took James to Bristol Children's Hospital to see Mr Wisheart in early November 1991. He explained the operation that James was going to have. He drew diagrams to make it easier to understand. I could never take everything in at any of the meetings with Dr Jordan, Dr Joffe or with Mr Wisheart. My mother would understand what we were being told, and when we got home she would explain everything to us. At this meeting we were told that during the operation the band on the aorta would be removed and the hole in James's heart would be repaired. I thought that Mr Wisheart said that the operation had a 95% success rate but my mother's recollection is that Mr Wisheart said that the success rate was 85%. I understood this to be Mr Wisheart's opinion [of his own] success rate, as did both of my parents. Mr Wisheart would be doing the operation, it was his success rate that mattered. He said that he knew what he was doing, he said that he had confidence in himself, he believed that the operation would be a success. We were not told that there were other centres where the operation could be carried out. We were not given the choice for the operation to be performed anywhere else. No comparison of success rates at Bristol with anywhere else was provided to us.
>
> 'We had been told by nursing staff on previous visits that Mr Wisheart was the best in his field. Dr Jordan and Dr Joffe had endorsed this opinion. Mr Wisheart told us that James would have to have the operation before he was five years old, otherwise he would die. This was the first time anyone had actually said outright that James would die without the operation. We were told that James' operation would take place the following year.'[275]

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[274] WIT 0232 0006 Amanda Boyland

[275] WIT 0232 0008 Amanda Boyland

235 Amanda Boyland recalled that:

> 'James had also been to see the hospital dentist. The food supplement, Polymer, had rotted James's teeth and he now had an infection in his mouth …
>
> 'Mr Wisheart came to see me on the ward. He asked me whether I wanted to cancel the operation because of the infection in his mouth. I asked him what his opinion was. He told me that he thought it would be best to go through with the operation as planned. On this advice I signed the consent form. Mr Wisheart at this time reiterated that the success rate for this operation was 95%. He said that nothing could go wrong. I believed him, I trusted him completely. ...
>
> 'On the day of the operation, 9th February 1993, my mother and I arrived on the ward early in the morning. … Around 8.30 am my mother took James down to theatre. We had been told that the operation would take between 4 and 6 hours.'[276]

236 Amanda Boyland stated that whilst they waited for James to come out of theatre: 'Every so often we would ask a nurse to ring down to theatre to ask after James. We kept being told that everything was fine.'[277]

237 She continued:

> 'James had been in theatre for 14¼ hours. He had been connected to the by-pass machine for the duration of this period. A couple of hours after being brought up to the ITU James had to be taken back down to theatre.
>
> 'Mr Wisheart came to see us. He told us that the operation was successful but that they had had difficulty getting James off the by-pass machine. I was told that when they had disconnected James from the machine they could not start his heart. They had attempted to do this 4 times. Thus, James was brought back to ITU still on the by-pass machine. At that time the operation wound had not been stitched up.
>
> 'I have been recently been told by Dr Martin, one of the consultants in Bristol, that the machine was an untested and unused adult heart by-pass machine and that in effect James was being used as a guinea pig to see if it worked. The machine was the only one available at the time and therefore the operation should not have gone ahead.'[278]

238 The UBHT responded to Amanda Boyland's statement by stating that the heart bypass machine had been used on both adults and children for many years prior to James' surgery, that the appropriate disposable pieces were available in various sizes and that the cardiac unit had had two such machines for many years.[279]

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[276] WIT 0232 0009 – 0010 Amanda Boyland

[277] WIT 0232 0011 Amanda Boyland

[278] WIT 0232 0011 Amanda Boyland

[279] WIT 0232 0032 UBHT

239 Amanda Boyland described the events surrounding James' death:

> 'I had been told that James was now well on his way to recovery, apart from the fluctuations in his blood pressure. However in the early hours of Sunday 14th February, there were serious complications … I was told that James had suddenly deteriorated. James was still on the ventilator at this time, but I was told that one of his lungs was filling up with blood. In effect James was drowning in his own blood … Mr Wisheart was then on the ward with James. My mother asked him to drain the lung. Mr Wisheart told us that it would take a week to drain the lung, my mother replied that it didn't matter how long it took, all we wanted was for James to get better.
>
> 'On the Sunday I was holding James in my arms when all the alarms started going off. I asked the nurses what the alarms were for. They said that it was only the alarm for his feeding tubes. They turned the alarms off. They then said that James had gone. He had died in my arms. It then dawned on me, although they did not tell me this, that they had switched off the machines so that James would die. They had not asked my permission to do so at all.
>
> 'I have since been told that at the time the alarms went off, Mr Wisheart had refused to give James any further medication to keep up his blood pressure and the food bags which contained medication once empty were not replaced …
>
> 'We asked the nurses if we could see James. They said we should wait until they had got him ready. James was detached from all the equipment and monitors and wrapped in a blanket. We were all given the chance, in privacy, to hold James and to say goodbye to him.'[280]

240 The UBHT responded that machines were only turned off after all tests had been done to ensure that a patient was dead. It stated that the family would have been involved in the detailed discussions surrounding the planning and turning off of the machines. It went on to say that family members might have found this so traumatic that they may not now be able to remember it clearly. In relation to the withdrawal of treatment, in the form of drugs and food, the UBHT stated that it is very unlikely that discussions took place without the family being involved in them.[281]

241 Penelope Plackett, mother of Sophie, explained what she was told in 1988 by the clinicians caring for her daughter:

> 'The cardiac catheterisation was carried out at the Bristol Children's Hospital by or under the supervision of Dr Benatar when Sophie was about 3 months old. Dr Benatar confirmed the diagnosis of Truncus Arteriosus Type I. He told me this was the easiest form of Truncus Arteriosus on which to operate. On the second day of that hospital visit, at which I was accompanied by Sophie's father, we were seen

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[280] WIT 0232 0011 – 0013 Amanda Boyland

[281] WIT 0232 0032 UBHT

by Mr Dhasmana. Mr Dhasmana had Sophie's notes and the results of the cardiac catheterisation. We met him in a little room in the baby unit at the Children's Hospital. Mr Dhasmana confirmed that Sophie had Truncus Arteriosus Type I. He also told me this was the easiest form of Truncus Arteriosus on which to operate. He stressed the urgency of operating but said that he wanted a lung biopsy to be carried out to establish that she had not suffered hardening of the arteries. He said that an operation to correct the heart defect would only be of benefit if there had been no lung damage. Mr Dhasmana gave the impression of being remote and vague. He did not inspire confidence …

'Mr Dhasmana carried out the lung biopsy in Bristol on 24th October 1988, when Sophie was about 3$^1/_2$ months ...

'After a fortnight, I telephoned Mr Dhasmana to ask if he had received the results of the lung biopsy. He told me that the pathologist at Bristol had been unable to draw any conclusions and that he had asked Great Ormond Street to assist. As Mr Dhasmana had stressed the urgency of the operation, I was very anxious. A further 3 weeks went by. I saw Dr Orme[282] at his clinic in Exeter, and he told me that Dr Berry, the pathologist at the BRI, had informed him that the results had arrived. He also stated that I should make contact with Mr Dhasmana. I therefore telephoned Mr Dhasmana. He told me that he had just heard from Great Ormond Street.[283]

'He said that although the biopsy was favourable, he still had serious misgivings about operating on Sophie because there had been a considerable time lapse since the biopsy was done. He said those four or five weeks could have had a disastrous effect on Sophie's lungs and she could, by now, be inoperable.'[284]

'… Mr Dhasmana told me that he had decided to operate on Sophie "to give her a chance". He said he was going to operate on 22nd November (1988). Sophie was then 5 months old. I have since become aware of a letter from the GOS pathologist in Sophie's medical records, in which he confirms that any damage to her lungs was reversible. I find it hard to reconcile this letter with Mr Dhasmana' s account of it.

'Throughout this period, Sophie's paediatrician, the cardiologists and Mr Dhasmana all said that, although there were risks, Sophie would have a normal life if the operation was successful. Nobody mentioned the risk of brain damage. I was not given any information about Mr Dhasmana's record in Truncus Arteriosus procedures. Nor was I informed of the complexity of Truncus Arteriosus in comparison to other types of congenital cardiac open-heart surgery. Mr Dhasmana did not tell me that he had by this time carried out 4 Truncus Arteriosus operations.

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[282] Sophie's paediatrician
[283] WIT 0012 0004 – 0005 Penelope Plackett
[284] WIT 0012 0014 Penelope Plackett

I now know that, of these, three of the patients had suffered from Truncus Arteriosus Type 1. All four of the children had died during or soon after the operation.'[285]

'We were admitted to the BRI with Sophie on Friday 19th November 1988. Sophie's father and I shared a room with Sophie. We saw Mr Dhasmana at about 6:00 p.m on Monday 21st November 1988, the evening before the operation, when he was doing his ward rounds. Our discussion with Mr Dhasmana lasted about half an hour. He explained that Sophie would be put on a heart/lung machine and that he would divide her single heart chamber into two and would then fit an artificial valve and artery. He said this would mean the pressure in her lungs would be reduced and her condition would improve. He said the operation would take up to 12 hours. Sophie's father was with me throughout this discussion. Mr Dhasmana examined Sophie, who looked healthy, strong and well. She had continued to develop normally; she was capable of holding her head up, grasping toys and enjoying her baby bouncer. Having told us on the previous occasions when we had met him that she had a 50/50 chance of survival, Mr Dhasmana now said that, because she was so well, her chances of surviving the operation were 80/20. Once more, he told us that if the operation was a success she would lead a completely normal life. He said she would need another operation – possibly as early as at age 3 – to fit a larger artificial valve and artery when she had outgrown those that would be fitted in this first operation. Mr Dhasmana mentioned no other risks and, therefore, I did not think there would be any. In my mind, Sophie was either going to live or die. If she survived the operation she was going to lead a completely normal life. Mr Dhasmana had said that she might not see her first birthday if she did not undergo surgery, and this convinced me that it must be right to proceed with the operation. On the basis of the information given to us by Mr Dhasmana, I signed the consent form.

'… Later that evening, Dr Benatar came to see us. We relayed what Mr Dhasmana had told us, including the fact that if Sophie did not have her operation she would be dead before her first birthday. Dr Benatar confused us totally by saying that this was not necessarily right, and I asked him if there were any other options. He said that we could leave her, but that she would be continually exhausted and would have a miserable life; she might eventually need a heart/lung transplant. We felt there was no option but to proceed with the operation the next day.'[286]

242 Penelope Plackett stated that after the operation:

'Mr Dhasmana told us that the operation had gone very smoothly and that she was making a good recovery. We found this reassuring. We asked him how long it would be before they would know that all was going to be well with Sophie and he said "usually 48 hours". During the first two postoperative days in ITU Sophie had a number of episodes of tachycardia, during which her heart rate would soar to 170–180. These were controlled by drugs … Once the first 48 hours had passed, we

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[285] WIT 0012 0005 Penelope Plackett. See Chapter 3 for an explanation of clinical terms

[286] WIT 0012 0006 – 0007 Penelope Plackett; Mr Dhasmana's response to this is at WIT 0012 0016 – 0019

> began asking if Sophie was going to be alright. We found the staff extremely reticent, and none of them volunteered any opinion as to the outcome. With hindsight I am sure they knew something was wrong. From about 7:00 a.m. until midnight each day, I was always at Sophie's side. Mr Dhasmana and Dr Masey came to see Sophie on their rounds, but I don't remember any visit from a cardiologist.[287]
>
> '… After a week, Sophie was weaned off her sedation and began to breathe for herself as the ventilator was turned down. I do not know why she remained on the ventilator for so long. At one point, within the first day after coming off the ventilator, Sophie suddenly opened her eyes. They were completely blank and unfocused and her arms and legs began to thrash more or less continuously for the next 2 days. During this period of fitting, Sophie did not sleep at all and we were extremely worried …
>
> 'A neurologist from the Children's Hospital or Frenchay, a Dr Schutt, came over to the BRI and examined Sophie. He carried out an EEG and asked us how we thought she was. We tried to be positive and pointed to the minute signs of improvement. In a conversation which lasted barely 2 minutes, Dr Schutt shot us down in flames. He told us (in front of a nurse, whose name I do not recall) that Sophie would never see, hear, move, or even suck or swallow. He said all her brain had ceased to function, apart from the cerebral stem. He said she would be severely epileptic. He stated that nothing could be done for her and that we should take her home and look after her. He said that, if she went into cardiac arrest, we should not resuscitate her, and should let her go. He did not say why this had happened. He asked us if we had any questions but we were too shocked and distressed to respond. This was just over 2 weeks after the operation. We were absolutely shattered and decided to go home that night to pass on the news to family and friends.'[288]

243 Sophie was then transferred to the BRHSC. Penelope Plackett continued:

> 'Despite the news we had been given by Dr Schutt, Mr Dhasmana told us at one point that this might just be a temporary swelling of the brain which would get better in time. Looking back, this was a particularly cruel thing to say. It gave me false hope. Mr Dhasmana persuaded me, much against my will, that I needed a break and should go home to Exeter for the weekend. I did so, although I did not feel that I could trust the staff to give Sophie proper care and attention. When I returned to Bristol, she had an appalling case of nappy rash with noticeable burns on her skin. She had obviously been left in a soiled nappy for a long time. I hated every second of the time Sophie and I spent at the Children's Hospital. I hated the nurses and the whole place. It was a nightmarish blur.'[289]

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[287] WIT 0012 0009 Penelope Plackett

[288] WIT 0012 0009 Penelope Plackett

[289] WIT 0012 0011 Penelope Plackett. The UBHT's response to this evidence is at WIT 0012 0022; Mr Dhasmana's is at WIT 0012 0020

244 Penelope Plackett stated that:

> 'Other than information as to the drugs that had to be administered, we were given no advice on how to care for a child in this severe condition either by the staff at Bristol Children's Hospital or at the Royal Devon & Exeter Hospital. Whereas Dr Orme had been supportive before the operation, his attitude had now changed. He said this kind of thing can happen and he was defensive of Mr Dhasmana.'[290]

245 Philippa Shipley, mother of Amalie, had moved to Swansea in 1986. Amalie's care was transferred to the Bristol team. Philippa Shipley stated that Dr Joffe was happy with Amalie's condition at the first meeting and the consultation was brief.[291]

246 In February 1988 Amalie was admitted to the BRHSC, as arranged by Dr Joffe.[292] After carrying out a catheterisation, Philippa Shipley stated that Dr Joffe discussed what he had learnt:

> '… he said that everything was looking good and that Amalie's open heart operation could be delayed for a good while yet … The meeting only lasted about 2 or 3 minutes … We did not see Dr Joffe again and Amalie was discharged the following day.'[293]

247 Philippa Shipley recalled that she and her husband heard of Mr Dhasmana when they received a letter asking them to attend an appointment with him,[294] which they attended on 20 April 1988:

> 'With very little introduction, he explained that he thought Amalie should have her Fontan operation as soon as it could be arranged. This was completely contrary to everything we had been told before, and I argued with him, pointing out that Dr Joffe had said Amalie would be fine for a good while longer yet. Mr Dhasmana cut me short, saying "Don't come into me with hearsay." … He … dismissively said, "There is significant medical evidence that children who weigh as little as 10kg can undergo this operation". The meeting lasted less than 15 minutes. Soon after… Andrew [Mr Shipley] wrote[295] to Dr Joffe asking if the operation might be postponed … I was very upset after the meeting with Mr Dhasmana … I cried tears of anger at the way we had been treated … We found him impatient and arrogant but we felt we had to take his professional advice, because we could not pretend to know what was the best course of treatment for our daughter.'[296]

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[290] WIT 0012 0011 Penelope Plackett

[291] WIT 0392 0009 Philippa Shipley

[292] WIT 0392 0010 Philippa Shipley

[293] WIT 0392 0011 Philippa Shipley

[294] WIT 0392 0011 Philippa Shipley

[295] WIT 0392 0042; letter from Andrew Shipley to Dr Joffe

[296] WIT 0392 0012 Philippa Shipley; Mr Dhasmana's response to this is at WIT 0392 0073

248 As regards the risks of the operation, Philippa Shipley stated that in January 1989, on the ward, after an echocardiogram had been performed, Mr Dhasmana:

> '… said that Amalie was "just above the line where this operation is possible". Nonetheless he said that she had more than a 50% chance of coming through it. He did not mention any other risks, such as organ failure or brain damage.'[297]

249 Philippa Shipley described events during and after the operation:

> 'Helen Vegoda … sat with us while we waited, but I did not find her presence at all helpful. Ms Vegoda passed the time by talking about family days out at St Fagans, Cardiff … Mr Dhasmana came to see us … He told us that things had not gone as well as he had hoped … He said we could go to see her in ITU. He warned us that she was a dusky pink colour. Amalie was a horrific sight … She had not been cleaned properly … there was blood in her hair and on her chest and the incision was not very adequately covered … Amalie's appearance was so awful that after her death I asked close family and friends not to visit her and pay their last respects since I knew they had only seen her at Christmas and would be appalled by her appearance. I was standing, trying to take this in, when I became conscious of Helen Vegoda physically pushing me towards the bed. I had not approached it myself, and she had taken it upon herself to encourage me to get closer to my daughter … When we went back to see her [Amalie], we were told that her kidneys had failed. The doctor who explained this to us asked if Amalie was our only child. When we said that she was, he put his head in his hands and sighed.'[298]

250 Lorraine Pentecost, mother of Luke, told the Inquiry how she came to know, in 1985, that Luke had a heart problem and required an operation:

> '… The day he [Luke] had his operation was the first I was told that there was definitely a heart problem. I was at home and I had a telephone call asking me to come over because he had deteriorated during the night. … I arrived at Bristol and I signed for him for a catheter. They sent him to have a catheter. I signed a form for the catheter. Luke came back from the catheter and it was — it seemed to be panic stations. I was told he had TAPVD and they were going to have to operate the same day, they were going to operate that afternoon … I did not have a choice, they said they have to operate immediately.'[299]

251 Lorraine Pentecost described what Mr Wisheart told her about the operation which Luke needed in the following exchange:

> 'He told me that Luke had TAPVD; that if he did not operate he was going to die.

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[297] WIT 0392 0015 Philippa Shipley

[298] WIT 0392 0016 – 0017 Philippa Shipley. The UBHT's response to this evidence is at WIT 0392 0074

[299] T95 p. 138 Lorraine Pentecost. See Chapter 3 for an explanation of clinical terms

‘Q. Did he give you some idea of what TAPVD was?

‘A. He ripped a piece of paper out of a notebook and with his pen he drew a quick diagram.

‘Q. You say “quick”; how long was your chat with him?

‘A. Couple of minutes, five minutes at the most.

‘Q. Were you on your own?

‘A. No, my husband at the time was with me.

‘Q. You discussed afterwards what had been said to you. No doubt you discussed what had been said to you afterwards?

‘A. Yes.

‘Q. Did you both take the same messages away from the meeting?

‘A. We were both led to believe that even though he said he had never seen this type of operation before —

‘Q. That is Mr Wisheart?

‘A. Yes. He said he had never done this type of operation before and he had never seen one, but he did know of a surgeon who had done one. He said he was going to contact him. I was led to believe that Luke’s condition was so rare that only a few — only one doctor had ever operated on it before.

‘Q. Did that give you the idea that it obviously was something which was really quite serious?

‘A. No, I was always led to believe that it was just basically a vein that had to be cut off, twisted round and stitched back on again. I know he said it was a 1 in a million chance of Luke actually having this, but he was so full of confidence, he was so full of himself to say that “Yes, this is an unusual type of operation, but I can do it”. I mean he never put any doubt in my mind that he was capable of doing it.

‘Q. If he was expressing confidence or giving you the impression of confidence, for what reason did you think he was saying to you, “Look, I have never actually dealt with such a case before but I know somebody who has and I will speak to him”? What did you think he was trying to convey by that?

‘A. At the time I never really thought about it, I mean I had just been told that he had this heart condition; that if they did not operate he was going to die. I never

> really thought that much about it at the time. I just thought if he does not have it, he is going to be dead.
>
> ‘Q. So in effect you had no choice?
>
> ‘A. No, I was given no choice.
>
> ‘Q. Whatever Mr Wisheart had said, you would have, assuming you had got the message from him that the situation was critical, you would have agreed to the operation, would you?
>
> ‘A. Yes. This surgeon that he spoke to or said he was going to speak to, I did not even know if he was in the country. There is major heart surgery all over the world. I just took it that Mr Wisheart was the only one who could do it, you know. I had no choice.’[300]

252 John Mallone, father of Josie, told the Inquiry that he felt that all he had received from the healthcare professionals in 1990 was ‘reassurance’, as opposed to useful information, and that he was not informed of the risks associated with the operation:

> ‘… Our daughter … was born in hospital and she never went outside. After a couple of days when she was not feeding properly, we constantly were given reassurance that it will be just some problem with a teat, try a different method and so on. Then it became obvious that she was not well, a heart murmur was detected and she was taken down to the SCBU, Special Care Baby Unit, and we were still being given reassurance all the time and we subsequently learned that the staff on that unit had suspected she had a coarctation because her femoral pulses were weak. They did not tell us about that at the time; they kept trying to make us feel that everything was okay.
>
> ‘… When it became apparent that she did have a serious heart problem, she had an echocardiogram and then Mr Wisheart – eventually after another couple of doctors saw us – came and explained to us she was going to need an operation for coarctation and later when she was older she would have to have open heart surgery as well, but he was immensely reassuring. He used the future tense, not conditional or anything. “She will never climb Mount Everest,” he said, “but she will be able to ride a bike and run around like other children.” There was never any doubt coming from him that, you know, she was safe, they would make her better, which we found immensely reassuring.
>
> ‘… But there was never any mention of any possible risk … She was paralysed as a result of the operation and the band itself was not of the right tension, so she subsequently died. But there was no mention of any possibility that she would be

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[300] T95 p. 152–4 Lorraine Pentecost

> paralysed, for instance, or brain damaged or anything like that. We were only given the opinion, a positive outcome was going to happen.'[301]

253 In his written evidence to the Inquiry, John Mallone stated that he had no recollection of Mr Wisheart's ever quantifying the chances of a successful outcome for the operation, but that his wife: 'clearly remembers him saying that there was a 95% chance that everything would be fine.' He also stated that: 'No risks other than that of Josie dying were mentioned.'[302]

254 John Mallone subsequently told the Inquiry:

> 'We were given a figure of 95 per cent success rate by Mr Wisheart himself, I think – if not him, by a junior doctor whom we saw on the same day. We saw two doctors who both explained what would happen in the operation and it was either Dr Ruth Gilbert or Dr Wisheart, I think, who gave that figure … We had [it] explained to us twice, by both this junior doctor and this surgeon who was going to perform the operation, and I felt I understood what was going to happen.'[303]

255 John Mallone indicated that the state in which he found Josie after her operation shocked him as 'she looked like a corpse in suspended animation'.[304] He stated that Mr Wisheart spoke to him and his wife after the operation and explained that the operation had not gone exactly as planned but had nonetheless been successful.[305]

256 John Mallone recalled that:

> '… Mr Wisheart was there … at 3.00 in the morning. One concern … that we both had at the time – was that he was operating at the end of a day when he had been at work since 9.00 in the morning. He started this operation at 7.30 in the evening and did not finish it until 3.00, finally went home some time after 4.00 and he was back on the ward at 8.00 in the morning. I could not understand how anybody could do that, physically stay awake that long and perform complex surgery, but he was there and he said he thought the operation was okay; he had performed the coarctation and everything was going to be all right, I think, at that stage.'[306]

257 John Mallone told the Inquiry that on 8 December 1990, Dr Martin told him that Josie had become paralysed 'from the waist down or possibly even higher … during the operation …'[307]

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[301] T95 p. 131–3 John Mallone

[302] WIT 0155 0005 John Mallone

[303] T95 p. 158–9 John Mallone

[304] WIT 0155 0006 and at T95 p. 161 John Mallone

[305] WIT 0155 0006 John Mallone

[306] T95 p. 161–2 John Mallone

[307] WIT 0155 0008 and at T95 p. 161 John Mallone

258 He stated further:

> '… We had a conversation with the unit's third Cardiologist, Dr Joffe. His prognosis was the gloomiest we had yet heard; indeed, he seemed to think Josie had no chance of surviving. He told us that she was not responding to any of the treatment, and that the "law of diminishing returns" was setting in. He asked whether there was anyone we wanted to see her before "the end". Did we have photographs of her? Were there any special clothes we wanted her to wear? He said he was going to consult with Mr Wisheart.
>
> 'At about 6 p.m. that day, there was a conference at which Mr Wisheart, Dr Martin, Dr Joffe, another doctor and at least two nurses discussed Josie's care. Our participation was not sought. At one point, I walked past the meeting and clearly heard Dr Joffe asking "But would you be considering this if it were ab initio?"
>
> '… When the conference had come to an end, Mr Wisheart and Dr Martin came and spoke to us about what they [had] been discussing. They went through what had happened so far, and Mr Wisheart told us what they wanted to do next. He said that all the problems with Josie's weight had been due to problems of chemical balance which had now been rectified. In his opinion, the chylothorax was likely to mend itself: he had never had to re-operate to repair the chyle duct. However, he said that they were fairly certain that Josie was now suffering from chylothorax on the right side of her chest as well. His suggested remedy was the insertion of a further chest drain on that side. He said that it was not yet clear what would happen with the paralysis; he knew of no child as young as Josie who had suffered permanent paralysis as a result of this operation, and the youngest he had ever read of was nine months old. His overall view was that there was every reason to proceed with treatment.
>
> '… When he was talking about inserting a further chest drain, Mr Wisheart stressed that he was just there to provide us with advice. I said, "You mean, if we say don't do it, then you won't?" He replied, "No, I would try to persuade you otherwise." This provides a fair summary of Mr Wisheart's dealings with us; he would supposedly present advice but, in fact, he was merely informing us what they were going to do. At the end of our long meeting with Dr Martin and him, we did not feel very convinced of the arguments with which we were being presented, but felt powerless to affect the outcome anyway.
>
> 'At about 10 p.m., the new chest drain was put in place by Mr Wisheart's registrar (a man who had, until that moment, had nothing to do with Josie's treatment).
>
> 'At about 11.30 on Sunday morning, Josie's saturations suddenly dropped, and a subsequent X-ray showed left-sided pneumothorax (i.e. a punctured left lung). I have no doubt that this must have been attributable to an incident that had occurred the previous morning: a doctor who we had never seen before had introduced himself to us as "a consultant" and, after pronouncing Josie's ventilator

> “a bit low” had turned it up drastically. The ventilator was set to 50 breaths-per-minute, which was 100% higher than it had been the day before, and 50% higher than at any point in the fortnight since Josie’s operation. The pressure was also drastically increased. We never saw the doctor again, and never discovered his name.’[308]

259 John Mallone described the events leading up to Josie’s death:

> ‘Mr Wisheart, Dr Martin and a nurse called Joyce spoke to us. They said that the looseness of the band meant that too much blood was getting to Josie’s lungs and, as a result, she could not adequately ventilate herself. We were offered two alternatives. The first was that they remove the artificial ventilation, giving Josie a chance of making it on her own without really expecting her to do so. The second was to do another operation to tighten the band; however, if this course of action was chosen, it would be necessary to do a diagnostic catheterisation first. They made it clear that this procedure, in itself, had a risk attached to it. I do not know why they even mentioned this course of action as a possibility, since we had, by this stage, already made it quite clear that we did not want Josie to go through another operation. By now, Dr Joffe’s earlier pessimistic approach to us began to seem by far the most human we had encountered. I got quite angry with Mr Wisheart, since he was now saying that it was possible to stop treatment whereas, before, he had seemed determined to go on to the bitter end. The only thing that appeared to have changed was that they now thought the paraplegia was almost certainly permanent. This meeting was a most unpleasant one. Ann would not speak. I was angry.
>
> ‘After over a month of looking on, feeling as if we had no say in Josie’s treatment, we had been presented with a huge decision: the choice between, on the one hand, letting our daughter die and, on the other, demanding the continuation of the increasingly painful and apparently futile fight for her survival. Mr Wisheart had stopped giving us instructions masquerading as advice and seemingly abdicated all responsibility for planning Josie’s care. I now know that deaths at units like Bristol’s are only counted as statistically significant if they occur within thirty days of an operation and, in my most cynical moments, I wonder how much of a coincidence it was that the point at which Mr Wisheart deferred to us for the first time came immediately after this watershed. For me, it is a travesty that Josie was, as far as Mr Wisheart’s record is concerned, a success.
>
> ‘We decided to refuse further treatment. Nothing we had been told gave us any hope that there was a genuine chance of Josie surviving without being put through what we considered an unjustifiable amount of further suffering, and the risk of an even less dignified death. Joyce, the nurse, said that we mustn’t feel that we’d given her a death sentence, but we both felt dreadfully guilty, even though we hoped that we were doing the right thing.’[309]

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[308] WIT 0155 0010 – 0012 John Mallone

[309] WIT 0155 0014 – 0015 John Mallone; Mr Wisheart explained his approach at WIT 0155 0064 – 0065

260 John Mallone told the Inquiry that he found Dr Joffe:

> '… actually the most human of any of the doctors that we met and I found the way in which he broke this news to us, I think it was done very sensitively, I thought he came across as a very caring human being and I did not feel it was done brutally at all. The shock came when at the end of the conversation he said "I will go off and talk to Mr Wisheart about it", the shock came when we were then told, after they had had a discussion about it for over an hour at which I could hear Dr Joffe arguing strongly that she ought to be allowed to die, the shock came when Mr Wisheart said he wanted to continue treatment. I found it appalling that we could have been told "There is nothing more we can do for her" and then a matter of hours later being told "We can go on and do this, this and that." I think they should have got their story straight before they spoke to us … I do not know why treatment was continued. I guess Mr Wisheart may have felt some kind of sense of his own pride in his work perhaps that he did not want to have this child die if he thought she could survive, I can understand that. What I do not understand is why, after having said "We can continue treating her", another two weeks later when nothing had changed in her condition whatsoever, at that point we were told if we wanted to, we could take her off the ventilator now and let her die … when one of them says "Your daughter is about to die" and the other one is saying "No, she is not", I felt they should have spoken to one another beforehand.'[310]

261 Maria Shortis' daughter, Jacinta, was operated on by Mr Dhasmana in November 1986. Jacinta died in January 1987.

262 In her written evidence to the Inquiry, Maria Shortis recalled Dr Joffe sitting with her husband and her and that he:

> '… started to draw a normal heart for us to see. He then drew a diagram of Jacinta's heart. It was readily apparent that Jacinta did not stand a chance of survival. She was completely dependent upon her patent ductus arteriosus to keep her alive until she was two or three. Dr Joffe listed the conditions from which she was suffering as absent septum, pulmonary atresia, transposition of the great arteries, and defective tricuspid and mitral valves. He said that Jacinta was 1 in 3 million, and that he would never see another baby like her in his lifetime. He also stated that he was surprised she had been born alive. Because her patent ductus arteriosus would close after a few days, Dr Joffe said that it would be necessary to perform a shunt operation during the first week of Jacinta's life. Dr Joffe said that he was impressed Jacinta had weighed so much at birth, and had been born so effortlessly. When we asked him about our options, he said that we could turn off the Prostaglandin that was keeping her ductus open. He stated that, if we chose to follow this course of action, she would "succumb" in about 48 hours. Dr Joffe then said that Jacinta was a strong little baby and, in his opinion, worth fighting for. He said that the shunt operation was not risky, and made it very clear that it would give Jacinta a few years

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[310] T95 p. 184–5 John Mallone

> of life. I specifically asked him what her quality of life would be for those two or three years. Dr Joffe assured me, categorically, that she would have as near normal a childhood as possible. I felt that I could not ask Dr Joffe to switch off Jacinta's life support at this stage, if there was some quality of life she could experience with her parents and her brother. We therefore agreed to go ahead with the operation.'[311]

263 Maria Shortis stated that Dr Joffe told her that a cardiac catheterisation would have to be done, and that she asked Dr Joffe about the risks involved:

> 'We asked about this, and about the inherent risks involved. We were told that there were no risks, which prompted me to comment that nothing in life is ever risk-free. At no point did Dr Joffe tell us about the effects of infections, jabs, drugs or post-operative care upon Jacinta. If we had known what questions to ask, we would have raised these issues. Instead, we agreed to the catheterisation procedure going ahead, and signed the appropriate forms.'[312]

264 Maria Shortis stated that Dr Joffe then later informed her that he: 'had spoken to Mr Dhasmana, the consultant paediatric cardiac surgeon, and that Jacinta had been listed for surgery the following afternoon.'[313] Maria Shortis recalled that Dr Joffe said that they were to see Mr Dhasmana the next morning who would give them details of the operation he was to perform. Maria Shortis went on:

> 'Dr Joffe stated that we were very lucky to be at a centre of excellence. I felt very relieved by this.'[314]

265 Maria Shortis described meeting Mr Dhasmana:

> '… we were shown into a small room by a nurse from ITU, who I think was called Jeanette, for our consultation with Mr Dhasmana. As we sat down, Mr Dhasmana said, "Had I got to you before the consultant cardiologist, I would have told you that your daughter is inoperable, and have asked you why you want to put her through such misery. I have cancelled the operation." It came out in a burst of frustration and anger, and I found the way Mr Dhasmana informed us of his decision was totally unprofessional. I heard Tim groan, and saw him slump back in his chair. My initial response was, "But you didn't get to us first." I was trying to collect my thoughts, and wondered what Dr Joffe had based his decision on. I had the impression that Mr Dhasmana was telling us the truth, but that his communication skills were appalling: he appeared to have blurted out his own decision, rather than presenting us with reasons. At no point had Dr Joffe stated that the surgeon did not think that Jacinta was inoperable. Now, I was faced with the possibility that my child's operation would not go ahead, and a surgeon who was

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[311] WIT 0222 0009 Maria Shortis. See Chapter 3 for an explanation of clinical terms

[312] WIT 0222 0010 Maria Shortis

[313] WIT 0222 0010 Maria Shortis

[314] WIT 0222 0010 Maria Shortis

> evidently angry with his colleague. I felt as though I had been drawn into inter-departmental hospital politics, particularly between these two men.
>
> 'Following his outburst, I said, "Mr Dhasmana, do you not want to operate on Jacinta because she is going to die anyway?" I believed this question would give him the opportunity to answer in the affirmative. Had he believed it to be a waste of time, I could and would have accepted it. However, Mr Dhasmana's reply struck me as illogical and cowardly, and made me cross. He moved back in his chair and shouted, "I am not talking about death, I just like to see my patients through." The implication of this was that he liked to have a good success rate. However, when I asked him about this, he informed me that there was no problem with this operation, and that Jacinta would come through it easily; he quoted me a 95% success rate …
>
> 'I felt that I was dealing with someone who could not give a straight answer, and said, "Mr Dhasmana, having cancelled her operation, what do you want to do with Jacinta?" He replied that he wished to take her off all her drugs, and monitor her progress. I interpreted this as meaning that he wanted to let her die, since Dr Joffe had already told us that Jacinta would die within 48 hours if she was taken off her medication. I therefore informed him of Dr Joffe's opinion. Mr Dhasmana stated that he had seen patients whose patent ductus arteriosus was still open and functioning at the age of 18. I remarked that I suspected these patients did not have five major heart defects. However, by this stage, I was so stressed by this conversation that I consented to Jacinta being taken off her drugs to see how she coped. I remember that Mr Dhasmana appeared to be very relieved, but also surprised at my reaction. I added that, as her mother, I wanted her to be put back on her drugs if she became cyanosed, and in danger of dying, since I was not yet ready to say goodbye to her. Mr Dhasmana seemed pleased that I had agreed with his plan, but stated, "As you have been promised the operation, I suppose I shall have to do it." He said this in a sulky manner, and it seemed such an unprofessional way to end our conversation that I left the meeting in some distress.'[315]

266 Maria Shortis stated that on the day before the operation, she saw Dr Joffe, who apologised for what happened in her meeting with Mr Dhasmana:

> 'He said that Mr Dhasmana was an emotional sort, who upset parents, but he could reassure me that Jacinta could and would have an operation. Dr Joffe seemed dismissive of Mr Dhasmana, and I was surprised by his apparent lack of professional loyalty. I did not raise my concerns that the lack of communication in the BCH was adversely affecting the level of care Jacinta was receiving, as I was too exhausted. Additionally, I had been told many times that the BCH was a centre of excellence by both Dr Joffe and the nurses. I believed that the staff were skilled experts in cardiac surgery, even if they did not have much skill in talking to parents.'[316]

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[315] WIT 0222 0011 – 0013 Maria Shortis

[316] WIT 0222 0014 Maria Shortis

267 Maria Shortis stated that Dr Joffe informed her that Jacinta's operation would go ahead the next day, and that:

> '… the operation carried very little risk, and quoted a 90% success rate. He also stated that we should give her the best opportunity.'[317]

268 Maria Shortis recalled that:

> 'I was very aware, throughout the course of this conversation, that the cancellation and subsequent reinstatement of Jacinta's operation had very little to do with me directly.'[318]

269 Maria Shortis stated that:

> 'Following Jacinta's death, I realised how optimistic Dr Joffe had been in his appraisal of her quality of life, post-operatively. For Jacinta, death must have been a welcome relief. For us, it was terrible … I now believe that, had Mr Dhasmana seen us before Dr Joffe, he would have told us that there was no operation which could give Jacinta a reasonable opportunity of normal life. However, he did not, and it appears that he did not feel able to assert his views against those of his colleagues.'[319]

270 Maria Shortis expressed her feelings on the matter now, in her statement to the Inquiry:

> 'I am still appalled at the lack of information that was available to us. I believe that Mr Dhasmana should have told me that one of the risks of the large shunt he fitted was heart failure … Dr Joffe, who recommended that Jacinta should have the shunt operation, never explained that heart failure would be one possible outcome. I also wish I had known what the side-effects of Digoxin were, as I found it terrible to watch my daughter's condition deteriorate, due to a lack of proper nourishment. Jacinta experienced all the side-effects associated with Digoxin, and it is awful to imagine that I gave her a drug which might have caused her death. At the time, I asked what the associated side-effects of Digoxin were, but never received a straight answer from any of the hospital staff. If I was the parent of a child who should be alive today, I do not know how I should feel towards the medical and nursing staff of UBHT. However, I do feel that Jacinta did not receive competent treatment, and that I and my family were burdened by unnecessary grief and guilt.'[320]

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[317] WIT 0222 0015 Maria Shortis

[318] WIT 0222 0015 Maria Shortis

[319] WIT 0222 0021 Maria Shortis

[320] WIT 0222 0023 Maria Shortis

271 Paul Roberts, father of Andrew, explained to the Inquiry the steps he took in 1985 to be sure that he understood what the various healthcare professionals told him and his wife:

> '… It was a lot to take in at the time, but we had a lot of help by the people who were looking after us … a lot of the people around us at the time, we had an extremely good health visitor. We had a health visitor who also lived across the road from us. We just talked to everybody we could. That was the biggest help, really. We just kept on talking to everybody at the hospital, friends, and eventually, as I say, that helped us through it, really.'[321]

272 Tony Collins, father of Alan, told the Inquiry:

> 'We had had it explained to us several times, but I understood the problem to be Alan had a blocked and narrow aorta … Mr Wisheart had actually drawn pictures when we saw him of what the problem was and what he was going to do to repair it, and also [Dr] Jordan and Dr Joffe came to see us and all drew pictures at that time of what was going to happen … Mr Wisheart and Dr Jordan and Dr Joffe had all told us that Alan's chances were not particularly good because of the amount of time he had been unwell leading up to being in Bristol, so the chances of his survival were not very good at all. I could not actually put a percentage on it, but I think it was less than 50 per cent … They told me but I cannot remember now what it was. I just know it was a little below 50 per cent.
>
> '… The situation we were in to begin with was the fact that Alan either needed to have the operation or he was not going to survive, so you can look at that and say there is no option, really. Given an option now, we would still have let Alan have the operation.
>
> '… There were so many things happening on the day with Alan having to have this operation and all the rest of it, that odds and — lots of different things we were told did not really register in the sense of all we were worried about was that Alan survived the operation.
>
> '… They said because of — not the amount of time of the operation, but they said there was a possible chance Alan could have brain damage or be paralysed from the waist down, the ultimate one being the fact he may not survive.'[322]

273 Susan Francombe's daughter, Rebecca, was diagnosed in 1986 about 18 hours after birth as having a heart problem.[323] She died aged 5 days, after an operation performed by Mr Dhasmana.

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[321] T68 p. 86–7 Paul Roberts

[322] T68 p. 73–6 Tony Collins

[323] WIT 0349 0001 Susan Francombe

274 Susan Francombe told the Inquiry:

> 'Certain things are very clear. Certain things stand out in my mind, certain pictures from throughout almost five days of her life. Other things are a blur and I do find difficult to remember.
>
> 'Some things I have not gone over and over, but in the light of the past two or three months, since I decided to contribute to the Inquiry, things have come to light, things have got stirred up. For example, I have since read her medical records, in the past two weeks, which I had never seen before.'[324]

275 Susan Francombe said that matters were always explained in an informative and caring way, with efforts being taken to make sure that she understood.[325]

276 Susan Francombe described meeting Mr Dhasmana for the first time:

> 'He had said that he had seen Rebecca as well as seen the results of the catheterisation and the cardiogram, the previous investigations. He drew us pictures of what that had shown and explained that surgery definitely was the only option; that he had not seen a heart formed in that way ever before, but he either said he was going to or later told us that he had consulted other cardiac surgeons in a London hospital.'[326]

277 Susan Francombe agreed that her impression was that Rebecca's condition was something which Mr Dhasmana had not met before, and that he was informing himself about how best to deal with it.[327]

278 Susan Francombe told the Inquiry that she discussed the likelihood of success of the operation with Mr Dhasmana:

> 'A. I thought he had said 50:50, but my husband remembers it was less than 10 per cent. I am quite prepared to think that I have blanked that out. My husband is better at remembering things than me.
>
> 'Q. What you do remember is Mr Dhasmana indicating that he had never come across the particular problem before?
>
> 'A. Yes.
>
> 'Q. So plainly, any estimate of success he was giving you was in that context?
>
> 'A. Yes.

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[324] T68 p. 9–10 Susan Francombe
[325] T68 p. 11 Susan Francombe
[326] T68 p. 11–12 Susan Francombe
[327] T68 p. 12 Susan Francombe

> ‘Q. And what was the alternative to the operation?
>
> ‘A. That she would have died.
>
> ‘Q. So there was no alternative?
>
> ‘A. There was no alternative.’[328]

279 Susan Francombe wrote a letter to Mr Dhasmana on 21 January 1987, in which she and her husband said:

> ‘… we could not leave it unsaid how grateful we are at all you did for our daughter Rebecca. We often think of the marvellous care and attention you gave her …’[329]

280 John McLorinan’s son, Joseph (Joe), was born with Down’s syndrome. He had AVSD, which was successfully operated on by Mr Wisheart on 14 February 1991.

281 John McLorinan described in his written evidence to the Inquiry the diagnosis and explanation which he was given by Dr Joffe:

> ‘… he came in … he was very calm and soothing and very professional, and he explained very carefully that the initial diagnosis was correct and that Joe did have profound heart problems, and he explained that there was a hole in the middle of the heart and the valves were not working properly and blood was sort of slushing around and not doing a proper job and that was affecting the breathing and everything else …
>
> ‘He explained it [AVSD] very thoroughly. Probably he explained what it was there and then, and so we grew into the term …
>
> ‘He made it quite clear that there were … options.’[330] The first option was to let nature take its course and the second was to do banding on the pulmonary artery.’[331]

282 John McLorinan told the Inquiry that Dr Joffe explained the option of heart surgery:

> ‘… the possibility was suggested that eventually, if we wanted to, we could be referred to the heart surgeon who would open the heart up and do a full repair, put it all back together again. But right from the outset, it was explained all sorts of hurdles and difficulties and dangers and it was looking so far ahead and in fact Joe was so ill at the time we were looking almost an hour or a day ahead.’[332]

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[328] T68 p. 13 Susan Francombe

[329] MR 2181 0012 – 0013; letter to Mr Dhasmana dated 21 January 1987

[330] T2 p. 128–9 John McLorinan

[331] WIT 0122 0001 – 0002 John McLorinan

[332] T2 p. 131–2 John McLorinan

283 John McLorinan went on:

> '… we did not really consider any other option than the full repair, because having brought a child into the world, we thought we would "go for broke", you know, it was not fair on Joe just to let him live a few months or a few weeks or whatever, he ought to have the opportunity of as full a life as possible, so we did not really consider either of the first two options, in all honesty. We wanted to go for it … we understood that he might not even get as far as corrective surgery. It was in many ways, talking to Dr Joffe, and people later on, in many ways it was depressing, because they were saying, "But, if, it might not, we have not got there yet, there is this problem." So they were very good at calming us down, "There is this problem, there is that problem, we cannot guarantee this."… I think surgery at that stage was so far in advance and perhaps so indeterminate that certainly no statistics were mentioned. We just knew it was a very difficult time.
>
> '… I think I should also explain that Joe not only had the heart problem, we were also made very aware of the Down's syndrome and that Down's syndrome people reacted very differently to things and were more susceptible to infection, and also he had this Hirschsprung's disease which was a major problem as well. Apart from the cardiac problem he was a whole mess as well and things all piled on top of each other, so it was very difficult to comprehend anything beyond an immediate fault. We were just very, very aware of how delicate his life was.'[333]

284 John McLorinan described the time when his son was getting worse:

> 'They were explaining what was happening, one step forward, two steps back. They were explaining the different drugs they were going to use, but on the heart business they were failing because the heart was not able to shift the blood and fluid around the body, so it was accumulating, getting worse and worse. The situation was just deteriorating and they were in the best possible way saying "We cannot do anything else" sort of thing. We really got to the stage where we thought we would be called into a discussion to say, "Well, do we call it a day?"'[334]

285 Joe's deterioration is recorded in the minutes of the joint cardiac meeting of 21 February 1990:

> '… in the light of Joseph's poor progress and difficulty being weaned off ventilation, it was felt that a palliative operation would be preferable to attempting a complete correction, which is likely to have a low likelihood of success.'[335]

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[333] T2 p. 133–5 John McLorinan

[334] T2 p. 143 John McLorinan

[335] MR 2469 0171; minutes dated 21 February 1990

286 John McLorinan discussed the effect information could have:

> 'One small incident I recall which happened before this operation is that we had had a consultation with Dr Joffe to discuss Joe's future and treatment. He made reference to some of the problems lying ahead but he had talked about this in a balanced way and also talked of what we might hope for in due course. Following this meeting, I left Gill in the waiting area … When I came back to pick her up I could not see her in the waiting area, and found that she had been taken by a nurse to have some privacy in a small ante room.
>
> 'She was upset and I talked things through with her and it became apparent that she found herself focusing on the difficulties ahead and the negative side of things, particularly the fact that the Cardiac Catheter procedure could come up with the result that Joe would be inoperable: on the other hand there had been much in our discussion with Dr Joffe that had been positive, and by the two of us talking it through together, we drew out these positive aspects. It seems to me illustrative of how a person's reaction to advice can depend very much on the listener as to what he or she focuses on, and how they react to that information.'[336]

287 He told the Inquiry:

> 'It struck home to us very much the importance of listening carefully and the fact we tended to select what we wanted to remember. We were in such a state of tension … we were both in such a state of worry and anxiety, it had gone on for so long, and we were so desperate for Joe to get fixed, that we were there listening and just by chance the brain would snatch on to one piece of information, it might be a good piece or a bad piece, but just the sort of things that stuck.'[337]

288 John McLorinan said that Mr Wisheart quoted a risk of 50:50:

> 'I think we were very well aware of the fact that even though Joe had had the banding, he was not doing particularly well and obviously his prognosis of life was not very good, and we realised that to make a success of Joe's life and any sort of permanency of life, we would have to have the surgery done. We have these figures here, 50:50, and these percentages, that is a big thing. I suppose our understanding of the statistics – we are both teachers and I sort of specialised in statistics and psychology in my final year – we are very much aware of statistics as something you can use one way or another without co-efficients of validity and reliability and all that. You spend years studying these things in education, and they say statistics do not mean very much anyway. By 50:50, we understood that Mr Wisheart, through the totality of his experiences and his skill – we understood there was as much chance of Joe succeeding in the operation as failing. Putting it crudely,

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[336] WIT 0122 0005 John McLorinan

[337] T2 p. 150–1 John McLorinan

> it was on the toss of a coin, but we wanted him to have that chance and we were confident.'[338]

289 As regards referral to other centres, John McLorinan responded in the following exchange:

> 'There were all sorts of rumours going on about reforms in the NHS and we were hearing stories and that, so we realised which hospital we would have been under had we moved up North [Yorkshire]. Our belief was that there was nobody up there with sufficient skill to perform these sort of operations; they would not have been offered. People in that situation were told, "I am sorry, it is inoperable."
>
> 'Q. Can I just ask you, you said that your belief was that there was nobody who had sufficient skill to carry out that operation up north?
>
> 'A. Yes.
>
> 'Q. On what was that judgment based?
>
> 'A. I believe there was somebody appointed at a later date in this hospital who was in fact trained under Mr Wisheart in Bristol.
>
> 'Q. Well, you were making a judgment at that time?
>
> 'A. Yes, at that time, we were told —
>
> 'Q. At that time you were told by whom?
>
> 'A. As I said, Gill was a bit worried about this, so she asked Dr Tizzard, I think she was part of Dr Joffe's team. She made enquiries and came back and said, yes, she understood it would not be possible.
>
> 'Q. Was that because nobody had enough skill to operate up north, or was it because —
>
> 'A. That is what we believed: that they did not do that operation in that particular place.
>
> 'Q. That may be two different factors: one is that nobody has the skill to carry it out; the second factor, which perhaps you mentioned, was that nobody would want to carry it out?
>
> 'A. Yes. I think there are two quite distinct issues here, and I think that is one of the reasons why I actually gave up the job and moved back down here. Certainly

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[338] T2 p. 158 John McLorinan

> I believe that the information was correct that they were not doing that operation there, but secondly, as the previous witness said, this is Down's Heart Group, and we were members of the Down's Heart Group. The Down's Heart Group obviously were promoting the support of children with Down's, with heart problems, and they were doing research and coming up with alarming statistics, that people with Down's syndrome were not being offered equal chances of these operations.
>
> 'Q. So from that, you thought there might be a problem in persuading another hospital to offer Joe this operation? Is that a fair summary?
>
> 'A. We were certain of that, and we were also certain that we would not get a better surgeon, a better team; we could not do better anywhere else. Quite apart from the actual operation itself, the follow-up afterwards'.[339]

290 John McLorinan told the Inquiry of his discussion with Mr Wisheart on the day before Joseph's operation:

> '… we understood it was a very, very serious operation with a very high risk. We were aware of little marks on Joe's notes saying that he was at very high risk, even from anaesthetic. Again, we have this thing of 50:50 and tossing a coin, but Mr Wisheart quite plainly said what he was going to do, it was a by-pass, a very intricate operation, and even if everything went well and he took him off the by-pass for some reason, some of these operations did not work. They had not got far enough in advance of understanding why these things did not work. He said sometimes it is one of those things that just does not work. He could not guarantee anything … there just was not an alternative because he was not thriving. He would have died sooner or later.
>
> '… we were fully aware of the risks and fully aware of the operation, but we signed it [Consent Form] willingly. We did not feel pressured. All the time we got the impression that Mr Wisheart and the other staff were putting forward all the alternatives, all the risks and that, and we were making the choices, but we desperately wanted to give Joe the chance. We thought he might die, but it is better – it is a horrible thing – for him to lose his life than die horribly later on, and we had this wonderful chance of getting him fixed.'[340]

291 After the operation, John McLorinan said that Mr Wisheart took his time and explained how things had gone.[341]

292 John McLorinan concluded that his experience in Bristol: 'sort of refocused my understanding of the role of the doctor, to almost be the servant of the patient or the patient's guardians. We were very much empowered to make the decisions. We

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[339] T2 p. 159–61 John McLorinan
[340] T2 p. 165–6 John McLorinan
[341] T2 p. 168 John McLorinan

really felt we were given what we needed to make the decisions, and it was our genuine free decision.'[342]

293 Belinda House's son, Ryan Batt, successfully underwent a Sennings operation performed by Mr Wisheart in 1990.

294 Belinda House told the Inquiry that she remembered Dr Joffe explaining the diagnosis in a calm and caring way and being receptive to questions.[343]

295 Belinda House described her meeting with Mr Wisheart on 3 January 1990 in the following exchange:

> 'Q. What did Mr Wisheart explain to you?
>
> 'A. He confirmed … [that Ryan] had simple transposition, and that there was an operation he could perform called the Sennings, and it was quite a successful operation, but he still did say, I think, there was a 30 per cent chance it could fail.
>
> 'Q. You say "I think". Is that something you have a clear recollection of, or is that something that is rather faint in your mind?
>
> 'A. Well, I could not decide whether it was 30 or 35 per cent, but at the time there was a reason for that, because he would not have survived until — he would have survived until he was 2 years old and to me, there was no question about him having an operation.
>
> 'Q. So whether it was 30 or 35 per cent, it made little difference to you?
>
> 'A. Whether it was 1 per cent of survival, I would still have had it done.
>
> 'Q. Because that was Ryan's only chance of surviving for about two years?
>
> 'A. Yes.
>
> 'Q. So he told you that there was an operation called a Sennings procedure?
>
> 'A. Yes.
>
> 'Q. What did you understand that that procedure would involve?
>
> 'A. We understood that it was to redivert the flow within the heart of the blood, because at the moment it was two closed circuits and they wanted to divert the oxygenated to the pumping side.

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[342] T2 p. 179 John McLorinan

[343] T6 p. 65 Belinda House

‘Q. And that would take place within the heart?

‘A. Yes.

‘Q. Did you ask any questions about whether or not a procedure could take place outside the heart?

‘A. Yes. We said “Why cannot the aorta and coronary artery just be swapped over?” because it seemed a lot simpler. He explained to us there was an operation that could do that, called the switch, but there were a lot of problems at the time, because the carotid artery was severed and it stopped the blood actually going to the muscle of the heart. At that point, Ryan would have been too old for that operation.

‘Q. When you say there were a lot of problems because of the treatment of the carotid artery, was that something you understood would be a particular problem in Ryan’s case, or was that a general problem with the development of the switch operation?

‘A. We felt that was a general problem in the development of the switch operation.

‘Q. Did you discuss how far developed the switch operation was at that time?

‘A. I remember discussing it a little bit further, and we were given the impression that the switch operation would be – would, in the future – well, when it was developed, it would be carried out on babies that were very young, and I felt that Mr Wisheart thought that this would be very traumatic for babies at an early age, because in two weeks — I know he was waiting for Ryan to be strong enough to have his operation and the two did not add up.

‘Q. You say Mr Wisheart was telling you the switch operation was being developed. Did he discuss with you where it was being developed at the time?

‘A. He did mention America, but I cannot remember any other places.

‘Q. Did he discuss, therefore, whether or not it was being developed in the UK at the time?

‘A. I cannot remember if that was said or not.

‘Q. Can you remember whether there was any discussion of whether it was being offered in Bristol at the time?

‘A. I am pretty sure it was not being offered in Bristol at the time. I think he said that.

‘Q. Would it come as a surprise to you, therefore, Miss House, to learn that at that time there had been approximately nine Arterial Switch operations carried out in Bristol?

‘A. Yes.

‘Q. Because your recollection is of Mr Wisheart telling you it had not yet been developed in Bristol?

‘A. I had the impression it was not developed in Bristol.

‘Q. Why do you say you had that impression? Can we just explore that further?

‘A. Because I cannot remember him exactly saying it had been developed in Bristol. It was just a feeling I had.

‘Q. So is it a fair summary to say you were being told that the operation was being developed, but it was at an early stage in its development?

‘A. Yes. I think so.

‘Q. And there was a discussion of the fact that that development was taking place in the USA?

‘A. I cannot say the development is in the USA. I know USA was mentioned, but I cannot remember any other hospitals being mentioned, or any other —

‘Q. At any rate, you got the impression that Ryan was considered to be too old for the arterial switch?

‘A. Yes.

‘Q. And that therefore, partly because of that, partly because the switch was at an early stage of development, a Sennings operation would be the appropriate one?

‘A. Yes.

‘Q. You mentioned that it was suggested there would be a 30 to 35 per cent risk of mortality, even if that was carried out?

‘A. That is right, yes.

‘Q. Was there any discussion of any other risks attached to the operation?

‘A. I know at the time we were very aware that even if he came out of the operation, you know, the recovery time was very crucial and as the days went on, he would

> become stronger, but it was the first few hours that were very crucial after he had had his operation.
>
> ‘Q. How did Mr Wisheart help you to understand the way in which this operation would be carried out?
>
> ‘A. He spoke very clearly about it and he drew diagrams to explain to us, and of course, he allowed us to ask any questions, so we explored it. I think that is all.
>
> ‘Q. Did you feel that you were being given an adequate opportunity to understand the nature of the operation?
>
> ‘A. Totally, yes, because it was an atmosphere where you felt you could ask any questions, whatever question it was. You did not feel as if you were going to be made to look kind of silly by asking any questions. I cannot remember what questions we did ask, but I know we asked a range of questions.’[344]

296 Belinda House commented on the communication between Mr Wisheart and Dr Sally Masey (the anaesthetist) and the teamwork:

> ‘I can remember them being there, and I can remember them discussing things together … Everything that Mr Wisheart would say would be reiterated by Sally, and the team seemed a very tight-fitting organisation, really. They were all speaking the same language … we never heard a different word from both of them, although I cannot remember them discussing something together in front of us.’[345]

297 Belinda House recalled that before the operation, they were allowed to take Ryan down to the anaesthetic room and witness the pre-medication being administered.[346]

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[344] T6 p. 73–8 Belinda House

[345] T6 p. 96 Belinda House

[346] T6 p. 84 Belinda House

Parents' evidence on the management of care and their encounters with other healthcare professionals at the UBH/T

298 Belinda House stated in her written evidence to the Inquiry that there appeared to be a shortage of staff and resources at the BRHSC, which she noted when her son Ryan was transferred from Southmead Hospital for his scan and catheterisation:[347]

> 'A Senior Nurse had to accompany Ryan with the equipment when he was transferred, but there needed to be someone of equivalent standing remaining in the SCBU, and it seemed that they could not find the necessary staff. At one point we even offered to pay for an Agency Nurse ourselves as no progress was being made. It also then appeared that there was no ambulance available in the whole area with the equipment needed for such a Transfer. It was a horrific situation for everyone concerned, until eventually a suitable ambulance was located. This was the beginning of our education to the fact that the NHS, at the time, was desperately underfunded, so much so that Ryan's life was put at risk.'[348]

299 Belinda House referred to events during the post-operative care of Ryan in the ICU:

> 'While sitting at Ryan's bedside my partner Julian noticed that the ventilator had run out of water as the nurse, who was a trainee on the ITU, had failed to check and notice this. Julian alerted the nurse who quickly filled it up. Unfortunately this was too late and Ryan's ventilator tube had become blocked with mucus which caused him to begin to suffocate. He had to be rushed back down to theatre to have a new tube inserted. Following this Ryan needed further sedation making him more dependent on the ventilator. This was a huge setback in Ryan's recovery and appeared to result in him developing a kidney problem, even though it was ultimately sorted out. The kidney problem meant that Ryan stopped passing urine and had excessive fluid in his body. They had to drain fluid from between the membranes of the chest cavity and apply intensive physiotherapy to get rid of the fluid.
>
> 'On another occasion we returned to Ryan's bedside after a short break and found that the window next to his bed had been opened and his blankets removed. The nurse caring for Ryan was used to adult heart patients becoming very hot, but the opposite was the case for Ryan, and he needed to be kept warm. Maintaining ideal temperatures for patients with very different requirements while in adjacent beds was a continual dilemma for the nurses. Ryan quickly turned blue, making the nurse, who appeared to have little experience of babies, quite distressed and she

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[347] WIT 0025 0002 – 0003 Belinda House

[348] WIT 0025 0003 Belinda House

> was about to call for a Doctor until a more experienced nurse took control of the situation and warmed Ryan.'[349]

300 Belinda House told the Inquiry:

> '… at one point Ryan appeared to have some kind of kidney failure. He had stopped passing urine … it was after his tube had become blocked. To us it seemed like the system had gone into shock; other children on the ward had kidney failure. And the children started to blow up, and it was something that was a great concern to the staff because once that happens, their whole system goes into deterioration. We knew this; we had the feeling we had kind of non-verbal messages from the nurses that Ryan was in deep trouble at this point. He had stopped passing urine. There was nothing further they could do, apart from diuretics, which were not working. Ryan was getting bigger and bigger and not passing urine, so we had a friend who was an acupuncturist, and we asked him what he would suggest, and he said he could treat him for that. Mr Wisheart said "I cannot allow the skin to be actually punctured, but I will discuss it with the rest of the team." He did discuss it and he allowed our friend to treat Ryan and within, I suppose, four hours, he started urinating and he was on the road to recovery. I remember Mr Wisheart coming round and he was very pleased with his progress.'[350]

301 She described her interactions with the staff:

> 'I feel in the beginning … I think the staff were very aware, "Do the parents really want to know the answers?" and as the time went on, when they realised we did want to know the answers and we were going to get the answers, they were very forthcoming. In the end, the nurses were asking us how we felt all the time, as I am sure they did with other parents, "How do you think the baby is?", "What do you think ought to be happening next?"
>
> '… One incident comes to mind. Ryan would not settle with his level of sedation, so I think … they could not seem to get it right. His heart was either going too slow and his body was writhing about, they could not seem to get it right, so I think they were going down in certain units, I do not know, half a ml, 0.2 of a ml, I did not know. We said, "Why not go down in 0.05 of a ml?" They said that would not make any difference. We said, "Why not try it? It can't do any harm." They said they would do that and he responded to it. He was obviously more sensitive than most babies.'[351]

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[349] WIT 0025 0006 – 0007 Belinda House

[350] T6 p. 96–7 Belinda House

[351] T6 p. 98–9 Belinda House

302 Belinda House said that she was given the opportunity to do practical things for Ryan, including:

> '… cleaning him, changing nappies. As he got better, I took more and more care in the nursery, which was a high dependency unit. It was total care in bathing, cleaning, changing nappies and feeding. On ITU when he did not have any tubes, we were feeding him.'[352]
>
> '… we did things like got our friend to give him acupuncture; we fed him garlic for an antibiotic. We gave him garlic to improve his bacteria, yoghurt and all sorts of things, cod liver oil, everything. We felt we had to fight to make him survive as much as any other professional there, and of course, we expected Ryan to die any minute, and babies died.'[353]
>
> '… I think the nurses read each parent very carefully and they wanted [the parents] to become involved with the babies, not to off-load any work for them [i.e. the nurses], but just because they knew that was a very important step in the recovery of the child …'[354]

She described the nurses as 'totally dedicated and always listened to us'.[355]

303 Amanda Evans, mother of Joshua Loveday, gave her impressions of the BRHSC in her written evidence to the Inquiry:

> 'In general, I remember that the level of information I received, as a parent, in the BCH, was very good. The staff would always let you know if they thought anything was amiss and never gave any false hope. They all seemed competent, and I got quite friendly with Joshua's nurse. She taught us how to administer a drip-feed and how to change nappies when there are wires in the way; I remember that the last procedure was, in practice quite complex.'[356]

304 Amanda Evans explained how she and her partner were notified of the date for Joshua's operation:

> '… a couple of weeks before Christmas … we returned to my grandfather's house, he informed us that he had just received a call from Mr Dhasmana's secretary. Apparently, there was a bed available for Joshua. If we wished the operation to proceed, we were to go to the hospital that evening.
>
> '… we could not contemplate an operation now as it was too close to Christmas. Consequently, we telephoned Mr Dhasmana's secretary and said that we did not

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[352] T6 p. 99 Belinda House
[353] T6 p. 106 Belinda House
[354] T6 p. 100 Belinda House
[355] T6 p. 92 Belinda House
[356] WIT 0417 0008 Amanda Evans

> want the operation to take place, as it was too near Christmas. She said that she would pass the message on.'[357]

The operation date was then changed to January, and they were able to spend Christmas together.

305 Malcolm Curnow told the Inquiry of his experience concerning the date of his daughter's operation:

> 'There was no problem in the fact that we had a month's notice; the problem was that we had no information prior to that, or confirmation that this was going to happen. We were left very much in abeyance and in the dark. If someone had said to us, "She will have an operation, it will be around September time, and we will give you a month's notice", then that would have satisfied myself. I was receiving no information back from the hospital about the likelihood of her having an operation at that point in time and I was wanting to know … I needed to plan, we needed to plan. A month is acceptable, I have no criticism of that, but I would have liked a lot more information in the lead-up to it that this was going to happen. We were left with the impression that it could, or it may not. All I wanted to know was that it was going to happen; nothing more.'[358]

306 Malcolm Curnow described an incident with one of the medical staff, which he said was distressing:

> '… once we had established ourselves in the hospital, on the very first evening, obviously, a number of nursing and medical staff came and undertook a number of checks. The one that sticks in my mind and will remain with me forever, until the day I die, is the arrival of a doctor. He was of foreign descent, I did not know his name then and I do not know his name now. He arrived and at the time my wife was nursing Verity in the chair beside her cot. He wanted to take blood from Verity and he tried several times to extract blood from her left arm. He was having great difficulty in doing so. He did not appear to me to be competent and proficient in trying to extract the blood. I had seen GPs take blood from her, I had seen doctors on previous occasions take blood from her with the catheterisations, and in my professional capacity, I had seen samples of blood taken on hundreds of previous occasions, but I immediately was unhappy with the way that this was being done.
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> 'He persisted several times trying to take blood from her left arm and could not withdraw a sufficient sample to satisfy him. Obviously, this was distressing Verity greatly. She was becoming increasingly blue and agitated; she was crying in a most

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[357] WIT 0417 0011– 0012 Amanda Evans

[358] T3 p. 33 Malcolm Curnow

> piercing, painful sort of way. My wife was becoming distressed. He then asked and attempted to take blood from her heel.
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> ‘On the first attempt, the pain was so excruciating for Verity that she began to obviously, move violently, to the point that was itself exacerbating the situation. I had to take over, my wife could no longer restrain Verity. I had to take hold of her physically in a restraint position and actually force her leg into a position where it would remain static whilst he took the blood.
>
> ‘My lasting memory, as he inserted the needle into her foot, was her looking at me as if to say in her eyes, “Daddy, why are you letting them do this to me?” and that look in her eyes will last with me until I die. He took the sample and he left the room, and we never saw him again.’[359]

307 Malcolm Curnow also referred to the physiotherapy that Verity underwent:

> ‘We were led to believe in the first day that Verity was suffering a build-up of fluid on the lungs, and in order to dissipate that, that she required quite vigorous physiotherapy … we knew that when Verity exerted herself and became stressed, that this exacerbated her problem. So when we see her coming off the ventilator and being very vigorously exercised by the physiotherapist, which certainly to my wife’s view, and mine, was causing further distress to Verity, and I say that because once the physiotherapy was completed, she was struggling to hold, you know, any stability, and she was obviously visibly worse after the physiotherapy than she was before it. She required hand bagging, and sometimes for a considerable period of time, during the physiotherapy. My wife’s intuitive feeling was, “This is not good for her; this is not doing her any good; this is making her worse, this is exacerbating the problem.” When you see your child being exercised as vigorously as she was, and it is supposed to be doing her good, but you can only see it making her worse, you are naturally concerned. We expressed our feelings to the physiotherapist. Her reaction was very abrupt: “I have to do this; it will make her better. It is for her own good.” ‘[360]

308 Diana Hill recalled events after Jessica’s death:

> ‘Someone brought me Jessica to hold. She was cold, and wrapped in a blanket. I cannot remember if I was asked whether I wanted to do this. I still find this a horrific memory and I know I will never be able to forget it.
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> ‘… When we went to collect our belongings, no nurses came to see me, everyone who had been looking after Jessica seemed to disappear.’[361]

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[359] T3 p. 35–6 Malcolm Curnow

[360] T3 p. 55–6 Malcolm Curnow

[361] WIT 0263 0013 Diana Hill

309 Michelle Cummings described the ICU ward:

> '… sometimes you found that you had a nurse 1 to 1, so there was one nurse looking after Charlotte on a continual basis; other times there was one nurse between two patients.'[362]

310 Michelle Cummings told the Inquiry of an encounter (when the ICU was being closed down) where, in her words, the hospital took a 'gamble' with Charlotte's life:

> '… the new Ward 5 intensive care unit had finished being built. So it was obviously due to be opened. What happened next was, we noticed that as the days were going on, less patients were being brought into the Intensive Care Unit, and eventually it stopped. We were told that the Intensive Care was being shut down to open the new Ward 5, and that two politicians would be coming around to open it, and that was Kenneth Clarke and Edwina Currie … We were really concerned about this, because Charlotte, after she had had the cardiac arrest, was seen to be in limbo. She was not moving either way at that point, and we were extremely concerned. She was extremely poorly, and there was another child who was also extremely poorly, and we were told, without question, that the ward, the Intensive Care, was being closed and that was it. I was not happy about this at all.
>
> 'What happened next was that we were told that they had tried to find life support machines in other parts of the hospitals and had only been able to find one and as the other little girl at that point was considered in a more critical condition, it was opted that she should be given that life support machine.
>
> 'Charlotte was to be sent to the Children's Hospital and put in intensive care there on a life support machine, but they could not move her for a couple of days. Anyway, inevitably, the visit was happening and the children had to be moved.
>
> '… she had to go to the Children's Hospital and they assured me that she would be given — she had to have a life support machine, obviously, at the Children's Hospital, so when the day came for the move, which, off the top of my head, was Monday 27th June, they came around and they took her off the life support machine, and she had to be hand ventilated because she could not breathe on her own.
>
> '… She was moved by ambulance to the Children's Hospital, straight through casualty, and up to the Intensive Care and they did not even know we were coming. There was no intensive bed for her, no life support machine, and they were still hand ventilating her, so we went through to the baby unit and they were full

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[362] T3 p. 143 Michelle Cummings

> up. There was no cot for her in there, because they were hoping they could have set up a mini intensive care in one of the rooms for her.[363]

> '… There was not [a ventilator] and there were no beds in the baby unit, and she ended up being put on the bed of a child who had gone down to have his tonsils out whilst they decided what to do with her. I have to say, at this point Mr Dhasmana, who at the time was caring for Charlotte because Mr Wisheart was away, he actually had no knowledge of what had gone on until his return, and he was furious, that is the only way I can describe it. The man was furious. He had not even been told she had been moved at that point, and he was absolutely livid when he got to the Children's to find us there and in that predicament. In fairness to the man, there was very little he could do at that stage. It caused untold distress for the nurses and doctors who were actually looking after her, let alone the unacceptable gamble that we had to witness being taken with her life.'[364]

311 Robert Briggs, father of Laura, told the Inquiry that in 1988:

> 'We saw Helen[Vegoda] several times. She was available quite a lot of the time that we were there if we needed to see her. We also saw people from the Heart Circle, and Helen Vegoda arranged for a family to come and meet us where one of the children had had very similar heart surgery. So it was very, again, reassuring to be able to speak to somebody who had already been through it and to draw on their experiences.'[365]

312 John Mallone referred in his written evidence to the Inquiry to an incident in the ICU that reflected on the communication between management and the ICU's staff:

> 'Josie's life was entirely dependent on the pieces of apparatus that surrounded her. On one occasion, I counted them all: the equipment was connected to thirteen electrical sockets. On one occasion during the fortnight before Christmas, the management of the Children's Hospital decided to cut the power, in order to test the emergency generator. It appeared that no one in ITU had been warned that this was going to happen. There were as many as seven or eight children dependent on artificial ventilation at this time. The power can only have been lost for about twenty seconds, but there was a real panic as staff scrambled to find hand-bagging equipment to keep the children breathing. They repeated the experiment later on during Josie's stay but, on this occasion, they alerted the staff to their plans, and the nurses were standing by when the time came.'[366]

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[363] T3 p. 147–9 Michelle Cummings

[364] T3 p. 151–2 Michelle Cummings. The UBHT responded to this evidence at WIT 0123 0060

[365] T68 p. 60 Robert Briggs

[366] WIT 0155 0009 John Mallone

313 This incident was explained by Mr Warr, the UBHT's maintenance officer:

> 'It was the accepted procedure at that time to carry out an "on load" generator test once a month on a regular basis, it was the practice of the day to let a number of departments know of the imminent change over of supplies due to the 15 second delay in the restoration of power to hospital systems.
>
> 'Then, as now, ALL departments are notified of a full years test dates in advance, then as now PICU, Theatres, Baby unit and Cardiac Catheter are notified of the imminent test procedure.
>
> 'The particular test took place at the predetermined time and date in December 1990, the generator situated in St Michaels Hospital was new, around three months old and had been fully tested and commissioned. It had been run "on load" a number of times without incident.
>
> 'Part way through the normal test the generating set stopped, this of course led to a failure of the essential electrical supply to all area's, fortunately I was in the vicinity of the generating set and heard it stop, I immediately went to the generator room to assess the situation, it was not obvious why it had stopped so I took all the necessary steps to restore the normal electricity supply.
>
> 'From memory I would estimate that the hospital was without the electricity supply for approximately two to three minutes.
>
> 'Subsequent investigation of the breakdown revealed that the engine fuel pump and metering device had malfunctioned and was replaced under warranty.'[367]

314 Tony Collins told the Inquiry that an ambulance was arranged to take his son, Alan, from Princess Margaret Hospital, Swindon to Bristol but that:

> 'There were difficulties in the sense that when the ambulance arrived at Princess Margaret's Hospital, the ambulance crew were not sure if the incubator Alan was in, would actually work in the ambulance they were going to use. And we had an agency nurse who had only come on duty and a doctor who had only just come on duty and none of them knew much about what had happened to Alan during the previous night. For all that, they were very good and Alan got to Bristol with no problems.
>
> '… I was actually told I would have to catch a train to Bristol because there would be no room in the ambulance with me and the doctor and the nurse and the rest of the people who were involved, to which the Sister who had actually come down from the ward with us insisted I did go in the ambulance. So I did go in the

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[367] WIT 0155 0055 (emphasis in original)

> ambulance eventually, but there was a bit of an argument beforehand as to whether I should go in the ambulance or go by train.
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> '… I found it very difficult that they were saying to me I possibly could not go in the ambulance with my son, given that I was being told he may not be alive when I got to Bristol. Also I had never been to Bristol in my life before, so I did not know where the Children's Hospital was, but also I did not know if Alan was going to be alive when I got there.'[368]

315 Tony Collins went on to describe the treatment which Alan received on arrival at Bristol:

> 'I would say the care that Alan received when he actually arrived in Bristol was second to none in the country. He could not have asked for a better surgeon and the staff there were brilliant, so I have no problems with Bristol at all.
>
> '… When we arrived, we were met by several staff at the hospital who took time to explain to us exactly what was going to be happening with Alan, and what the procedures would be. We were given a room to stay in, and there was always somebody there if we needed to talk, and everything was just explained to us from the moment we arrived.
>
> '… up to actually arriving in Bristol, I did not feel as if we were really being that involved in what was happening with Alan. Once we arrived in Bristol and the staff talked to us and explained things to us, I felt as if we were being brought in and had a lot more to do with our son's care and what was going on with him.
>
> '… from the lady cleaning the ward to the surgeon [they] would always be available to talk to you if you needed to talk, whether it was about Alan or any other issue on your mind at the time. A member of staff was always available.'[369]

316 Susan Darbyshire, mother of Oliver, told the Inquiry that she received a telephone call at about 10 am on 15 July 1993 telling her to go to the BRI by noon the same day so that Mr Dhasmana could operate on Oliver on the day after, 16 July:[370]

> 'We made it with five minutes to spare … We filled in a couple of forms down in reception, at the BRI, and then we were shown up to the cardiac unit, shown Oliver's cot and then literally left alone all afternoon and we just could not understand what was happening. Oliver's surgery was due to happen on the Friday morning, and we knew there were blood tests, probably an echocardiograph to do, ECG, everything and nothing was being done; we were just being totally ignored.

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[368] T68 p. 67–9 Tony Collins

[369] T68 p. 70–2 Tony Collins

[370] T5 p. 142 Susan Darbyshire

> Nobody explained anything to us, nobody introduced themselves to us, only the nursery nurse that actually came to fill out Oliver's admissions.
>
> '… Oliver's cot, his little space, was situated right opposite the Heart Circle office, and we saw a lady during the course of the afternoon coming and going, [she] appeared to be extremely busy. We assumed she was the Heart Circle counsellor for the parents, and the last we saw of her was about 5 o'clock when she locked the office door and went home. She did not introduce herself to us. We assume that is who it was. She did not introduce herself to us, so we were left literally stranded.
>
> '… We were told … by Helen Vegoda at the Children's Hospital, that there was a paediatric cardiac counsellor situated at the BRI … She was coming and going all afternoon, she was so busy… We never had eye contact with her. She could not fail to see us, we were right opposite her office, but you could not make eye contact with the woman. She seemed to have a mobile phone stuck to her ear constantly all afternoon.[371]
>
> '… She must have known we were coming, Helen Vegoda must have been notified when we were transferred over to the Children's Hospital … Oliver was not due to be admitted until the Friday, but she must have been notified we were coming in as a cancellation or whatever for an opening, and Oliver was going to be operated on on the Friday. So we did not really even have time to get our bearings; we were in there, we expected tests to be done and Oliver to go to the theatre on the Friday. Surely she should have supported us.'[372]

317 Susan Darbyshire described what happened later that day:

> 'A doctor literally stuck his head around the door, did not introduce himself or say who he was, just to say "There is a message from Mr Dhasmana. Oliver's operation will not be going ahead tomorrow. He will be around to see you later." That was it. He disappeared. [I] thought, "Well, what is going on?" My husband came back. I was in a real bad state. We telephoned family, friends, everyone, "Oliver is being operated on tomorrow", and now we were told it was not going ahead, we did not know when it was going ahead. My husband went to reception to find out what was going on and nobody seemed to know anything.'[373]

318 Susan Darbyshire said that they later saw Mr Dhasmana who explained the situation:

> 'Mr Dhasmana came to see us … straight from theatre. He was extremely apologetic. He said he had been called, I believe it was to Birmingham to assist on a life-or-death operation on a new-born baby, and he was really sorry that Oliver at that time … was not classed as a life-or-death operation and he had no choice but to reschedule Oliver's surgery for the Tuesday morning. We were quite happy with

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[371] This, as they later found out, was Helen Stratton

[372] T5 p. 142–5 Susan Darbyshire

[373] T5 p. 146 Susan Darbyshire

> that. If Oliver had been in the same sort of situation, we would have wanted that sort of service for him. Once it was explained to us properly, then we were quite happy with that.'[374]

319 Susan Darbyshire then described what happened later that evening at about 7 o'clock:

> 'We went down to the shop. We got back and we were told by a nurse that Oliver's operation was back on again, but this time Mr Dhasmana was not operating at all, it was Mr Wisheart. We had never even heard of Mr Wisheart, we did not have a clue who he was. All our faith was in Mr Dhasmana. He had operated on Oliver for the first operation. We trusted him completely, implicitly, and it was just a nightmare.
>
> '… Then she came back and told us it was not going to happen on the Friday, it was going to be now the Saturday morning, and it would not be Mr Wisheart but his understudy. By then, I mean, it was just a joke. We just totally ignored the whole lot and thought "Until we hear from Mr Dhasmana what is going on, we will just take it with a pinch of salt", but it did not help. It really did raise the stress levels. We refused and said, "No-one is going to touch Oliver apart from Mr Dhasmana. We are happy with him operating, and it will go ahead Tuesday as planned." No one seemed to know what the other person was doing down there. It was just dreadful.
>
> '… It was an awful situation. We felt really uncomfortable. We are not the sort of persons that like to complain. We were there for Oliver's benefit, we just wanted to get ready for Tuesday. We did not want problems thrown at us. We wanted to spend some time with him and enjoy the time we had left with him. We did not need all this. We just felt "As long as everything goes okay from now on in, let us all try and get on." It was just getting out of hand.'[375]

320 Susan Darbyshire said that on the night before Oliver's operation she and her husband were told they had a free licence to do with him as they wished, as he might not survive the operation. She said that they had been promised the 'Blaise Room'and that it had been cleaned especially for them:[376]

> 'At 9 o'clock the evening prior to Oliver's operation, we asked for the key. We had baggage and things we wanted to get sorted out. They could not find the key anywhere, and it transpired the nursery nurse had taken the key to the Blaise Room home in her pocket so we could not have the room until the night after Oliver's operation. So my husband spent the night before Oliver's operation in the corner of the ward on a mattress, and I sat up all night in a chair.'[377]

321 In their written evidence to the Inquiry, Susan and Kenneth Darbyshire recalled an incident when a nurse prepared Oliver's drugs but the Digoxin was not the paediatric

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[374] T5 p. 147–8 Susan Darbyshire
[375] T5 p. 148–9 Susan Darbyshire
[376] T5 p. 151–2 Susan Darbyshire
[377] T5 p. 152 Susan Darbyshire

mixture, but the adult mix'. They went on that this led them to draw up Oliver's drugs themselves.[378] Mrs Darbyshire told the Inquiry that she found it 'unbelievable' that her husband was given a 'free licence' to the key to the drugs' cabinet so that they could draw up Oliver's drugs.[379]

322 Susan Darbyshire told the Inquiry about her first meeting, on 16 July, with Helen Stratton:

> 'She just sort of came over to us and she introduced herself. I spoke to her. My husband had no intentions of speaking to her, he was so disgusted with the fact she had not introduced herself the day before.
>
> '… She must have known we were being admitted on that day, otherwise there was a great breakdown of communications somewhere.
>
> '… She asked us to go into her office. I looked at my husband, he looked at me and before he opened his mouth and said a word, she made a statement: "I can tell you don't like me. I do not really care what you feel about me. I have been told, I have had this reaction from other parents, and I really do not care."
>
> '… I went out of my way to be polite to her, to make up for the fact that my husband did not want to speak to her … she should take into account parents are going to be stressed out, in a situation like that. … She just asked if we were involved in the Heart Circle. Up to that time we had not been. Oliver took up all our time and the other children. She gave us a few leaflets and I think she mentioned a book we could buy and that was it, basically. We had no further contact with her until the morning of Oliver's operation. We still got our support from Helen Vegoda at the Children's Hospital. We phoned Helen up on a regular basis and spoke to her.'[380]

323 Susan Darbyshire recalled meeting a nurse:

> '… we were introduced to another Helen … She was going to be Oliver's personal nurse in ITU. She came in and introduced herself to us. She took us to ITU. We spent a couple of hours with Helen, I think on that evening. She took us into ITU and showed us the bed where Oliver would be. None of it shocked us because we had seen it at the Children's Hospital, the actual bed and tubes and everything, we knew what was going to happen to Oliver. She explained about the procedure, what would happen when Oliver came back from theatre. She was really nice; she was really helpful.'[381]

324 Susan Darbyshire told the Inquiry that Helen Stratton offered to carry Oliver down to the theatre for his operation but that she and her husband declined. She said that they

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[378] WIT 0125 0015 Susan and Kenneth Darbyshire

[379] T5 p. 153 Susan Darbyshire

[380] T5 p. 156–9 Susan Darbyshire

[381] T5 p. 159 Susan Darbyshire

also indicated that they were unhappy with the way in which Oliver was taken from them in the theatre:

> 'She [Helen Stratton] could see we were getting ready to take Oliver to the theatre. She came over and said she would accompany us to the theatre and would it be all right if she carried Oliver, which we adamantly refused and my husband carried Oliver to the theatre … we were under the impression, we were told [at the Children's Hospital] we could stay with Oliver until he was asleep. We expected to be able to do that [at the BRI], and we got into the anaesthetist's room. Oliver was taken from my arms, I was not asked to hand him over, he was taken from me. He was screaming, he was crying, he was flailing around. My husband took him, they said "Have one last cuddle with Dad", and they gave him to my husband. He gave him a really quick cuddle and I had him back again and they ushered us out of the room and that was the last thing we saw: Oliver was flailing around in the nurse's arms, screaming and crying. That was totally unnecessary. We were told we could stay with Oliver until he was asleep. I kept feeling "If he does not come out of here, this is going to be the last impression we ever have of Oliver", and that was really upsetting. The time before, his other operations, we had always walked out of there and he was asleep, we could see he was peaceful and that was a good memory to take. It was a nightmare to watch him. They did not wait until we had got out of the room, they were poking things in him, I did not know what they were doing. I was just too upset by them … [Helen Stratton] just ushered us out of the room, we were left there and we did not know what to do. We did not know what to do. We were told not to report back to IT for hours and hours. She did not give us any support whatsoever.'[382]

325 Susan Darbyshire said that they went to see Helen Vegoda for support:

> 'We went to the hospital canteen, had coffee, and then we walked straight up to the Children's Hospital and sat outside Helen [Vegoda's] office until she arrived … She knew Oliver's operation was that day. We were obviously really upset and we went in. She made us tea and we sat with her for an hour and a half and we told her how disgusted we were with the treatment we had down at the BRI.'[383]

326 Justine Eastwood told the Inquiry of the strain of being in the ICU:

> '[Oliver] was in an intensive care environment, which perhaps was a little bit of a strain on me. You could not really leave his bedside. This perhaps was my problem. I was perhaps relied on a little bit too much. I could not really even just pop out. Because I was looking after Oliver, he had maybe a Sister looking after him. They had other jobs to get on with, so I was left more to get on with it.'[384]

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[382] T5 p. 165–6 Susan Darbyshire

[383] T5 p. 166 Susan Darbyshire

[384] T95 p. 85 Justine Eastwood

327 Justine Eastwood referred to the insight of the nurses in her written evidence to the Inquiry:

> 'I was very upset on 14 February [1994] to be told after an investigation by the ENT surgeon Mr Moore … that Oliver would probably need another operation in the future and that because his condition was so unique, the future was uncertain. The nurse was perceptive enough to see how upset I was so that Dr Hayes came to talk to me later that day and informed me that … all would be well, unless he got a really bad chest infection.'[385]

328 Justine Eastwood referred to another occasion, on 21 June 1994, when Dr Mather discussed the options which were available and told her 'that we were coming to the end of the line'. Justine Eastwood said that Dr Mather told her 'that Oliver was not getting any quality of life at the moment'.[386] She stated: 'As before, a nurse was perceptive enough to work out that I was shaken up by the talk by Dr Mather and got Dr Hayes to come and talk to me.'[387]

329 Marie Edwards, mother of Jazmine, recalled an encounter she had in 1993 with Dr Joffe:

> 'He did not tell me she was inoperable; he basically said "Go home, take her home, she will be dead by the weekend." He did not use the words "She is inoperable." He just told me "There is the door, please leave. You are wasting our time, you are wasting our resources and another child could do with the bed that your daughter is laid in."'[388]

330 Philippa Shipley compared the nurses and nursing care which she witnessed at Liverpool with that in Bristol:

> '… when Amalie was admitted, [somebody] dropped a child off and left. We … just looked after him. I think he was operated on the same day as Amalie. I thought that that would not have happened at Liverpool. The ward sister … held it together with a real iron fist … There were three, they were all chopsy Liverpool girls, but that was the one who was particularly in charge. She would take great steps to organise the care of the children. Obviously parents could not be there all the time and if children were going to be there 10, 11 or 12 weeks, as was the case with us, you would not expect the parent to be there all the time. I certainly heard one conversation about a little boy, the sketches of Paul Broomhead in a book. She rang them up and said, "Your son needs a pacemaker. Get to the hospital. It needs doing now", and rang them at home. I remember that conversation.
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> 'I can also remember a little girl called Claire who was dreadful sickly – all heart children are dreadful feeders, really. Her mother, I think, had a lot of other children

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[385] WIT 0022 0010 and WIT 0022 0056 Justine Eastwood

[386] WIT 0022 0091 Justine Eastwood

[387] WIT 0022 0013 Justine Eastwood

[388] T95 p. 136 Marie Edwards

> and could not get to the hospital very often, so it was arranged that Claire would go to Warrington and the nurses were brought to Liverpool and told how to feed her, so they could take her back to Warrington and her mother could learn how to start to feed her. Although there was quite a good element of control there [Bristol].
>
> '… I did not really see a great deal of the nurses. We had one very brief stay at St Michael's Hill. The chap who admitted her, who shot over, was doing his exam for the Royal College of Surgeons the following morning. "We are going to get a complex case like this. I am going to admit your daughter." He wrote out the wrong drugs, which the nurses did point out, and we had to continue to administer our own supply. The nurse who brought her back from the catheter lab did not seem to realise that Amalie was very hot. She said she had a temperature. I said she will have; she was wrapped in a huge amount of blankets, far too many. If somebody is hot, you do not cover them in something, do you, you remove layers, which I did. Then we left the following day.
>
> 'At the BRI, when we first went into the ward for admission, she was quite theatrical; she came from Wales so she told us about Bryncethin and was chattering away, quite flamboyantly dressed. As we got into the ward, a nurse said "Nobody likes her." It was an odd thing to say. She was the receptionist of the ward. At Liverpool, the Almoner there, who had a similar role to Helen Vegoda, she looked like Miss Marple but nobody ever said so; they did not make observations like that. I thought at Liverpool – I am not trivialising this – it existed more as an organic whole, like it was a more cohesive unit.
>
> '… It was one team really, that was the impression I would have from Liverpool. I think there were things they could have controlled better at Bristol. Certainly there was a baby in the bed next to Amalie and another little girl who had been there 10 weeks, and the mother had two of her other children staying with her. Really, they disturbed Amalie and I wanted her to be in the best most rested position. At night they would be jumping on her bed and all sorts of things. I thought the nurses should really have taken steps to control that. That is one thing I thought. We did not really see a lot of them, to be honest. The night Amalie was in ITU, there were three of them down the end of the ward watching TV. That was the main ward. I can remember one sister in ITU. I can't really remember a great deal about seeing a lot of them.'[389]

331 Marie Edwards told the Inquiry of an encounter which she had with the nurses and Dr Joffe:

> 'I used to cross-sign all the medication because I found I could not remember which of the two drugs Jazmine took. It was kept in the fridge and it was particularly cold and if you put that down the NG tube, it would make her react, to retch. So I used to run it under the tap in the actual syringe in the sterile packets, to

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[389] T95 p. 165–8 Philippa Shipley

> lift the medication back up to body temperature. I found a lot of the time the nurses did not have time to dedicate to that, so I cross-signed and made sure the medication was brought up to body temperature, because she was vomiting quite a lot. It scared me to think I did not know how much medication was actually being absorbed.
>
> ‘In the morning, the early hours of the Wednesday, I heard the medicine trolley being brought through the ward. This nurse administered Jazmine’s medication in a matter of — it could not have been longer than three minutes. For me it is usually closer to 10 by the time I have filled the syringes and warmed one of them and pushed it down slowly so it did not hit the stomach and make her retch. I heard the trolley go away and I could hear Jazmine really struggling; she was retching. I could see she had been placed on her back, which really puzzled me. I remember hitting the emergency sirens to bring the nurses back as soon as possible because I was fearing from the colour she was going that she was going to have another heart attack. As she was being sick the NG tube was coming out and going back in.
>
> ‘This nurse came in with the sister and I said “What is going on? Why was she left in her back?” In 1993 it was on your side. Jazmine could not sleep on her front because of her heart complaint; she did not find it comfortable. The sister actually informed me that my daughter was in the cot death research. I said who had given her permission to be in a cot death research when she is very very sick? She said, “All the babies are, here, and it is Dr Joffe who has given permission.” I demanded to see him as soon as possible. They explained to me that he had worked to the early hours and they would get him to see me.
>
> ‘… She was being placed at risk in my eyes, unnecessary risk …
>
> ‘Dr Joffe explained that whilst Jazmine and the other babies are on this ward, he is guardian, and basically, if he wants them on the cot death research, that is what he was going to do. I was really shocked and I said “I do not want her to be researched on. You cannot give me any guarantees of what would happen to her health if she did not react by turning her head when she threw up. Would she have asphyxiated? You do not know. That is what you are researching.”
>
> ‘[Dr Joffe’s reaction was] “Fair enough, we will remove Jazmine.” That was all that was said about it. But I was horrified to hear that sickly children were being used.’[390]

332 John Mallone gave the Inquiry his views on the nurses:

> ‘I found the nurses were extremely sensitive and thoughtful to me all the time. Initially I do not think they were quite sure how to react to us. We were both staying in the hostel, which is immediately adjacent to the ITU ward in the Children’s

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[390] T95 p.170–2 Marie Edwards

> Hospital, so we were there perhaps 20 hours a day or something, by Josie's cot. They made every effort to involve us in her care … I found it distressing at first because she had been paralysed. You had to press on her abdomen in order for her to urinate; she could not pass water otherwise. I found that quite distressful, but I soon got used to that.
>
> '… We were encouraged to touch her, to handle her, I think they thought it would both involve us and help her. We gave her her feeds through a tube.
>
> '… once I had overcome my initial reluctance to do that, I was very grateful. I wanted to be looking after my daughter, and so did my wife.
>
> '… I wanted to be involved. I was glad I was involved. They did not pressurise us to do it, they said, "Would you like to?" … It was encouraged. It was two or three days before I felt happy to do it and I thought they were very sensitive about it at all.'[391]

333 He went on:

> 'I felt there was tremendous continuity in the nurses because they work 8-hour shifts … and so they got to know us and they got to know their patients, the children who were in there, they treated them as human beings. I found the doctors, they would come round perhaps on a 10-minute ward round twice a day and I always had the impression that they did not see the children, the babies, as human beings, more just as anatomical problems that had to be solved. For example at one stage Josie's weight ballooned enormously, she went up over 3 kilograms and then came down, she lost almost 50 per cent of her body weight in 24 hours at one point simply because she had been too heavy before, I do not know, there was a problem controlling her fluid. They talked about it as a chemical imbalance problem.'[392]

334 Penelope Plackett described encounters which she had with nurses at the BRHSC:

> 'When I returned to the BRI, I was told Sophie was being moved to Bristol Children's Hospital. I was very unhappy about this. At the cardiac catheterisation and biopsy at the Children's Hospital, the staff on the baby unit were uncaring. They seemed to spend their days drinking tea and chatting to one another, emerging every 4 hours to feed the babies. The transfer to the Children's Hospital went ahead. I only saw the nurses when they came with Sophie's drugs, and her care was left entirely to me. She was being bottle fed but I could not get her to suck or swallow. I asked for help with her feeding over and over again, but nobody came to my assistance. I later found out that the problem resulted from Sophie pressing her tongue against the roof of her mouth. A simple instruction from one of the nurses would have enabled me to deal with this. I felt I had no support at all. Babies were crying all the time but no one seemed bothered to check that they were all

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[391] T95 p. 172–4 John Mallone

[392] T95 p. 180 John Mallone

> right. On many occasions, Sophie's drugs chart was not signed, and, when I questioned this, I was told that agency nurses were not allowed to sign. If this was right, I could not understand why they were allowed to give out drugs. Sophie was never given the Nystan she was supposed to receive. I remember this period as nightmarish. The care seemed slapdash and entirely unsatisfactory. Sophie screamed constantly, and I felt demoralised and very unhappy. In contrast to the nurses at the Children's Hospital, the ITU nurses at the BRI had been fabulous, particularly two called Lou (Louise) and Eunice (who left soon after). They all worked very hard and were very supportive.
>
> 'Whilst Sophie was at the Children's Hospital, Mr Dhasmana made occasional visits. He was reticent and said very little to me. On one occasion, he said he had no idea how Sophie had suffered her brain damage. Mr Dhasmana mentioned the possibility of oxygen starvation, and suggested that, in opening the heart, they must have dislodged a "floret". He explained that this was part of an existing valve which must have made its way to the brain. He described the appearance of a valve as being surrounded by "cauliflower florets". I had the distinct impression that they did not know what had happened, or that they did know, but were not going to tell me.'[393]

Communication after the operation and when the child died

The clinicians' evidence

335 Dr Joffe told the Inquiry about the measures taken to co-ordinate the child's care with the health visitor service, or the GP, in order to ensure that parents were supported:

> '… with regard to the general practitioner, the parent is given a brief note at the time of discharge, something of the diagnosis noted, the major elements of treatment provided during the admission, and with a list of the drugs which he or she should continue to take, and the doses. That information is given to the parent who is asked to take a copy to the general practitioner as soon as reasonable.
>
> 'In addition a more detailed summary of the patient's admission is sent, usually within two or three weeks, with more detail of what took place during the admission and with information. Incidentally, the first form would have information about the next expected visit to outpatients, and the nature of the condition and the treatment would be expanded in the case summary, which would be sent to the general practitioner. Occasionally, if the health visitor has been involved

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[393] WIT 0012 0010 Penelope Plackett

> previously, and is known, a copy of that summary could be sent to her, and was sometimes done.
>
> 'In patients where there are community elements involved, social services, et cetera, a communication is normally sent from the senior nursing staff or the cardiology counsellor to these various services, to inform them of the patient's status at the time and, again, their medication that they would be taking.'[394]

336 As regards follow-up and monitoring, Dr Joffe indicated that generally any patient without symptoms might be told to return in six months, whereas a symptomatic patient would be given an earlier follow-up and appropriate information at each visit.[395]

337 Dr Joffe described his practice when a child died:

> 'If a child died, I was always ready to arrange to talk to the parents at a mutually suitable time, if requested by the surgeons or the parents themselves.'[396]

338 Mr Dhasmana stated that he dealt with parents as sensitively as possible, although he acknowledged that being open and frank, which he felt was necessary when speaking to parents, did upset some of them.[397]

339 As regards communicating with parents after operations whatever the outcome, Mr Dhasmana stated that he:

> '… always made a point of talking with parents after a bereavement, or if the child had suffered a permanent disability.'[398]

340 As regards communicating with parents whose child had died, Mr Dhasmana stated:

> 'I learnt that it was important to speak in clear terms about the event, with as much sensitivity as possible. … I would talk with the parents accompanied by a senior nurse and expect her to provide further support and information to the parents after my meeting with them. … I always offered to see the parents again, if they desired, when I would discuss the post-mortem findings with them. My junior staff would also ring the family doctor so that arrangements could be put in place for the family to be visited soon after their return home. I would personally write a brief summary of the medical report and forward this, with the autopsy findings, to the family's GP…'[399]

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[394] T91 p. 58–9 Dr Joffe

[395] T91 p. 61 Dr Joffe

[396] WIT 0097 0317 Dr Joffe

[397] WIT 0084 0104 Mr Dhasmana

[398] WIT 0084 0103 Mr Dhasmana

[399] WIT 0084 0103 Mr Dhasmana

341 As regards communicating with parents whose children suffered some disability after the operation, Mr Dhasmana stated that:

> ‘In the case of a child suffering a disability i.e. neurological damage, I would talk with the parents and inform them of the problem. Unfortunately the information I could provide was incomplete, as the extent of neurological injury and permanent disability would not be known for a few weeks post-operatively. I used to be as sympathetic as possible … I would ensure that parents understood that a recovery might not occur and explain that a neurologist would explain the situation and prognosis to them in more detail …’[400]

342 Mr Wisheart stated that he had discussions with the parents and both the surgical and nursing teams once the child’s discharge time had been determined. The topics discussed included:

> ‘… medication, the activities which the child may indulge in, the care of the [surgical] wound, the role of the General Practitioner and District Nurse, the next outpatient’s appointment … the future and particularly about any foreseeable complication or need for further surgery. It was my personal practice always to ask children to attend my outpatient clinic at least for one or two visits following surgery.’[401]

343 Mr Wisheart explained that after discharge, patients were seen by the paediatric cardiologist, or the surgeon, from time to time, but that the day-to-day counselling and support was provided by the primary care team and also by the paediatrician in the District General Hospital.[402]

344 Mr Wisheart stated that it was his practice to inform the GP when a child died. He stated that usually the referring paediatrician was also informed, but that this was sometimes ‘overlooked’.[403]

345 Mr Wisheart described his practice after the death of a child:

> ‘I, together with a nurse and/or the counsellor, always talked with the parents of a child who died as soon as possible after that death … Towards the end of the conversation I informed parents … it was highly likely that [the coroner] would require a post-mortem examination … I invited the parents to meet with me again when the stress and emotion was less immediate. I normally suggested that six weeks or later would be appropriate, but it was left to the parents to decide when they felt it would be helpful. I indicated that this would be an opportunity to review all the circumstances leading up to the child’s death and also to consider any new findings that might have been identified at the post mortem examination. I did not

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[400] WIT 0084 0103 – 0104 Mr Dhasmana

[401] WIT 0120 0232 Mr Wisheart

[402] WIT 0120 0232 Mr Wisheart

[403] WIT 0120 0234 Mr Wisheart

> keep a detailed record but I imagine about 50 per cent of parents took up that offer … If the parents wished, the services of the paediatric counsellors were available for a long time after the child's death.'[404]

346 When a child suffered some disability, often in the form of neurological damage, Mr Wisheart stated that the primary objective of the cardiac team was 'to ensure that the best specialist advice available in the field is provided for the child and the family.'[405] This included advice, support and counselling services and community and social services.

347 Mr Wisheart stated that the cardiac team did not withdraw from the care of the child once the neurological specialists became involved:

> 'They continue to see the child and to have a role, sometimes as part of a team and sometimes as the one performing a key co-ordinating role of a number of services who are providing care to the child.'[406]

Evidence from other members of the staff at the UBH/T

348 Ms Joyce Woodcraft[407] stated in her written evidence to the Inquiry:

> 'Some nurses and doctors will find it very difficult to hide their own emotions on the death of any patient. This is particularly true of a baby or child that has been "specialled" by a nurse for a long period of time. A more senior nurse may take over parental support if this was deemed necessary, but [this] did not happen frequently in my experience.'[408]

349 The Reverend Yeomans stated:

> 'I felt that staff showed immense sensitivity when dealing with parents and were supportive every step of the way. They provided comfort throughout and became involved in all cases. Staff too, were upset when patients died, and may have found it difficult because of their own grief or lack of experience, to give parents what they wanted all the time. It can be very difficult to anticipate and give what bereaved parents want in their grief, distress and anger, when at that moment of time they may be inconsolable.'[409]

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[404] WIT 0120 0234 – 0235 Mr Wisheart

[405] WIT 0120 0236 Mr Wisheart

[406] WIT 0120 0236 Mr Wisheart

[407] Joyce Marian Woodcraft, Senior Sister BRHSC ICU 1985–94

[408] WIT 0121 0020 Ms Woodcraft

[409] WIT 0274 0009 The Reverend Yeomans

Evidence from parents

350 Antonio Chiarito, father of Maria, stated:

> '[The staff] said that they had taken Maria to the Chapel of Rest, if we wanted to see her again. We went to see her … but she had already been taken away. We both found this distressing … Since I have taken up my new employment, as a psychiatric nurse, I now understand how to treat people during times of emotional crisis. I do not think the staff at the BRI knew how to do so. I think that someone should have taken the time to explain things, and to answer our questions. As it was I got the impression they were covering up for some mistake.'[410]

351 The UBHT responded to Antonio Chiarito's comments:

> 'Evidence has been given to the Inquiry as to the bereavement and counselling facilities made available by the Trust. Unfortunately, they were insufficient to meet the needs of some parents.[411]

352 Rosemary Walker, mother of Ryan, stated:

> 'After Ryan died, we did not really see anyone in the hospital. We did not know what to do, or where to go. We were not even offered a cup of tea or coffee – there was certainly no offer of counselling.'[412]

353 Philippa Shipley described talking to Mr Dhasmana immediately before and after Amalie died:

> 'Mr Dhasmana came out of the ITU and spoke to us with tears in his eyes. He explained that Amalie was dying, and that he had tried everything he could to save her. I said that I wanted to be with her. Andrew and I went to the ITU and sat with Amalie. Within seconds, her heart had stopped beating. A male nurse said "She has died now." We sat there for a few minutes, holding her.'[413]

354 Philippa Shipley told the Inquiry:

> '… I spoke to Mr Dhasmana in the corridor after Amalie had died, when we were still waiting for my parents at about 7 in the evening, he walked over and said "Amalie would never have been able to run and play like other children, she would not have been as strong as them" and went on to say there was significant evidence that the Fontan operation caused chronic damage to the liver and she may have needed a transplant when she was 13. I should certainly have known about the

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[410] WIT 0291 0015 Antonio Chiarito

[411] WIT 0291 0022 UBHT

[412] WIT 0458 0013 Rosemary Walker

[413] WIT 0392 0018 Philippa Shipley

> liver damage prior to that operation and I still cannot understand what was the point of doing the operation if it was not going to improve her quality of life.'[414]

355 Paul Bradley, father of Bethan, told the Inquiry:

> 'Within a few days [after the death of Bethan] our GP, Dr Hayes, came along to see us at the house, and at that time we just wanted to be left alone; we just wanted to be on our own. But we did appreciate his call to us. He just wanted to make known his sympathy. I think at that particular point, if he offered help, counselling, I am not sure if we were in the right frame of mind to take in what he said. But we do acknowledge his sympathy coming to us … I think we were of an expectation that something would come to us in a written form, and — we say this with hindsight, but we feel that if it had been done even before Bethan's operation, and I think we are thinking about the counselling role, that if there had been some sort of liaison with us as to what the facilities were that were available, even before the operation had taken place, because at that particular point, after Bethan died, it was so difficult for us to be of sober thinking and of a proper mind, and to have had as a reference point in the house something which had been sent to us, even well before the operation, I think that that might have helped us.'[415]

356 Paul Bradley explained further:

> 'We did not receive any letter, no appointment was offered to us in writing to go back to the hospital, and we had a terrible ordeal with a series of events, when it seemed as if Bethan had just been forgotten. Bethan before the operation, the day before, she had done some drawings. We asked for these drawings to be returned to us. We were informed they had been thrown away and we were shocked by that. We were very upset by that. We had no meeting with Mr Wisheart until we asked for one and then we had no meeting with Dr Joffe until, again, we asked for one. That was 18 months after the operation. When we asked for the meeting with Dr Joffe, we did that through Helen Vegoda. We expressed our grief that he had not met with us. When Helen Vegoda responded, this was 18 months after the operation, she said she did not know that Bethan had died. We just could not believe this. We could not comprehend how she did not know. We were confident that Dr Joffe did know, but we could not understand why they had not come back and therefore this awful feeling that Bethan had been forgotten, as if she had not existed. We could not understand — it did not make sense with our experience before, when they did seem to be so caring and they did seem to be so concerned.'[416]

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[414] T95 p. 202–3 Philippa Shipley

[415] T53 p. 32–3 Paul Bradley

[416] T53 p. 40–1 Paul Bradley

357 In his written evidence to the Inquiry, Paul Bradley stated:

> ‘We did not receive the option of any bereavement counselling. No help was offered to us to know how best to cope, discharge and manage grief positively. It would have meant a great deal to us if someone still expressed an interest in Bethan and showed us ways and means of positively remembering Bethan in future years.’[417]

358 Jean Sullivan, mother of Lee, stated:

> ‘Since leaving the ward and Lee to meeting Mr Wisheart, I have had no contact with the hospital whatsoever. Notwithstanding the fact that they knew that I had psychiatric difficulties they never sent anybody to see me and the only contact I did have was a condolence card from the hospital’.[418]

359 She also stated that:

> ‘The lack of aftercare which was shown to me also caused me considerable distress. Had I received some counselling it may have helped me to come to terms with Lee’s loss … I was not given any assistance whatsoever to cope with what had happened and I feel that when I look back on the manner of Lee’s death and the dreadful scene which I witnessed I am filled with bitterness.’[419]

360 Lorraine Pentecost told the Inquiry about communication surrounding and immediately after Luke’s death:

> ‘I had a telephone call to say something like, Luke was slipping away. I went over to Bristol and when I walked into ITU his cot was empty and they were washing down a mattress. I asked them where he was and the nurse said, “Oh, he has gone, he went a few moments ago” and I said “I know because I felt it.” She took me into a side room and she said “If you unwrap him and look at him, you will notice an extra plaster on his heel.” I said with everything else I was not going to notice a pinprick. Then she left me and she came back in about 10 minutes later and she showed my dad where we were. About an hour later my husband came over with my mother and we were asked if we wanted a cup of tea. About half an hour after that we left, but we were not rushed, we never saw anybody to rush us.’[420]

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[417] WIT 0229 0020 Paul Bradley told the Inquiry that, with Mrs Vegoda, he and his wife produced a booklet entitled *‘Remembering Your Child’* sponsored by the Bethan Amanda Bradley Fund set up in his daughter’s name, to assist other parents in knowing how to remember and grieve for their child. See T53 p. 38–9 Paul Bradley

[418] WIT 0016 0012 Jean Sullivan

[419] WIT 0016 0014 Jean Sullivan

[420] T95 p.194–5 Lorraine Pentecost

361 Lorraine Pentecost stated:

> 'Nobody had said anything to me. When I was outside the hospital I realised that I did not know what I had to do. I therefore went back to the Intensive Care Unit and asked a doctor who told us that the hospital needed to do a post-mortem to establish why Luke had died. I remember being told to go home and have another baby. I said that a baby was not something you went out to get from a supermarket … I was sent an appointment card for Luke to have a check up. The date of his examination fell a few days after his funeral.'[421]

362 Sharon Peacock, after the death of her son, Andrew, in 1995, stated that she had meetings with Dr Martin. At one such meeting Helen Vegoda was present. Dr Martin later wrote a letter[422] to Sharon Peacock summarising the meeting. Sharon Peacock told the Inquiry:

> '… every time I would see Dr Martin I would come away with more questions because he would answer in such a way that you would come away thinking you had not really got an answer, so I thought by putting them on paper I might have got some.'[423]

363 Other parents told the Inquiry that after the death of their child, not only were they not offered support, but staff appeared anxious for them to leave the hospital.

364 Rosemary Ridette-Jones, mother of Luisa, stated:

> 'One thing which I felt very strongly about was that we were not supposed to speak to other parents on the general ward. One just didn't speak about the death of one's child.'[424]

365 Karen Meadows, mother of Sarah, stated:

> 'We went back to the hostel and picked up our stuff. We drove the hundred miles back to Torquay in despair. We felt that once our child had died the hospital ceased to feel that we had any medical needs'.[425]

366 Malcolm Curnow stated:

> 'Both my wife and I felt under pressure to leave the hospital. We were not given adequate time to mourn, or to be left alone. I felt as if we were on a conveyor belt. One of the nursing staff asked us to clear our room, as it was needed by another family.'[426]

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[421] WIT 0267 0014 – 0015 Lorraine Pentecost

[422] MR 0572 0004, 0006; letter from Dr Martin to Sharon Peacock

[423] T95 p. 43 Sharon Peacock

[424] WIT 0421 0012 Rosemary Ridette-Jones

[425] WIT 0415 0009 Karen Meadows

[426] WIT 0004 0009 Malcolm Curnow

367 Philippa Shipley stated:

> ‘We were told that we would have to leave the hospital as our presence there would upset other patients and their families.’[427]

368 Responding to these statements, the UBHT set out its policy in its written evidence to the Inquiry:

> ‘… the Trust’s policy was for the parents to get home as soon as possible, and for the General Practitioner to be informed of the situation immediately so that appropriate support could be given locally.’[428]

369 Sharon Peacock, however, stated that:

> ‘Since I have lost Andrew, I have received much support from Helen Vegoda … and Helena Cermakova, the hospital chaplain. Helen helped me to prepare for my meetings with Dr Martin and talked with me about all the questions that I wished to ask. She also helped me with my fertility treatment appointments that I underwent, and would visit me to give support both before and after my operations. Helena and I have meetings often, and I speak to her on the phone regularly. I do not think I could have coped without their help and support. Helena conducted Andrew’s funeral service, and has always been very supportive.’[429]

370 Carol Kift stated:

> ‘No member of staff came to see us after Steven died. The only person who had been supportive, the hospital chaplain, was away for the weekend so we did not see her either. She had helped us to organise Steven’s baptism and had been supportive for us whilst we were at Bristol. We were touched when she wrote to us to offer her condolences after Steven’s death.’[430]

Involvement of the GP, health visitor and social services after surgery

371 Susan and Kenneth Darbyshire stated that:

> ‘The support we had when we took Oliver home was faultless. Our GP Dr Chris Irvine and the health visitors Anne and Rosemary. Anne would make three time weekly visits and Rosemary would always be there if Anne was not available.’[431]

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[427] WIT 0392 0020 Philippa Shipley

[428] WIT 0421 0019 UBHT

[429] WIT 0011 0031 Sharon Peacock

[430] WIT 0461 0005 – 0006 Carol Kift

[431] WIT 0125 0006 Susan and Kenneth Darbyshire

372 Julie Johnson said that Mrs Vegoda had arranged for her to be visited by a health visitor when she returned home. She described this arrangement in the following exchange:

> 'Q. I think it is right, is it not, that there was some follow-up support at [*sic*] which Helen Vegoda took some steps to organise?
>
> 'A. Yes.
>
> 'Q. In particular, with the Social Services department?
>
> 'A. Yes.
>
> 'Q. And I think it is not necessary to go to the correspondence, but you are aware of correspondence, for example, in 1993, between Helen Vegoda and the Social Services department?
>
> 'A. Yes, that is true.
>
> 'Q. And that Helen Vegoda was in contact also with your GP and health visitor?
>
> 'A. Yes.
>
> 'Q. Did the health visitor continue to visit you and Jessica after her discharge from hospital?
>
> 'A. Yes.
>
> 'Q. How did you find that? Was that of assistance?
>
> 'A. I found that of assistance, yes.'[432]

373 Linda Burton, mother of David, told the Inquiry about contact from the health visitor:

> 'The day after David's surgery … the health visitor from our local practice turned up at my house and informed my parents that the surgery had received news from Bristol that David had had his operation and that things were not going well. We did not know that.'[433]

374 Jean Sullivan described contact between UBHT and her GP:

> 'The second night [after Lee's death] I spent at my mother's and whilst I was there my GP came down and told me that I had to make an appointment to see him. When I eventually saw him he read to me a letter which had been sent by the hospital to him. That was the letter signed by the Registrar Mr Chatterjee. Once he

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[432] T44 p. 136 Julie Johnson

[433] T5 p. 33 Linda Burton

> had completed reading it I told him that it was wrong. I told Dr Perkins that that was not how it had happened and I told him exactly what Mr Wisheart told me. He said to me that what he had read [to] me was in the letter and that the hospital, not I, knew what they were talking about.'[434]

375 Helen Rickard told the Inquiry:

> 'My GP called to see me, I believe the following day that we had returned back from the hospital. He had obviously been notified by the hospital of Samantha's death, and he called to my house, which was next door to the surgery, and asked if there was anything that he could do. I initially asked him for medication, which I was given … and then I sought counselling … [which was arranged through the GP]'.[435]

376 After Jessica's death, Diana Hill told the Inquiry that she saw Mr Dhasmana to find out more about what happened:

> 'When he came back from holiday my sister and I went to see him because I felt nothing had been done correct for her [Jessica], I had this feeling nothing had been done properly for her. We went to see him and he said "You know the critical bit was going to be after the operation" and he was even then very matter-of-fact, very blunt. It was as if he was watching the clock to get me out of the room … He was always very blunt. There was not a compassion to him, it was a very blunt man. He appeared a very sort of blunt, matter-of-fact man which I found uneasy because I was trying to get questions out but I felt I should not be asking those questions … I was feeling rushed … and it was just his bodily manner, everything, I just felt I should not be asking these questions. … He said it was a very rare case, which confused me because I was told she had a VSD … No [he did not explain why her condition was rare]. I mean he drew diagrams, when we saw him he went into depth about the pulmonary hypertension, but he was saying she was a very rare case which I could not quite understand … It came across that she had a very rare thing that no other baby had.
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> '… I then thought "They are not going to have the right drugs then" and it came across that they would not have done. I do not know, it seemed very — not quite right. I mean at the time when Jessica was on ITU two other babies died as well and I remember that to this day, two other babies died and I remember thinking "Why are these babies dying?" and I asked a nurse and she just said it was a bad patch and that is something I can remember … When me and my sister left him [Mr Dhasmana] we felt really uneasy, we felt we did not really know anything more than we knew. I wanted really to see somebody to tell me something proper. Because Mr Wisheart had never seen us after Jessica died, I think we saw a Registrar who just went over things. I wanted to see somebody who I thought knew

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[434] WIT 0016 0012 Jean Sullivan

[435] T52 p. 160–1 Helen Rickard

> what they were talking about. That is why we went back, we were just uneasy with what happened to Jessica.'[436]

377 Diana Hill explained her reasons for not arranging to see Mr Wisheart after Jessica's death:

> 'Because when Jessica died it was like we were told to get our bits, it was all a bit of a rush because she died at 3.00. We were then at 6.00 told to get … I was trying to keep alive basically because I did not want to be here in this world any more. At 6.00 we were told to get our stuff, we were told to get Jessica's stuff and so we collected our stuff from the room, we collected Jessica's stuff from the room. The thought of going to see Mr Wisheart or somebody just did not cross my mind. Helen Vegoda came to see us.
>
> '… I think it is because I never met him [Mr Wisheart]. I never met Mr Wisheart therefore I thought Mr Dhasmana would be the one to explain and tell me what happened. But really when I think of it, Mr Dhasmana was not there either, so who would be the best person to tell me?'[437]

378 Linda Burton told the Inquiry that a few days after the operation she was called to the hospital because David's condition was deteriorating:

> 'We met a Registrar again, I do not know who it was, never seen him before, who said that they were having problems with David's saturation levels. They were having to bag him more often than previously. They suggested about 6 o'clock in the evening that it would be a good course of action to insert a chest drain, which they did. We were informed that Mr Wisheart was not in Bristol … [at] about 10 o'clock at night a consultant anaesthetist was called in, and it was explained to us that David's lungs were becoming very stiff and that it was taking greater effort on the part of the nurse who was doing the bagging to actually force the oxygen, air, whatever it was, into his lungs. This was then explained to us, that the condition would probably get worse to the point where the lungs would be so resistant to this bagging process that if it went on too long, his lungs would burst … They suggested that the course of action open to them was to give him a massive dose of Frusemide … After the consultant had explained that they had given him a great dose of Frusemide, the idea was to try and drain off, so we understood, fluid from his body to enable his lungs to function. When it was explained to us that his lungs could possibly burst, I took my husband and my mother-in-law into the family room which is attached to the ITU, the unit, and when the nurse came with us, I said that it was pretty obvious that David was not going to make it, was it possible to turn the ventilator off. The consultant anaesthetist came to see us, a very nice chap, and understood what I was asking him to do. He explained that it was not possible, that he was not allowed legally to do what I was asking, and that, having given him this dose of Frusemide, they then had to wait and see what effect this drug would have.

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[436] T83 p. 26–8 Diana Hill

[437] T83 p. 29–30 Diana Hill

> If it proved to be ineffective, they could then put him back on the ventilator; the ventilator would then fail to oxygenate his blood adequately, his blood saturations would drop. They would drop sufficiently that he would become brain dead, and then they could turn the ventilator off … we actually were given no choice. I had asked him to turn the ventilator off. He informed us he could not do that and that he had to — that he had given this dose of Frusemide and if that had no effect, then they would put him back on the ventilator and the ventilator would fail to oxygenate his blood because of the problems he was having and brain death would occur. We agreed that … that is what would happen. The anaesthetist explained to us that unfortunately he had no idea how long it would take for the saturation levels to reach that critical point, but … it would happen eventually. We returned to ITU. The nurse on duty suggested that we sort of, you know, held David's hand. I insisted on holding him. It took seven minutes … After David had died, once the saturation levels had dropped, the consultant anaesthetist came along. He took one look at the readings … they had tumbled — and he said death had occurred. He switched the ventilator off. The nursing staff then suggested that if we returned to the family room, which is a short walk … from the IT unit, that they would dismantle all the life support equipment and then we could go back and see David.'[438]

379 She described an encounter with a 'junior doctor' immediately afterwards:

> 'We had barely got back into the [family] room and sat down when a doctor appeared, a junior doctor. I have no idea who he was; I can only assume he was a junior doctor, because he came through the door with a piece of paper in his hand. He approached my husband and asked him to sign this piece of paper. When my husband asked him what it was, he said it was an agreement for the hospital to do a post-mortem. I mean, we had literally come out of ITU and got back into this family room, I mean, a matter of minutes, five minutes at the outside, and there was this junior doctor suggesting that we should agree to a post-mortem. This had never been raised with us.
>
> '… When the doctor appeared with this piece of paper, asking my husband to sign it, we were both horrified. It had never arisen that a post-mortem would be necessary. We understood that because David had lived as long as he did after surgery that a post-mortem was not required. However, the nurse who was with us, who came with us back to the family room after David died, was horrified at this doctor's lack of sensitivity, and ushered him out of the room. She then came back and said, you know, "You obviously have time to think about this. It is a hospital post-mortem and it will enable learning to be done from David's death." Obviously David's operation had not been successful and it would enable them to find out why. We spent some time discussing this between us, and in the end, we concluded that something good in the way of learning of what, if anything, went wrong … that they could gainfully acquire from David's case, that we would give permission for a post-mortem.'[439]

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[438] T5 p. 39–42 Linda Burton

[439] T5 p. 43–5 Linda Burton

380 Linda Burton recalled an encounter with the duty nurse:

> 'After David had died, the nursing staff dismantled his life support machine equipment, and we returned to ITU to see him. The nurse on duty at the time, when she came to take us back to ITU, had obviously been smoking. We had this discussion over the merits of smoking on a cardiac ward, considering smoking is supposed to be one of the main reasons of cardiac disease, [and she apologised].[440] She said that she never ever had come to grips with the death of a child and that they had had a bad week. We knew ourselves they had lost at least two other children that week.'[441]

381 Linda Burton told the Inquiry that she and her husband later:

> '… wrote a letter to Mr Wisheart thanking him for what he had done.'[442]

382 Mr Wisheart wrote[443] to them expressing his sympathy, apologising for his absence and inviting them to see him if they wished.

383 Linda Burton said that they did not return to see Mr Wisheart but that they:

> '… asked for a copy of the post-mortem. When we got it, we took it to our GP. He readily admitted that bits of it were beyond him, that it was too technical, but he did inform us that a page was missing from it, but we felt that we probably were not going to ever really fully understand the technicalities of David's death. We felt as satisfied as we could have done that everything that could have been done for him had been done.'[444]

384 Stephen Willis stated that some efforts at communication during Daniel's operation were 'insensitive and distressing'.[445]

385 He stated that when he and his wife Michaela returned to the hospital while Daniel was still in the theatre:

> 'We were introduced by Helen Stratton to a nurse who was from the Intensive Care and who we were told would be supervising Daniel's care on his return from the theatre. I and … Michaela, were on an immediate high because we immediately assumed that Daniel had come through the operation. I said to Helen Stratton, "Does this mean that Daniel is okay?" She replied "Oh no there are many problems"… To have caused us to be elated by her first sentence only to dash that elation in answering my question was cruel and indeed was the worst moment that we were to experience other than being told Daniel had died'.[446]

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[440] WIT 0001 0010 Linda Burton

[441] T5 p. 48–9 Linda Burton

[442] T5 p. 49 Linda Burton; the letter is at MR 0267 0027

[443] MR 0267 0026; letter from Mr Wisheart

[444] T5 p. 51 Linda Burton

[445] WIT 0285 0010 Stephen Willis

[446] WIT 0285 0010 Stephen Willis

386 Stephen Willis stated that when he asked her to explain ‘many problems’, Miss Stratton was unable to satisfy him with her answers and went to get Mr Dhasmana.[447]

387 Stephen Willis said Mr Dhasmana explained that:

> ‘… there were indeed complications and that he could not get Daniel off the life support machine. For some reason … things were not working and he was going to go back and have another try … things had worked for a while but then they had failed and he had to put him back on.’[448]

Mr Dhasmana then left and they were taken to a parents’ room.

388 Stephen Willis stated they were:

> ‘… left in this room for a significant amount of time and during this period I made repeated attempts to contact Helen Stratton to find out what was going on. At no stage was I able to contact her as she was unavailable.’[449]

389 Having found Miss Stratton, Stephen Willis stated:

> ‘She came back to the room with me and it was there that she said to us that we should not hold out much hope. That was … a second and very depressing piece of information that she had given us and she then left.’[450]

390 Stephen Willis stated that there was no further communication until he was told that Daniel was dead:

> ‘… we were visited by Mr Dhasmana and Helen Stratton at approximately 8.30 pm. Mr Dhasmana was wearing his operating gown which was green and blood was splashed all over his chest and left shoulder. He was obviously distressed, there were tears in his eyes and he said that Daniel was dead. I can specifically recall him saying that the operation had been a success but he could not get his heart to beat again and he did not know why he could not save Daniel … I felt sorry for him because of his distress … at that particular moment we felt more for him than in reality the grief that we should be feeling.’[451]

391 After Mr Dhasmana had left, Stephen Willis stated that Miss Stratton persuaded them to go and see Daniel. He was also offered and accepted a lock of Daniel’s hair and a print of his footprints.[452]

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[447] WIT 0285 0010 Stephen Willis
[448] WIT 0285 0011 Stephen Willis
[449] WIT 0285 0011 Stephen Willis
[450] WIT 0285 0011 Stephen Willis
[451] WIT 0285 0011– 0012 Stephen Willis
[452] WIT 0285 0012 Stephen Willis

392 John McLorinan stated in his written evidence to the Inquiry:

> ‘In the weeks following the operation … Mr Wisheart was regularly monitoring the situation, and when we met with him, he was helpful and informative. He often seemed to be turning up at all times of the day or evening, whether it was to see our son or other patients of his … We were kept well informed at every stage. Issues and procedures were explained to us well, and medical notes were readily made available to us, and we were made to feel comfortable and involved …’[453]

393 Marie Edwards told the Inquiry that she welcomed the polaroid photograph of Jazmine that Helen Stratton gave her after Jazmine died. After seeing the photo, she said that she made up her mind that she needed to see Jazmine. Helen Stratton asked her if she wanted Jazmine in a shawl or a Moses basket:[454]

> ‘They brought her in a shawl. We spent about an hour, an hour and a half with her and the last half an hour I had Helen Stratton coming in, asking that she thought it was enough time now and she would bring a nurse in to actually take Jazmine away from me, and I had actually said to her “I need more time” and she said “Okay, but I actually finished work at 7.00” and I said “Yes, but I really need some more time” and she said to me “I will ask the nurse to come in in 15 minutes, will that be enough?” and I said “I do not know, but I do not think so” and with that I said to Helen “Would it be possible to take Jazmine down to the Chapel of Rest?” “Well, she is not going there”, she said. I said “Fine, can I take her to the morgue?” I needed to know where she was going to be laid to rest. She said, no, that was not possible. She said, “No-one is allowed to go down there.” I said “Fine”. The whole time Jazmine was in hospital I knew where she was, in the theatre, in an anaesthetic room, I knew where she was and the thought of leaving her and not knowing where she was really upset me. With that, my partner said, “It is hospital rules, just let it go.” So I said, “Fair enough, I know that she will be on this side of the building.” About 20 minutes later, that would have been about 7.20, she brought a nurse in — she said “I am going to go and get a nurse now” and I actually walked over to Helen Stratton … I actually handed Jazmine over to Helen Stratton knowing that she had never held a dead body, a dead baby, but I felt compelled in doing that so she would never bully another parent into handing their child over when they are clearly not ready to let go … [and I felt] frustrated that I had to give up this last moment with my daughter.’[455]

394 In response, Helen Stratton stated that she would not have put pressure on parents in the manner described by Marie Edwards. She stated that it was usual for parents to spend about 2 hours on the ward with their child’s body (with no fixed time limit), after which she might start to discuss the need to remove the body to the mortuary. She further stated that she had no finishing time and she commonly worked late hours especially when a child died. Miss Stratton confirmed that it was against

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[453] WIT 0122 0011 – 0012 John McLorinan

[454] T95 p. 190 Marie Edwards

[455] T95 p.190–2 Marie Edwards

hospital policy for relatives to be taken down to the hospital mortuary. She also stated that it was incorrect to say she had never held the body of a dead baby.[456]

395 Samantha Harris recalled in her written evidence to the Inquiry the day when her daughter, Kimberley, died and how the she was told of this by one of the nursing staff. She stated that on returning to the hospital, a Ward Sister met her and she was then informed, by telephone, by one of the surgical team that they were having trouble in getting Kimberley off by-pass. Samantha Harris stated that the Sister said 'things were not looking good.'[457]

396 Samantha Harris stated that subsequently the Sister came to see her again and they sat on the bench between the ward and the parents' accommodation:

> 'I remember that she put her arms around me, and told me that Kimberley was dead. I think that she was crying too … A male member of the surgical team arrived to explain what had gone wrong. He said they could not get Kimberley off by-pass and that they were sorry. A short while after this, Mr Dhasmana came to see us. He was accompanied by some other men and was dressed normally, rather than in his theatre gown. They also said they were sorry and Mr Dhasmana stated that they had not been able to get her off by-pass and that they did not know why.'[458]

397 Samantha Harris stated that she met Mr Dhasmana later to discuss the post-mortem report:

> 'Mr Dhasmana agreed to write to my local hospital, requesting that I should undergo a scan during my next pregnancy, to identify any congenital heart condition. I felt reassured …'[459]

398 Erica Pottage remembered how, during Thomas' operation, Helen Stratton had informed her twice that 'they could not get Thomas off the by-pass machine although the operation was successful.'[460] She stated that she was told that this was not unusual.

399 Erica Pottage continued in her statement, explaining that:

> 'At about 6 pm Mr Dhasmana came to us to say Thomas had a massive heart attack and he had lost him. He seemed genuinely upset. My husband and I could not take it all in. We were asked if we wanted to see Thomas which at the time seemed horrifying. Helen Stratton said most parents in these circumstances want to go home straight away, so we packed up our belongings and my husband drove us back to Teignmouth … Looking back, I felt the care we received as parents was

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[456] WIT 0414 0027 Miss Stratton

[457] WIT 0302 0012 Samantha Harris

[458] WIT 0302 0013 Samantha Harris

[459] WIT 0302 0016 Samantha Harris

[460] WIT 0260 0003 Erica Pottage

> appalling … The nurses were very kind but they were only interested in my medical condition. I did not receive any counselling and had nobody to talk to about my worries and concerns.'[461]

400 In response, the UBHT stated that:

> 'One can understand that Mrs Pottage felt very alone … although it is to be noted that she had been seen by Mrs Helen Vegoda … at the BRHSC.'[462]

401 Susan Francombe's daughter, Rebecca, died shortly after her operation. Susan Francombe recalled that she did not see Rebecca when her condition deteriorated. She stated that 'We were encouraged to go away, which is something that I have regretted ever since.'[463] She also said that she was told that although Rebecca's condition had deteriorated, the operation had gone well.[464]

402 Susan Francombe stated that she was 'provided with no aftercare and support following the death of our child.'[465] She told the Inquiry that her GP came once, prescribed Valium and left.[466]

403 Susan Francombe stated that Mr Dhasmana wrote a personal letter expressing his sympathy, which was 'consistent with his compassionate approach throughout the whole experience.'[467] Susan Francombe also wrote a letter[468] of gratitude to Mr Dhasmana.

404 Anne Waite, mother of Caroline, told the Inquiry of her experience when Caroline died:

> '… We … were staying behind at the hospital at the BRI in Carolina House. We were rung to say that Caroline's blood pressure had dropped dangerously low, there was not much time, could we get over there as quickly as possible. We rushed over there, we were put in a room with a fish tank … I cannot remember who it was came to see us, I think it was a nurse came to see us. She said "She is in a bad way, we are doing internal cardiac massage, we do not know how long she has left", if she was going to stay alive. We were left again for a while and the next thing, we saw Mr Dhasmana. He came out, theatre cap on, gown on, covered in blood. "I am sorry", he said, "she is dead." He said "I tried everything, I did everything I could, we could not revive her." We then were taken to a room while she was being cleaned up because we wanted to see her. We had offered her organs to transplantation but due to the drugs she was taking they were unable to be

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[461] WIT 0260 0003 – 0004 Erica Pottage

[462] WIT 0260 0006 UBHT

[463] T68 p. 17 Susan Francombe

[464] WIT 0349 0003 Susan Francombe

[465] WIT 0349 0006 Susan Francombe

[466] T68 p. 25 Susan Francombe

[467] WIT 0349 0006 Susan Francombe

[468] MR 2181 0012 – 0013; letter from Susan Francombe to Mr Dhasmana

transplanted, he told us. He also told us there would be a post-mortem by the Coroner's request. We also were in favour of that because we wanted to know why she died because we were not given any answers.

'… Once you are given a 5 per cent risk, you think it cannot happen. It is an eventual situation that probably does not happen anyway. You are in pretty high spirits, you are given a 95 per cent chance of everything going right and then suddenly you are one of that 5 per cent that go wrong. It has put me in a position where I cannot trust doctors any more, it has completely dashed my faith in doctors, I could not trust any of them with my other three children. If they had to go into hospital now I do not know what I would do.

'… We were taken to a room where we telephoned our parents back in Newport to say Caroline had died and could they come up as soon as possible for a visit because that is the last time they would probably see her. We were left about an hour and a half with constant pots of tea and pats on the back, sort of thing. We went to see Caroline after she had been cleaned up. She was still in a bad way, she was still attached to tubes, she still had a tap on her hip into the femoral artery — she had no catheter in. She had dried blood around her nose, quite a nasty state to look at. She was very blue and when I actually picked her up then she actually passed urine all over me which I found very distressing. You do not expect that to happen, you know, you expect the bodily fluids to be out of the body by that time. She had been dead for about 1 hour and a half, somewhere round then. But we were left with her … on the ward with the curtains drawn around until we were ready for our parents to come over and see her and then we left.

'… I did ask could we come back up to Bristol and see her because obviously I did not want to say goodbye at that point, I wanted to see her later on in the day … and maybe the next day. We were told not to go down to the morgue because it was a nasty place, very dark place, very creepy, "You do not want to go down there" … "Remember her as she was and see her back in Newport when she comes back home."

'Unfortunately when she got back to Newport she was not in the same state. Obviously travelling makes a difference to a body and she was bruised, very bruised on the head. It did not feel like the same child as I left in that bed.

'… I held her until she actually developed rigor mortis, I could not let her go.

'The last memory we have of Caroline is in a coffin, a massive bruise on her forehead and a soft-feeling chest, which we could not understand, a crinkly sort of material underneath which felt to me like a dressing and padding.

'… She had quite a lot of her organs taken unknown to us.'[469]

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[469] T95 p. 195–9 Anne Waite

405 Tony Collins described his experience after the operation on his son, Alan:

> ‘Mr Wisheart came to see us after the operation and said that everything had gone well, but the next twenty four to forty eight hours would be critical. We felt confident from his manner that things would be alright … Helen Vegoda was available at all critical time[s] during Alan’s stay … She was there when Alan came back from surgery. She was in and out to see us during Alan’s stay.’[470]

406 Christine Ellis’ son, Richard, was operated on successfully by Mr Dhasmana. She stated in her written evidence to the Inquiry that she was quite happy that she was informed by way of pictures what Richard would look like in the ICU and that this prepared her. She praised Mr Dhasmana, as he came to see them frequently after the operation and explained what to expect. She stated further that the nurses too were friendly and efficient.[471]

407 Malcolm Curnow described his and his wife’s experience after surgery:

> ‘My wife was shocked by the tubes coming out of her. I was … worried … by Verity’s colour. She was not bright pink, as Mr Dhasmana had said that she would be. Rather, she was ashen grey … In the recovery room, we saw Mr Dhasmana for the last time. When he came in, his head was bowed, and he did not look me in the eye. He said, “Sorry, when I opened her up, things weren’t as I expected.” He gave little explanation for the disparity between the prognosis and the result other than that he could not do the shunt he had intended, and that he had had to do something different. He said that he did not know whether this would work or not. I had the impression that Mr Dhasmana knew it was unlikely that Verity would survive. No cardiologist came to see us during the day.’[472]

408 After Verity’s death, Malcolm Curnow stated:

> ‘I went back to our room to find some clothes for Verity … No-one said anything. The staff seemed upset, but took it as a matter of course. I still felt that the question of how such a simple operation could have gone so tragically wrong was unanswered … Both my wife and I felt under pressure to leave the hospital. We were not given adequate time to mourn, or to be left alone. I felt as if we were on a conveyor belt. One of the nursing staff asked us to clear our room, as it was needed by another family … we were taken to the Chapel of Rest to see Verity … It was cold, dimly lit, and felt subterranean. I did not find it reassuring or welcoming. We were left alone with Verity for about ten minutes. We were then taken back to the hospital, where we were informed that the relevant documents would be forwarded to us in the post … As we left, we were approached by the doctor who had tried to

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[470] WIT 0021 0008 Tony Collins

[471] WIT 0023 0010 Christine Ellis

[472] WIT 0004 0006 – 0007 Malcolm Curnow

> resuscitate her in ITU. He stated that one in a thousand children die of heart disease, and that it was just unfortunate that it was ours.'[473]

409 Malcolm Curnow told the Inquiry:

> 'I recall the presence of what I believe to be the cardiac liaison nurse, who made some very what I felt were inappropriate comments, such as, "I know how you feel." No-one can know how we felt at that time, unless they have lost a child of their own, and I am afraid I was probably very intolerant of that person, and I wanted her nowhere near me or my wife, so our contact was extremely brief … From our point of view, the time between the moment your child dies and that you leave the hospital is probably the most critical of all. At that point, you are trying to come to terms with the loss of your child; you are confused, emotional and extremely stressed. But you can be extremely rational through it all as well. What you want is answers; answers to questions: Why did my child die? Why am I in this situation? Why me? If somebody could have spent just a little bit of time explaining or even just being available to sit with us and to answer any of the questions we had at that time, it would have been appreciated.'[474]

410 After Verity's death, Malcolm and Jane Curnow wrote to Mr Dhasmana.[475] Dr Jordan replied, in response to their letter to Mr Dhasmana, explaining why Verity died, giving follow-up advice and discussing fundraising for equipment for the Intensive Care Unit.[476]

411 Michelle Cummings stated that Helen Vegoda was available at all critical times throughout Charlotte's stay in the BRI and the BRHSC[477] and was very supportive.[478]

412 Michelle Cummings was present in the hospital when Charlotte died:

> 'I walked through the doors … and another mother came through the door screaming at me, that something was wrong with Charlotte and I had to come quickly. We went back into where she was, and she was totally delirious and screaming, like I have never heard. She was screaming terribly, in pain, and all the emergency people were arriving and they were trying to stabilise her. This went on for some time, and I think it was about — this happened around half 1, and at one point I had her on my lap trying to give her oxygen, and she was fighting, her bodily functions went and they had to put her in a nappy. It was about 3 o'clock. I phoned Rob – we were told that he ought to come up – and at 4 o'clock they moved her to the intensive care upstairs. Dr Jordan and the other doctors, they fought so hard to save her. She had septicaemia throughout the body and her heart was failing. She just screamed and screamed and screamed, just awful screaming and pain. They

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[473] WIT 0004 0008 – 0009 Malcolm Curnow

[474] T3 p. 62–3 Malcolm Curnow

[475] MR 2374 0092; letter from Malcolm and Jane Curnow to Mr Dhasmana

[476] MR 2374 0084 – 0085; letter from Dr Jordan

[477] WIT 0123 0025 Michelle Cummings

[478] WIT 0123 0031 Michelle Cummings

> could not sedate her because they were desperately trying to keep her going and her heart was getting slower and slower. Eventually, one of the doctors came out and said that she was, you know, going. She was going. We went in and I asked them to switch off, because basically, her heart was beating so slow, she was getting no oxygen to her brain and she had not done, I think it was for over half an hour, anyway. They said, "Will you sit with her for a while?", and "You think about what you want to do", and they lifted her off the bed and she was still all drips and everything, and they gave her to me. She died in my arms at a quarter to 6: that was it.'[479]

413 Michelle Cummings described her contact with staff after Charlotte's death:

> 'They were brilliant. I mean, Helen [Vegoda] came to visit us. She wrote letters on our behalf to the Council for us to move. After Charlotte died and we went to the hospital, she was always there to greet us. She helped us around and one of the doctors would always be there to greet us and support us if we went to the Chapel of Rest and that included Mr Dhasmana on one occasion, I have to say. We met him, he came to look for us, I think it was the day after Charlotte died, and he met us in the corridor. He was incredibly, extremely distressed that Charlotte had died. I remember him giving me a big hug and expressing his sorrow: an incredibly genuine man, and very sensitive to our loss.'[480]

414 Michelle Cummings stated that Mr Wisheart came to see them after Charlotte's death, as soon as he finished operating. She went on that she remembered 'dressing Charlotte and with Dr Jordan cleaning her shoes.'[481]

415 Michelle Cummings stated that Dr Jordan explained the procedure for autopsy and indicated that she could come back when ready to discuss it. Michelle Cummings stated that she returned on three occasions to discuss the autopsy and that Dr Jordan explained how and why Charlotte had died.[482] She told the Inquiry that the meeting she had with Dr Jordan was quite a 'sensitive meeting and very candid and very informative.'[483]

416 Timothy Davies' son, Richard, underwent a Switch operation performed by Mr Dhasmana in 1992 but died shortly afterwards. Timothy Davies described, in his written evidence to the Inquiry, his experience after the operation and after Richard's death:

> 'Mr Dhasmana … invited us into his office. He sat behind his desk, removed his glasses and said something to the effect of "All weekend I have been thinking about sewing him up – what do you want me to do?" I said, "You're the surgeon!" That

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[479] T3 p. 166–7 Michelle Cummings

[480] T3 p. 178 Michelle Cummings

[481] WIT 0123 0031 Michelle Cummings

[482] WIT 0123 0032 Michelle Cummings

[483] T3 p. 170 Michelle Cummings

> was all I can remember being said to us. At about 4 pm, Mr Dhasmana came into the waiting room and I am sure he had tears in his eyes. He bowed his head and said "I am very sorry, he is gone." I went berserk, running up and down the corridor, screaming my head off. Eventually, I calmed down … The nurse came in and said that we could see Richard … he was carried into us in a Moses basket. They had cleaned him up, but his arms were still bruised with all of the injections. The nurse stayed with us for about 10 minutes. She then said she had to take Richard. I said I did not want her to but, naturally, I had to let him go … We were told that I had to ring the Coroner's office the next morning. I remember doing so from a phone box, and being very distressed. I am sure the Coroner's Officer … stated that the cause of death recorded on Richard's death certificate was congenital heart disease. Just hearing it said to me caused me such distress that I broke down in the phone box. I knew this was the position, but that did not stop the impact of what was being said to me. I remember that I had to collect Richard's birth and death certificates at the same time.
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> 'It was arranged for Julie and myself to meet Mr Dhasmana [five to six months after Richard's death]. Dr Joffe was also there. There were a lot of questions we wanted to ask; we wanted to know what had gone wrong. We were told that Richard had congenital heart disease, and that the death was probably due to an infection. That was it.'[484]

417 Maria Shortis recalled her conversation with Dr Joffe after Jacinta's death:

> 'Early the same morning [22 January 1987], I contacted Dr Joffe to tell him of Jacinta's death. His first words to me were, "She shouldn't have done. That surprises me. But, Mrs Shortis, you always thought she would die early." He did not offer me any condolences. His final comment left me feeling that I had wished my child's death upon her. As her carer, I felt responsible for her well-being, and Dr Joffe's words only made me feel more guilty…'[485]

418 Maria Shortis stated:

> 'The GP and our Health Visitor were great. The GP had always wondered what the hospital was trying to do. Both agreed with me that she could not have gone on living for very long in the state she was in, and neither appeared to be particularly surprised. My GP organised some counselling for me whilst Jacinta was still living, and this continued for a short time following her death. I have no complaints regarding the Health Centre, the visiting GPs or the Health Visitor. Many of them came to Jacinta's funeral.'[486]

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[484] WIT 0160 0013 – 0014 Timothy Davies

[485] WIT 0222 0020 Maria Shortis

[486] WIT 0222 0021 Maria Shortis

419 Maria Shortis continued:

> 'I received no support from the hospital, or from any of the voluntary organisations associated with it. In 1987, Dr Joffe let me read the post-mortem report, but I do not feel that this constitutes adequate emotional support. In 1995, I had a meeting with Dr Joffe, during which we discussed Jacinta's care, and his prognosis. Dr Joffe maintained that she should not have died so soon, but did not appear to be able to give me any reasons as to why she should have lived.'[487]

420 On 28 January 1987 Mr Dhasmana wrote to Tim and Maria Shortis offering his 'heartfelt condolences.'[488] On 17 February 1987, Tim and Maria Shortis wrote to Dr Joffe. Apart from requesting another appointment to see him, they wrote, '… thank you for explaining … the results of Jacinta's post-mortem … Thank you so much for the help and courage you gave us.'[489] Tim and Maria also replied to Mr Dhasmana expressing gratitude and support.[490]

421 Justine Eastwood recorded in her diary that:

> 'We knew that things weren't right when Mark [Mr Eastwood] saw Mr Dhasmana and Pat Weir [the anaesthetist] walking down the corridor with heads bowed. The family room where I was sitting was quickly cleared of other parents by one of the nurses and we had the news broken to us by Mr Dhasmana and Pat Weir who were both crying.'[491]

422 Justine Eastwood stated:

> 'We had the news of Oliver's death broken very gently and privately to us. Privacy, at times like these, was uppermost on the minds of the staff. We were given the option to clean Oliver up and prepare him after his surgery which I declined. We were then allowed as much time as we required just to be with him alone. I remember being spoken to about the necessity of a post-mortem and inquest because of the circumstances under which Oliver died. We did speak with the coroner at a later date about the findings of the inquest.'[492]

423 John Mallone described how 'on the morning of Friday 11th January it was clear that Josie was going to die.' He stated that screens were put up to give them privacy and Josie was taken out of her incubator and placed on a pillow.[493]

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[487] WIT 0222 0022 Maria Shortis

[488] MR 2388 0067; letter from Mr Dhasmana

[489] MR 2388 0064; letter from Tim and Maria Shortis

[490] MR 2388 0066; letter to Mr Dhasmana

[491] WIT 0022 0135 Justine Eastwood

[492] WIT 0022 0015 – 0016 Justine Eastwood

[493] WIT 0155 0016 John Mallone

424 John Mallone described his experience after Josie's death:

> 'Dr Martin came and certified her dead. He said that there had to be a post-mortem. We immediately replied that we did not want one. He said that it was a legal requirement to protect patients. We argued against it, saying that he knew exactly why she died. He made it clear that we did not have a choice, assuring us that Josie would not look any different, as the pathologist would cut into her from behind …
>
> 'A young doctor called Caroline expressed her condolences and said that she felt that they "had learnt something," hastily adding "I hope you don't think that it was some kind of experiment." Eventually, we took Josie down to the Chapel of Rest where we laid her in the little crib … We didn't feel under any pressure to leave the hospital; we found the nursing staff exceptionally kind and sensitive after Josie's death …
>
> 'We came to visit Josie in the Chapel of Rest each day. We had been warned that the post-mortem was to take place on Monday 14th January, so we braced ourselves as we went to see her that evening. To our relief, Dr Martin's promise that she would be "the same old Josie" held true. She did not look any different. We returned the following day, Tuesday 15. When we saw her, we were horrified. She was dressed in another baby's clothes, she had blood on her face and her expression had changed completely. We learned that they had postponed the post-mortem for one day without telling us, and that this was the result. We were very distressed and angry.
>
> 'A month or two after Josie's death, Ann and I arranged an appointment with Dr Martin, so that we could discuss what had happened. He went through the post-mortem report with us, and I remember being surprised that it did not mention the pulmonary artery banding. We wanted to know why Josie had been born with heart defects. He said that no one really knew. He tried to reassure us that it was unlikely to be the result of anything either of us had done, but that, having had one child with a heart defect, there was an increased risk of having another. I thought to myself "How can you increase 100%?"
>
> 'At the meeting with Dr Martin, I asked if I could look at Josie's medical records. He arranged for me to do so, and I spent three or four two-hour sessions reading through them and taking notes. I just wanted to understand what had happened to our daughter; I was not suspicious or looking for anything in particular, I just wanted to know more about Josie … I found the experience quite helpful in my attempts to come to terms with losing her.
>
> 'After Josie's death, I went on many occasions to see Helen Vegoda, the BCH bereavement counsellor, the last occasion being in 1995. We also returned to the

> ITU at Christmas and on anniversaries of Josie's death for several years. We were always received warmly by the nursing staff.'[494]

425 John Mallone stated that he had no further contact with Mr Wisheart after Josie's death:

> 'Mr Wisheart didn't make any contact with us after Josie's death. There could be good reasons why he wasn't available at the precise moment she died, but even a brief letter would have been welcome. It would have meant a lot to think that he actually noticed.'[495]

Parents' suggestions for improvements

426 Paul Bradley told the Inquiry that a written diagnosis of the condition would be helpful as a point of reference so that it could be studied:

> 'At that time we did not think to ask for a written diagnosis, but with hindsight, we realise it would have been helpful because obviously they explained to us and with diagrams as well, but it was verbal so we were trying to think in our minds exactly what was said and so invariably, at subsequent appointments, we seemed to be always in the process of clarifying exactly what was said the time before. So it would have been useful to have had in our minds earlier and quicker exactly what Bethan's condition was.'[496]

427 Paul Bradley referred to the difficulty of making 'informed decisions' and made a proposal:

> 'About … informed consent … It was difficult for us to absorb all the information and so to be fair to them, for us to make an informed decision it was difficult for us because we had no medical expertise. So the ability of ourselves as parents to make an informed decision about an operation we accept is very difficult, but in the light of what we now know, and what we have thought about since, we would have wished that there was perhaps just … outside of the hospital — an outside team, panel of experts, to which Bethan's case, because of the complexity, could have been referred to. They could have decided, perhaps overridden, rather, with regard to Bethan, the decision for Bethan's operation to take place in Bristol, but perhaps to take place somewhere else where there was more experience to maximise the possible chance of survival.'[497]

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[494] WIT 0155 0017 – 0019 John Mallone

[495] WIT 0155 0060 John Mallone

[496] T53 p. 8 Paul Bradley

[497] T53 p. 18 Paul Bradley

428 Paul Bradley suggested a particular role for counsellors:

> ‘A counsellor is there to help a parent, to make sure that the parent understands what is being told by the medical team, that their role is to make sure that parents understand and to clarify any misunderstanding in what is said perhaps in the diagnosis or in what treatment is being proposed, and as to what the parents’ understanding is concerning the risk. We perceive that that is within the role of a counsellor and not so much in the role of the medical team … we have always seen the role of counsellor as a befriending role, helping us to get through this awful situation, and being there to help us. I think that would have been greatly valued, if right down the line they were there, not just as a friendly face but also as a person who would help us to make sure we understood what the different aspects of Bethan’s condition was and the treatment proposed and the risks and so forth.’[498]

429 Paul Bradley expressed the view that any discussion of mortality rates should be realistic and not unrealistically optimistic. He said that there should also be consistency among those who discuss the issues with parents. Discussions of such matters as bereavement facilities, post-mortems and administrative matters surrounding death should, he said, be conducted ‘when one is in sober mind’,[499] some time before the operation when the trauma and other conflicting tensions were not at their highest.[500] He told the Inquiry that:

> ‘We would have liked it if even perhaps a year or so, but certainly a few months before, if there had been what I describe as just a routine appointment with a liaison counsellor and that particular person, as a matter of routine, if they had just said to us, “It is my job, my job description to go through this with you, Mr Bradley, it is not because of Bethan’s particular case, I have to do this with every patient.” If they had that expectation to deliver certain information such as what bereavement facilities were available in the unfortunate event of death, what was entailed with post-mortem, what that exactly was, so that we were clear …
>
> ‘Our impression was that for the staff at the BRI it was almost as if they found it difficult to contemplate failure as well, and as if it was a management problem for them. When Mr Wisheart conveyed to us the problem of there being a 1 in 4 chance of failure, this was earlier on, the nursing staff would turn around and say, “But you must look at it the other way, Mr Bradley, a 3 in 4 chance.” So the emphasis was put on the other side. We can understand both sides of the line, but then again, we would have wished that as a consistency there had been a tempering of both sides, of the optimistic side and of the what I would call, not the negative, but the realistic side …’[501]

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[498] T53 p. 37–8 Paul Bradley

[499] T53 p. 46 Paul Bradley

[500] T53 p. 35 Paul Bradley

[501] T53 p. 35–6 Paul Bradley

> 'The way that we would have liked it in our circumstances is if it had been conveyed before death, and I say "before death" because if it had been done in a routine manner; what was the procedure for complaints, what the line of communication was, to whom we should go, what the facilities were as regards bereavement, what postmortem meant, but also, especially about the retention of organs. I think we would have perceived it better if it had been a few months or even a year or so before the operation; not just before the operation, but a few months before.
>
> 'Obviously it is something that we would have hoped never to have come to pass, but we see that it would have been as it were an aspect of the tempering of the things that we were looking for, the optimistic, the mortality rate like the 3 in 4 success, that that would have been an aspect of the tempering, and we would have accepted it, that it was not being negative to Bethan's case, but just as a matter of protocol, a matter of routine, that that was part of their job to do well beforehand, I think well before the operation, not the day before, but well before, when we were in a spirit receptive to receive that information.'[502]

430 Paul Bradley suggested that, as a point of reference, all post-operative counselling and support procedures should include an invitation in writing to return and meet the clinicians.[503] He said that a parent, traumatised after the death of a child, might find it difficult to remember what was said at the time, whereas written information was something that they could return to and consider in the future.

431 Sharon Tarantino, mother of Corinna, told the Inquiry that she would have been upset if such matters as post-mortem and organ retention had been discussed before an operation and that she would not have found it helpful.[504]

432 She agreed that it would be useful to have some formal system whereby an arrangement could be made to come into the hospital to speak to a counsellor who would ask, amongst other things: 'Is there anything you want to know which you do not know and feel we can help you with?'.[505]

433 Sharon Tarantino also agreed with the value of written information being that one has the opportunity to:

> '… take it, think about it and understand it when one had the time to get one's mind around it.'[506]

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[502] T53 p. 38–9 Paul Bradley
[503] T53 p. 43 Paul Bradley
[504] T53 p. 74 Sharon Tarantino
[505] T53 p. 69 Sharon Tarantino
[506] T53 p. 76 Sharon Tarantino

434 Michelle Cummings suggested:

> 'I think parents do need as much information as they can personally take on board and I think if information is going to be given to parents, it needs to be in a form that can be understood and that misunderstandings are less likely to happen, and I think perhaps with that, you need consultation and I think that perhaps there needs to be clear guidelines so that parents know what to expect and what their options are. But I think in 1988 or 1987, for myself and Rob, these questions were not being asked. There was no reason in our eyes for them to be asked. We trust Mr Wisheart; we always have done. We trust Dr Jordan, and always did, so that was not a concept that we thought about at the time. We had a sick child and we needed help and these people offered to help her. I think that also is a major consideration for families.'[507]

435 Sheila Forsythe said that it would be helpful if the pre-operative conversations and estimates of risk and descriptions were put in writing:

> 'I think it would definitely help, because so many people take so many different things away with them. I know from our point of view, again, we had taken different views of what had been said. It is quite clear that those parents who were supported, who had a piece of paper with a diagram, seem to have been able to understand more.'[508]

436 Justine Eastwood suggested:

> 'Any information extra to what you have been told, if there is anywhere where parents can go to read up, to watch videos, anything. At that particular point, where you have been told your child has something wrong with them, you just want to absorb as much information as you possibly can, from any source, really.'[509]

437 Some of the parents suggested that they would want complete frankness from the clinicians, no matter how upsetting it was initially.

438 Michelle Cummings said:

> 'I think one of the things I feel is that it can be difficult if, as a parent, you obviously do not go into hospital wishing your child to die. You go into hospital because part of you feels that this is the right place to be and these people will help to make your child well, so that you can bring them home. With that, I think, goes an unrealistic expectation of what you think other people can do for your child, and that can be difficult, then, when you are actually taking on the information that is being given to you, because you can be selective, and you do not want to hear certain views. Mr Wisheart was extremely honest with us. He went into every risk factor, every

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[507] T95 p. 60–1 Michelle Cummings

[508] T95 p. 68 Sheila Forsythe

[509] T95 p. 70 Justine Eastwood

> possible thing that he, at the time, felt may go wrong or would go right. There were no angles that we had not covered. But there was still that element that I felt, "Yes, but I want to take her home, so, you know, you have to do it right, so what if this happens, what will you do if you cannot do that?" I did go into those questions with him and that can be very difficult, because how much information in that state can I actually credibly take on board and how much does that clinician — do they know how much to give me? And when you have reached saturation point, it is just going over your head. I think that is a very real problem.'[510]

439 Marie Edwards suggested that not all parents wanted as full an account:

> 'I think it goes through more on a judgment of the person feeding the information to the parent. The parent [*sic*] needs to be able to communicate clearly and decisively the needs of each individual parent. Some parents want to know, other parents wish, and choose not to. I feel strongly that each individual should be treated in that way, as an individual person.
>
> 'I feel the person should be able to have a feel of what that character is and what their needs are as a parent and to ask their wishes … Give them time to actually get their heads round the situation. You go into immense shock, almost a shutdown of knowing that your child is in hospital per se and never mind the severity of the operation, it is an operation, it is terrifying to any parent because you know there is a risk factor. It really … takes time for you to actually absorb and to digest before you can move on to asking why, how, when? So I feel it is up to the person that is delivering the information to be skilled enough to read the signs when it is time to give that parent enough space to be able to gather their thoughts, as it were … Be it 10 minutes, 15 minutes, 2 hours, that break can be immensely important. Just to allow the parents to realise what is going on. With me it was a terrible shock to hear that my daughter was not going to obtain an operation, yet she was going to die, was not given that choice, the chance of life. To me it terrified me but I can only speak from my experience and I feel any form of 5 or 10 minute break to allow that parent to understand and gather their thoughts and discuss it with their partners if they have a partner with them.'[511]

440 Justine Eastwood said that she did not think it was always appropriate to leave parents with hope:

> 'I think you need to know. It hurts. You do not want to be told your child is possibly not going to survive the operation, you want the surgeon to say "Everything is going to be fine, I am going to pull the child through." It hurts to hear it, but you need to know the truth. I do not want to be told everything is going to be jolly and fine. It is a fact of life.

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[510] T95 p. 79–80 Michelle Cummings

[511] T95 p. 134–5 Marie Edwards

> '… You do not want people to be cruel to you, but you need honesty in a situation like that. You just have to deal with it. You are in a situation that you cannot get out of; you have to deal with it.'[512]

441 Richard Lunniss, father of William, told the Inquiry that:

> '… you cannot trust people if you do not think they are being honest, even if they are being nice. Once you think that they might not say the thing as it is, then you can never believe quite — there is no working relationship from that point on.'[513]

442 Michelle Cummings told the Inquiry:

> 'I … have a concern … of what actually informed consent is and how do you sort of measure that? How do we, as parents, know exactly what our rights are in terms of informed consent? If you asked me, I feel that I was fully informed and I have no illusions of what I was told. I am quite, you know, firm on that. But if you asked another person who I feel perhaps was given the same information, their opinion and their analysis of what they were told was completely different. So I wondered whether part of the Inquiry would be to look at ways of perhaps providing guidelines for parents so that we actually know when we are going into hospital, before we go into hospital, exactly what we can expect, what our rights are, and exactly what informed consent is for us, what it means to us so that there can be no misunderstandings … I think it has to be for clinicians as well. It is no good telling the parents one thing if the clinicians do not know. It has to be something that everybody knows what the other person's role is. So otherwise, it will not work. But if the clinicians are in a position where they are uncertain what their position is regarding informed consent and they feel in good faith that they have acted and given the information over, but the parents' interpretation does not agree with that, then you have a problem. So if you have guidelines, perhaps, that both the parents and clinicians understand, perhaps it will help towards clarifying it.'[514]

443 John Mallone told the Inquiry that:

> 'I think consent for the operation has to be fully informed consent and if, as I hope will happen, surgeons are going to be made to say what their percentage success rates are, then that should be part of that informed consent[515]… I think the more channels of communication you use to inform one the better the information is going to be received, understood … a video … book, diagram, face-to-face contact, to reinforce one another. There is no ideal method, you need to have them all.'[516]

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[512] T95 p. 80 Justine Eastwood

[513] T95 p. 81 Richard Lunniss

[514] T95 p. 92–3 Michelle Cummings

[515] T95 p. 201–2 John Mallone

[516] T95 p. 203 John Mallone

> '… Doctors must be trained to communicate more openly and effectively with patients and those responsible for them, for example parents. There is a fine line between not wanting to worry people and being unduly optimistic to the point of misleading them … Doctors and others involved in patient care must also be more aware of the need to communicate effectively with one another. It should not be possible for a parent to be told that a child is going to die and then for this information to be flatly contradicted by another doctor.'[517]

444 The evidence set out in the Interim Report of the Inquiry[518] (as to the retention of organs and the giving of consent for post-mortems) has not been repeated here, but nonetheless forms part of the body of material upon which the Inquiry has drawn for its conclusions. Reference should be made to the Interim Report for a review of the evidence received by the Inquiry specifically in relation to informing parents of the need for a post-mortem examination and as to the information given concerning retention of their child's tissue and organs.

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[517] T95 p. 209 John Mallone

[518] The Inquiry's Interim Report *'Removal and retention of human material'*, May 2000

Chapter 18 – Medical and Clinical Audit

Introduction

1 The practices and systems in use for informing the Department of Health and Social Security (DHSS), Department of Social Security (DSS), Department of Health (DoH), National Health Service Management Executive (NHSME), National Health Service Executive (NHSE), the regional health authorities (RHAs) and district health authorities (DHAs) of the performance of units for which they had responsibilities are of such importance that they call for separate consideration.

2 In the first part of this chapter the development, over time, of ideas and practices of what has become known as audit is charted. A definition of audit is given at para 5 below.

3 The way in which these developments at a national level found reflection in the practices and systems applicable to the Bristol Royal Infirmary (BRI) and Bristol Royal Hospital for Sick Children (BRHSC) throughout the period of the Inquiry's Terms of Reference is set out in the second part of this chapter. (The collection of data by Dr Stephen Bolsin and others, with specific reference to paediatric cardiac surgery, is dealt with from Chapter 26, when the evidence as to the expression of concerns and the grounds for those expressions is set out.)

4 In the final part of this chapter we set out the extent to which there was audit of paediatric cardiac surgery in Bristol.

Audit: the national perspective

Defining audit

5 There are many definitions of audit, but the most widely cited in the UK during the period of the Inquiry's Terms of Reference was the definition given by the DoH in 1989:

> '… the systematic, critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources, and the resulting outcome and quality of life for the patient.'[1]

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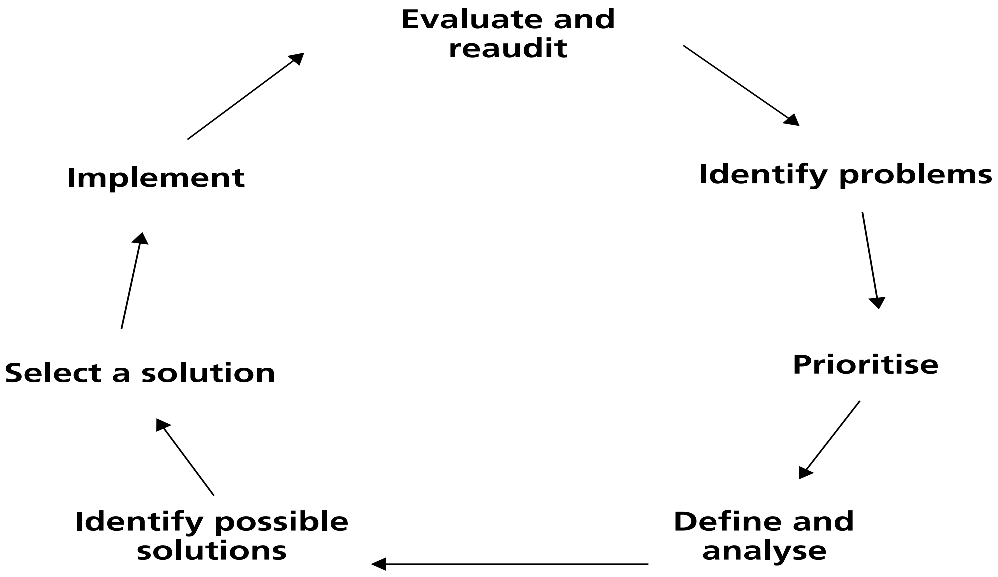
[1] HOME 0003 0127; DoH, *'Working for Patients: Working Paper 6'*. London: HMSO, 1989

The assessment and then the improvement of quality are widely regarded as forming a cycle of activity (see Figure 1 below) which together produce continuing improvements in quality.[2]

Figure 1: The audit cycle



6 The setting of standards against which to measure activities and performance was seen as a key aspect of audit. Miss Lesley Salmon, General Manager of Obstetrics, Gynaecology and ENT at the BRI from October 1994 to date, observed:

> 'The setting of standards is something that runs throughout the Health Service. In a sense, it is the first step in audit, in that if you were going to audit your performance, generally speaking you would be within a department or a service setting standards to then measure yourself against to ensure you were meeting the standards already set, whether they were clinical or non-clinical standards. Audit is then auditing your performance against the standard that has been set and it can be either one internally you have set or it can be something that compares you to other services, similar services, elsewhere.'[3]

7 This aspect of audit, the concern for measuring conduct against agreed standards, is not prominent in the 1989 definition set out in para 5, above. During oral evidence, Counsel to the Inquiry referred Sir Barry Jackson[4] to that definition in para 5, and compared it to the definition of audit set out in the Royal College of Surgeons of

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[2] Fowkes F. 'Medical audit cycle: a review of methods & research in clinical practice'. *'Medical education'* 1982; 16: 228–38. Illustration reproduced with the kind permission of Blackwell Science Ltd

[3] T31 p. 94 Miss Salmon

[4] WIT 0048 0001 Sir Barry Jackson, President of the Royal College of Surgeons of England, from July 1998 to date

England (RCSE) paper. The Royal College explicitly included the question of prescribed targets and standards, stating:

> 'Audit is the systematic appraisal of the implementation and outcome of any process in the context of prescribed targets and standards.'[5]

8 Sir Barry Jackson said:

> '… I think at the time these documents were written there was no clear understanding amongst everybody as to a uniform meaning of the term "audit". … I also know that in the minds of surgeons and other doctors, not just surgeons, throughout the country, there was enormous confusion as to what audit actually was and to how it should be used, and its importance. There is no doubt at all in my mind that the definition that you see on the screen currently is the correct definition of "audit", that is to say, it is a systematic appraisal or analysis, if you wish, of any particular process in the context of a prescribed standard which has been set, a comparison of what is actually being done against that standard or target which has previously been identified, and that should there be a disparity, then measures should be put into place to rectify the disparity, or alternatively, to change the standard or the target which might of course be incorrect. … I think that some of the confusion may have arisen between these three terms, "audit", "medical audit", and "clinical audit". I say no more than that because I think it was a very confused area. I think it is still confused to some extent in the minds of many, even today'.[6]

9 Sir Barry Jackson said that:

> 'The setting of the standards have created considerable problems in many areas, and in 1989/1991 those standards in most instances were not recognised; therefore, to all intents and purposes, they did not exist. This is where I think some of the confusion has arisen as to what one is meaning by "audit" because so often what was perceived as audit — and I have to say, going back to the HRC [Hospital Recognition Committee] and the SAC [Specialist Advisory Committee] visits … the audit that they were looking at was probably not audit in the true sense of the word; in other words, comparing against an accepted standard.'[7]

The development of definitions

10 Whilst an early definition of audit is set out above at para 5 above, the understanding of the term, and the meaning ascribed to it, varied and was developed across the period with which the Inquiry was concerned.

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[5] WIT 0048 0117 Sir Barry Jackson

[6] T28 p. 87 Sir Barry Jackson

[7] T28 p. 92 Sir Barry Jackson

11 Initial uncertainties about the meaning and scope of audit were captured in the first paragraph of the *'First Report of the Royal College of Anaesthetists' Audit Committee'*,[8] November 1989:

> 'What is Audit [?]
>
> 'Audit is derived from the Latin and means "hearing". In financial terms it derives from the practice of a landowner calling his steward to give an account of the use of the landlord's property. (Look at the parable of the talents, Matthew, 25, 14–30). *"The Economist's Pocket Accountant"* shows that the aim of a financial auditor is to present a true and fair view of the financial state of an organisation. Essentially the accounts should show how the organisation has used its resources in the preceding defined period.
>
> 'There seems to be no generally accepted definition as to what medical audit is. But the idea behind most schemes is that the participants can demonstrate to themselves and their colleagues (not only in medicine) the quality and quantity of the work that they are doing. This entails an account of the use of the resources and the outcome of the clinical practice, to demonstrate the limitations of the clinical service and the needs for improvements.'[9]

12 Dr Jane Ashwell, who was, at the relevant time, a Senior Medical Officer at the DoH, referred to the Inquiry's Issues List in her statement[10] and said:

> 'I think the way the word audit is being used in issue M [the Issues List] is actually rather different from the Audit I am talking about and which the DH [Department of Health] was introducing in the early 1990s. There were no systems — it was new and developing. Much of the research information on which to base audit was not available and much of my work was aimed at helping doctors to establish research such that robust guidelines could be produced to do audit against. You can't look at practice unless you establish a standard to compare it with. Audit was not a means of measuring outcomes but a way of comparing what doctors did as against what the research evidence indicated they should do. Some professional bodies did collect anonymised outcome data as did NCEPOD [National Confidential Enquiry into Perioperative Deaths] but it was not robust research that could link the outcome with causes nor was it, strictly speaking, audit.'

13 For clinicians, therefore, audit could form an aspect of research and scientific development. It was also a form of continuing professional education, in that it involved scrutiny of aspects of clinical practice and care.

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[8] The Committee was subsequently renamed the Quality of Practice Committee: see report of May 1991, WIT 0065 0595 Professor Strunin

[9] WIT 0065 0589 Professor Strunin. In the next report, May 1991, the definition in *'Working for Patients: Medical Audit'*, Working Paper No 6, was set out. See WIT 0065 0595

[10] WIT 0338 0003 Dr Ashwell

14 The Standing Medical Advisory Committee wrote:

> 'Since the technical competence to assess quality of medical care belongs to doctors, medical audit must be conducted by the medical profession as its success depends so much on medical knowledge. Medical audit needs to involve all doctors who should take corporate responsibility for it.
>
> 'Medical audit should lead to a better standard of patient care by better informed doctors. It must be an educational process, and this form of audit should not be used for disciplinary purposes.'[11]

15 Mr James Wisheart, consultant cardiac surgeon, saw audit as having:

> '… a place in terms of education and peer review…to be an activity conducted by doctors in the interests of their education …'[12]

Further,

> 'The initial view of audit was that it was an activity which was to be led professionally and undertaken professionally as a peer review, educational exercise.'[13]

Dr Trevor Thomas, consultant anaesthetist, and chairman of the United Bristol Hospitals NHS Trust (UBHT) Medical Audit Committee said that medical audit, was:

> '… a system which was being used as an educational system …'[14]

Mr Janardan Dhasmana, consultant cardiac surgeon, stated:

> 'The audit of one's own data was always considered essential in maintenance of professional standard and in improving performance.'[15]

16 Counsel to the Inquiry asked Dr Sally Masey, consultant anaesthetist at the BRI since 1984, what she thought the purpose of audit was. She replied:

> 'The purpose of audit in the broadest sense is to have a mechanism to look at our practice in order to improve the quality of care in the broadest sense.'[16]

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[11] *'The Quality of Care'*, report of the Standing Medical Advisory Committee, DoH, 1990, p. 16
[12] T41 p. 82 Mr Wisheart
[13] WIT 0120 0384 Mr Wisheart
[14] T62 p. 99 Dr Thomas
[15] WIT 0084 0026 Mr Dhasmana
[16] T74 p. 22 Dr Masey

17 Mrs Margaret Maisey, employed at the UBHT from 1986 to 1997 as a General Manager (South and later Central Unit), Director of Operations and Director of Nursing, stated that:

> 'The term [audit] has had a rather equivocal meaning during my recent employment within the NHS. To some it has meant an educational process, a structure for reviewing the process of health care, rather than the outcomes of that care. To yet others, it merely borrowed the word from accountancy to refer to the stocktaking process when applied to various aspects of the health care system.'[17]

18 Mrs Maisey demonstrated the use of 'audit' to describe aspects of managerial activity, by giving the example of a 'lifting equipment audit' that was instituted in 1992 by Janet Maher, then General Manager UBHT, and was an information-gathering exercise about the facilities for lifting, moving and handling patients. The results of this 'audit', according to Mrs Maisey, were very helpful and a minimal lifting policy was introduced, but:

> 'There is no way in which such management activity can be called "clinical audit" as I understand the term to be used when applied to clinical situations today.'[18]

She continued:

> 'I recall that the various advices and circulars from the centre, the College and others, over a number of years defined audit differently at different times. The view of what it might be, how it might be implemented and applied to one's own area of responsibility, changed with time.'[19]

19 Dr Ian Baker, Consultant in Public Health Medicine with the Bristol and District Health Authority (B&DHA), said:

> '… I think health authorities were interested in audit in so far as it was a way of considering the heading "Quality" in contracting terms, and I think those of us in public health medicine had a professional interest in this tool, providing information on quality.'[20]

20 When Dr Baker was asked what obstacles stood in the way of the development of audit, he said:

> 'I think the main one was the feeling that audit was going to become some form of inspectorial management tool of professional practice. I think, in general, the medical profession, and possibly others, closed ranks to some extent to take ownership of this process to try and accept it as something which was educational

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[17] WIT 0103 0072 Mrs Maisey

[18] WIT 0103 0072 Mrs Maisey

[19] WIT 0103 0072 – 0073 Mrs Maisey

[20] T36 p. 101 Dr Baker

> and related to training and practice in that way, rather than a more general approach to quality assessment.'[21]

21 The 1992 UBHT Medical Audit Committee (MAC) report stated:

> '… medical audit … must continue to be seen to be a confidential and independent educational process — not merely the inquisitional arm of purchasers under the auspices of the Regional Health Authority.'[22]

22 Equally, audit was seen as a potential tool to persuade managers that further resources were needed. For example, the Audit Committee of the Royal College of Anaethetists (RCA) listed amongst the 'good reasons' why audit should be performed:

> '… the need for information to identify strengths and weaknesses of the various services, to ensure effective training of junior staff and finally to ensure that the capital and recurrent expenditure associated with anaesthesia is used effectively, and increasingly, economically. Audit should be usable in demonstrating to colleagues and managers that resources are used well and that claims for additional moneys are well supported.'[23]

23 In May 1991, the RCA advised its members:

> 'Representatives of the employing authority have a legitimate interest in those aspects of audit which include resource management, staffing levels, list cancellations or overruns and the use of ITU and recovery facilities.'[24]

24 There was potential confusion as to the difference between expressions or activities such as 'quality assurance'and 'audit'. Sir Barry Jackson gave evidence that:

> '"Quality assurance" is a jargon phrase, which is widely in evidence at the moment.[25] I think it just refers to the broad field of quality in its entirety. Audit, I think, will be one aspect of a method of trying to ensure satisfactory quality, but there would be others such as the CME [Continuing Medical Education] and CPD [Continuing Professional Development], for example, … examinations and other aspects of ensuring quality.'[26]

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[21] T36 p. 103 Dr Baker

[22] UBHT 0032 0080; MAC report 1992

[23] WIT 0065 0589; *'First Report of the Audit Committee'*, November 1989

[24] WIT 0065 0598; *'Report of the Quality of Practice Committee'*, May 1991

[25] WIT 0307 0018; Dr Kieran Morgan, Director of Public Health, Avon Health Authority commented on Mr Jackson's evidence that the phrase 'quality assurance' was jargon. He said: 'The term "quality assurance" is not a jargon phrase. It very clearly refers to the obligation of providers of services to demonstrate to those who receive the service that that service is of high quality'

[26] T28 p. 89 Sir Barry Jackson

25 Dr Kieran Morgan, Director of Public Health Avon Health Authority (Avon HA), took the view that there were standards or benchmarks in relation to structures and processes even though there were none in relation to outcomes of care. He stated:

> 'Much of the monitoring we were trying to introduce was about following the introduction and development of structures and processes and, of course, this is something that the UBHT felt was not a concern of the Health Authority and wholly the responsibility of the Trust (see the note of the clinical audit review meeting of the UBHT in November 1992).'[27]

26 In a paper commissioned by the Inquiry entitled *'Medical and Clinical Audit in the NHS'*, audit is explained as follows:

> 'To health professionals, audit offers a systematic framework for investigating and assessing their work and for introducing and monitoring improvements. The process of carrying out an audit involves a characteristic sequence of events which includes:
>
> - 'defining standards, criteria, targets or protocols for good practice against which performance can be compared;
> - 'gathering systematic and objective evidence about performance;
> - 'comparing results against standards and/or among peers;
> - 'identifying deficiencies and taking action to remedy them; and
> - 'monitoring the effects of this action ie. "closing the audit loop".
>
> 'Audit is regarded as a cyclical activity, on the assumption that reviews of this sort should be carried out continuously.'[28]

27 Dr Kieran Walshe, Senior Research Fellow in the Health Services Management Centre at the University of Birmingham, recognised there were various interpretations of the term 'audit':

> 'I think the definition offered in the Inquiry's paper is a helpful one … I think the definition you have offered in this paper is in some ways more helpful [than the Department of Health's 1989 definition referred to in para 5] because it makes it clear the process involves both gathering information about the quality of practice and performance, identifying problems and opportunities for improvement and then taking action to remedy those problems or difficulties, to bring about change. There are ways in which you can make differentiations — and the paper referred to distinguishes between medical audit, clinical audit and organisational audit and

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[27] WIT 0307 0015 Dr Morgan

[28] INQ 0011 0009; *'Medical and Clinical Audit in the NHS'*

> quality assurance and TQM [Total Quality Management] and CQI [Continuous Quality Improvement]. There are lots of definitional discussions you can have. What brings all those definitions all together is that they are all about systematically attempting to identify problems with the quality of care, and then taking action to understand their causes and bring about changes that make improvement in the quality of care take place.'[29]

The national scene: a brief history of audit[30]

Key events

28 Prior to 1980, explicit concerns about quality appears to have been largely absent from the thinking and policy documents of the NHS.

29 The medical profession was expected to be the regulator of the quality of clinical care, and had been since the Medical Act 1858 established the General Medical Council (GMC) to regulate the medical profession on behalf of the state. This legitimated the profession's claims to autonomy and its right to self-regulation. When, in 1948, the NHS was created, the regulation of the medical profession was left largely in the hands of the profession through the GMC (and, in matters of training, the Royal Colleges).

30 Audit as a notion and a practice was conceived as being wholly associated with the activities of the medical profession until relatively recently. However, to the extent that it is concerned with quality of care, widely understood, it is inevitably concerned also with the conduct of all the other carers involved in the care of patients.

31 The *'Historical Perspective'* to the formal introduction of the obligation to undertake audit within the NHS was summarised by the Standing Medical Advisory Committee in 1990.[31]

> 'The idea of medical audit is not new: indeed, reference to it can be found in the Charter of the Royal College of Physicians of 1518 which states that one of the College's functions is to uphold the standards of medicine "both for their own honour and public benefit". Examples of medical audit which are currently taking place [in 1990] include the Confidential Enquiry into Maternal Deaths, which began in 1952 and is run jointly by the Department of Health and the Royal College of Obstetricians and Gynaecologists. The Royal College of General Practitioners was involved early on in medical audit in general practice. Much of the work of the Birmingham Research Unit in the 1950s and 1960s was concerned with designing the tools for audit. In pathology the National External Quality Assessment Scheme (NEQAS) was started in 1969 and encompasses all commonly used numerical investigations in pathology. It is a voluntary scheme open to NHS and private

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[29] T62 p. 5 Dr Walshe

[30] The distinction between medical and clinical audit and the shift in policy from the former to the latter is discussed at paras 59–66 onwards. Medical audit carried out by doctors and the audit of nursing care by nursing staff was realised to be less instructive than the multidisciplinary approach to the examination of overall care of the patient that became known as 'clinical audit'

[31] *'The Quality of Care'*, report of the Standing Medical Advisory Committee, DoH, 1990, p. 7–8

> services. The Royal College of Physicians conducted a survey in 1980 of causes of death in medical wards of all patients under the age of 50. The Association of Anaesthetists and the Association of Surgeons together carried out an enquiry into perioperative deaths in three Regions (CEPOD); this was extended into a national confidential enquiry at the beginning of 1989. The Health Advisory Service, which was established in 1976, is an example of multidisciplinary audit; it carries out reviews of hospitals and community health services provided for the elderly and the mentally ill and makes recommendations for the improvement of care.

'The Department of Health's health service indicators include measures of activity, and some of outcome … These provide some indication of the quality of medical care. The health service indicators also include a set of data which compares death rates by region and district for certified causes of death from conditions considered 'potentially avoidable'… The incidence of potentially avoidable deaths (that is those from conditions amenable to treatment) has been analysed for each Health Authority and shows large variations between Health Authorities even after adjustment for social factors. All these may provide some indication of the quality of medical care.'

32 Dr Morgan stated:

> 'Recognisable medical audit has taken place throughout the Health Service for many years but a systematic approach to engaging all clinicians became evident in the NHS only in the late 1980s.'[32]

33 Prior to 1980 explicit concerns about quality appear to have been largely absent from the thinking and policy documents of the DoH.[33] Dr Graham Winyard[34] considered that the DoH's relatively limited involvement in the field of audit and outcome assessment at the time reflected the then established division of responsibility for standards of professional practice, which were set by the GMC and the medical Royal Colleges:

> '… through general and specialist examinations, the inspection of training posts and involvement in consultant appointment committees. However, the prime responsibility for a doctor's ongoing standard of professional practice lay with that individual and was seen very much as a matter for him or her. General peer pressure was undoubtedly important in maintaining overall standards but could prove much less effective when an individual was, for whatever reason, resistant to criticism.'[35]

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[32] WIT 0307 0011 Dr Morgan

[33] INQ 0011 0007; *'Medical and Clinical Audit in the NHS'*

[34] Dr Graham Winyard was the Medical Director of the NHS Executive and Deputy Chief Medical Officer from 1993 to 1998

[35] WIT 0331 0002 Dr Winyard

34 Thus, the evidence indicated that prior to 1989 there was a varied and patchy pattern of audit. Dr Walshe elaborated:

> '… in most hospitals you would have found a small number of clinical professionals, particularly doctors, who were gathering data about their own practice, who were, if you like, audit enthusiasts and who were engaging in a process of clinical audit for themselves. You would have found, I think, in most parts of most organisations, relatively little activity. There would have been some traditional mortality and morbidity meetings or death and complication meetings going on, at which problems to do with the quality of care perhaps got reviewed, but you could not have said that in I think almost any health care organisation at that time in the NHS there was a systematic program of quality assurance or quality improvement in place. You would also have found some important national initiatives which were focused on particular areas of care and were important in those areas but were somewhat isolated in that they did not have a wider remit or impact. Examples would be the Confidential Enquiry into Maternal Deaths and the National Confidential Enquiry into Peri-operative Deaths, work done by the Royal College of General Practitioners on standards for general practice, and things like that. So there were important initiatives, but there was no system that covered even a large minority of the care being provided.'[36]

35 Attitudes began to change within the medical profession itself. For example, some parts of the medical profession gained extensive experience of quality assessment exercises set up by bodies such as the Royal Colleges, notably into anaesthetics and obstetrics, as well as confidential enquiries established on a national basis to study maternal, infant and peri-operative deaths.[37]

36 Formal arrangements for audit were in their infancy throughout the NHS during the 1980s. Progress was limited because no additional resources were allocated for audit whether for the supra regional services or in the NHS generally. It was only with the introduction of the NHS reforms in the 1990s that funding was made available for the specific purpose of introducing audit.[38]

37 The publication of the DoH's White Paper *'Working for Patients'*[39] in January 1989, set out plans for the creation of the internal market. Together with the '*Working for Patients: Medical Audit Working Paper 6'*, it also set out plans for a comprehensive system of medical audit, covering both primary healthcare and the hospital and community health sector. The Government made it clear that all health-care providers in the NHS in England should develop medical audit programmes that involved all medical staff in critical examination of the quality of care and practice. Subsequently, the DoH broadened this programme to provide some funding for an audit programme in Nursing and Therapy as well. Uni-professional audit was proposed at that time; that

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[36] T62 p. 13–14 Dr Walshe

[37] INQ 0011 0008; *'Medical and Clinical Audit in the NHS'*

[38] WIT 0049 0021 Dr Halliday

[39] HAA 0165 0145; *'Working for Patients'*

is to say medical audit for doctors, nursing audit for nurses and their own audit for the Professions Allied to Medicine (PAMs).

38 *'Working for Patients'* sets out the fundamental principles, 'to which the Government is committed', as follows:

> '(a) Every doctor should participate in regular systematic medical audit.
>
> '(b) The system should be medically led, with a local medical audit advisory committee chaired by a senior clinician.
>
> '(c) The overall form of audit should be agreed locally between profession and management, which itself needs to know that an effective system of medical audit is in place and that the work of each medical team is reviewed at regular and frequent intervals to be agreed locally.
>
> '(d) The results of medical audit in respect of individual patients and doctors must remain confidential at all times. However, the general results need to be made available to local management so that they may be able to satisfy themselves that appropriate remedial action is taken where audit results reveal problems.
>
> '(e) Where necessary management must be able to initiate an independent audit. This may take the form of external peer review or a joint professional and managerial appraisal of a particular service.'[40]

39 It was Dr Winyard's opinion that the proposals in the working paper recognised that audit:

> '… needed to be owned by the medical profession if it were to be effective in stimulating genuine peer review and changing clinical practice where that was indicated. They sought to strike a balance between this and the wider and equally legitimate interests in the quality of care by ensuring confidentiality for the audit process itself, while insisting that the "general results" of audit were made available to management.'[41]

40 The DoH's policy at the outset was that medical audit should be primarily the concern of providers, rather than district health authorities or other purchasers. As the NHS reforms took effect, structures and audit activities would therefore need to be based at a provider level:

> 'Health authorities are responsible for establishing a medical advisory structure. With the separation of the purchaser/provider functions, medical audit will become

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[40] HOME 0003 0130; *'Working for Patients'*

[41] WIT 0331 0004 Dr Winyard

> a provider unit based activity and it will be to unit managers that regular reports of the general results of audit are addressed.'[42]

41 The benefits of the audit programme were expected to be profound and wide ranging. An internal discussion paper in the DoH stated:

> 'Medical audit should trigger changes in practice within specialties, across specialties, across provider units and across boundaries including those between primary, secondary and tertiary care. The findings of medical audit should encourage comparison and challenge working practices throughout the NHS … This should result in optimal delivery of effective and appropriate care by the right professionals, in the right combination, in the right setting and at the right time.'[43]

42 Dr Walshe identified three elements which in his opinion were the catalyst for these audit reforms in 1989, a year that many witnesses regarded as marking the introduction of audit as a formal process:

> 'I think there are three things that had happened. One was the rise of general management during the 1980s and the arrival of individuals, some clinically qualified, some not clinically qualified, but individuals who had general management responsibility and authority for healthcare services, and had more of a remit and a legitimate right to ask questions about the quality of care. Second was the rise of concerns about quality of performance across public services, and indeed private services. It was a theme in Government in the 1980s and a focus on the role of managers and managerialism and a concern about the power of the professions running across education and health and social services, and other sectors. I guess I would also point to the fairly positive experience of those initiatives I have described going on in the 1980s, seen as examples of good practice that perhaps we should be trying to emulate and roll out on a wider scale. I do not think I could point to one particular event or set of circumstances which led the Government then to say "we have to have systems of medical audit". It was a combination of things.'[44]

43 The aims and objectives of the DoH's audit programme from 1989 to 1993 are set out in Figure 2, below.

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[42] HAA 0164 0025; HC(91)2. *'Medical Audit in the Hospital and Community Health Services'*

[43] INQ 0011 0012; NHS Management Executive. *'Steering the Audit Programme'* (Internal Discussion Paper), 1991

[44] T62 p. 15 Dr Walshe

Figure 2: Aims and objectives set by the Department of Health for its audit programme[45]

1989	1992	1993
'To enhance the quality of care given to patients in the NHS.' 'To provide the necessary reassurance to doctors, patients and managers that the best quality service is being achieved within the resources available.' '[To develop] a proper organisational framework for the introduction of systematic medical audit in each Health Authority and Family Practitioner Committee.' 'Every doctor should participate in regular systematic medical audit.' 'The system [of audit] should be medically led, with a local medical audit advisory committee chaired by a senior clinician.' 'The overall form of audit should be agreed locally between the profession and management, which itself needs to know that an effective system of medical audit is in place and that the work of each medical team is reviewed at regular and frequent intervals to be agreed locally.' 'The results of medical audit in respect of individual patients and doctors must remain confidential at all times. However, the general results need to be made available to local management so that they may be able to satisfy themselves that appropriate action is taken where results reval problems.' 'Where necessary management must be able to initiate an independent audit. This may take the form of external peer review or a joint professional and managerial appraisal of a particular service.'	'Medical audit should be shown to lead to change in quality of care and health outcome.' 'Medical audit should be fully embedded throughout the NHS.' 'Medical audit should be an integral part of undergraduate, postgraduate and continuing education in all specialties.' 'National audits investigating important areas using approved methodologies and producing valuable and generalisable findings should continue to be supported centrally.' 'Audit should be seen as a process of setting standards and comparing practice against standards in order to achieve change.' 'Healthcare commissioning for populations should be informed by both national audit findings and also by the findings of local medical audit.'	'[Audit should] be professionally led.' '[Audit should] be seen as an educational process.' '[Audit should] form part of routine clinical practice.' '[Audit should] be based on the setting of standards.' '[Audit should] generate results that can be used to improve outcome of quality care.' '[Audit should] involve management in both the process and outcome of audit.' '[Audit should] be confidential at the individual patient/clinician level.' '[Audit should] be informed by the views of patients/clients.'

44 In order to meet these objectives, the Department of Health allocated almost £221 million to facilitate the development and implementation of medical audit (later clinical audit) programmes in every health care provider in England, and to support central initiatives such as audit projects and programmes at the medical Royal Colleges. The provider units received £28 million, allocated for funding the newly created medical audit committees in the first two years (1989 and 1990). This rose to £48.8 million in 1991/92, the year in which the committees began to function fully.[46]

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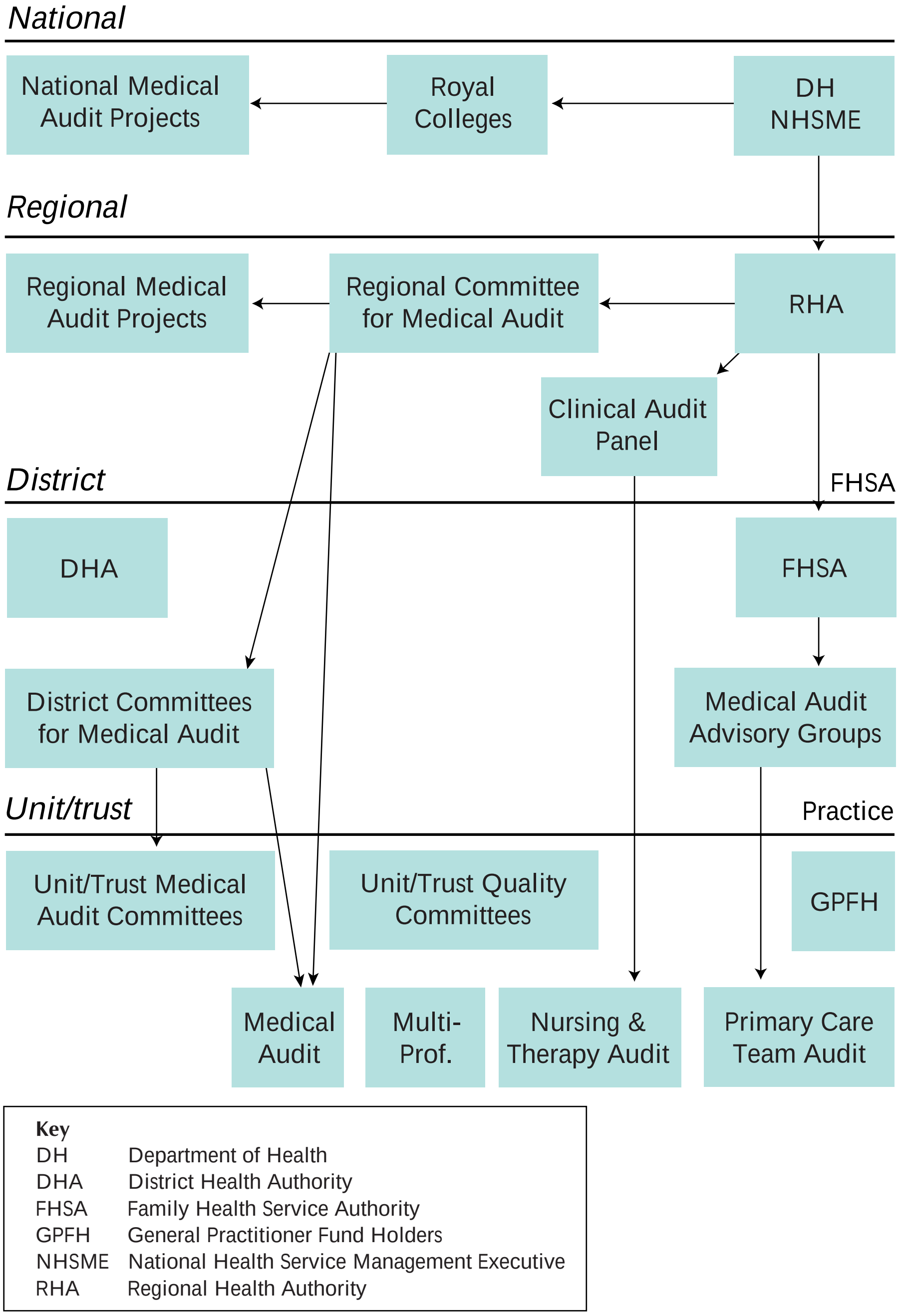
[45] *'Evaluating Audit: Provider audit in England: A review of twenty-nine programmes'* 1995 CASPE Research. Illustration reproduced with the kind permission of CASPE Research

[46] INQ 0011 0012; *'Medical and Clinical Audit in the NHS'*

45 A separately funded Nursing and Therapy audit programme was also introduced, from 1991 onwards. It received £2.3 million in 1991/92.[47]

46 Figure 3 shows the flow of funds for clinical audit between 1990 and 1994.

Figure 3: Flow of funds for medical and later clinical audit 1990–94[48]



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[47] INQ 0011 0013; *'Medical and Clinical Audit in the NHS'*

[48] Reproduced with permission from the author. *'Evaluating clinical audit: past lessons, future directions'*, edited by Kieran Walshe, International Concerns and Symposium Series 212. Proceedings of a conference organised by the Royal Society of Medicine and CASPE Research, London, 27 April 1995

Reactions to the Government's proposals

47 Medical reaction to the White Paper proposals as a whole were generally negative. The reactions are set out as follows:

- concern that the proposals failed to address the chronic under funding of the NHS;
- doubts about the need for such a major reorganisation of the system;
- scepticism about whether patients would benefit from the changes;[49]
- doubts about whether there would be adequate time for audit and whether confidentiality could be maintained;
- suspicion about the possible covert use of the policy as a diversionary device to deflect attention from insufficient resources;
- concerns about a shortage of skills, lack of interest, lack of adequate data and information systems, lack of willingness to focus on key issues such as appropriateness of treatment, reluctance among consultants to judge their peers and risk of attribution of blame to junior staff; and
- the view that, to the extent that audit remained a private activity internal to the medical profession, the need for greater public accountability would remain unmet.[50]

48 The Inquiry's expert on audit agreed that the reaction from members of the medical profession to the White Paper as a whole was generally very negative but:

> '… the reaction to the ideas for audit from the Royal Colleges and others speaking on behalf of the medical profession was strikingly positive.'[51]

Thus, although medical audit was promoted by the DoH and, formally, initially led by the RHA, it was also actively promoted by the Royal Colleges. In the case of the RCSE, guidelines on audit were published in 1989 that were revised and updated in 1995.[52] The Colleges in their publications reiterated the principle that medical audit was educational, confidential and non-judgmental.[53]

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[49] INQ 0011 0013; *'Medical and Clinical Audit in the NHS'*

[50] INQ 0011 0014; *'Medical and Clinical Audit in the NHS'*

[51] INQ 0011 0013; *'Medical and Clinical Audit in the NHS'*

[52] WIT 0048 0119 Sir Barry Jackson. *'The Royal College of Surgeons of England – Guidelines to Clinical Audit in Surgical Practice, March 1989'* RCSE 0001 0051 (revised June 1995)

[53] INQ 0011 0013; *'Medical and Clinical Audit in the NHS'*

49 In turn, the DoH took care to emphasise the positive aspects of medical audit, compared to existing quality control mechanisms such as the GMC's disciplinary procedures and the law. The various documents relating to medical audit avoided such terms as 'mandatory' or 'compulsory' and there was no mention of penalties for those who resisted.

50 Further, the endorsement of 'medical' audit was not supported by all:

> 'At a time of increasing recognition of the importance of a team approach in clinical work, the emphasis on uni-professional audit was criticised, by the Director of the Royal College of Nursing among others, as inappropriate and potentially divisive.'[54]

51 The commentators with a management perspective went one step further and challenged the appropriateness of segregating audit from other management initiatives relating to quality, such as resource management. The Director of the Institute of Health Service Managers argued for the integration of professional audit into a much wider model of co-operative working.

52 Doubts about the wisdom of a policy focusing on the methodology rather than the purposes of clinical quality assurance were also expressed. For example, there were concerns that:

- audit would become an end in itself;
- topics chosen would be chosen because they were easy or interesting or data already existed;
- aspects of practice might be neglected entirely because they were not susceptible to audit;
- important problems might be dealt with ineffectually through audit when they could be dealt with more satisfactorily in some other way;
- the weakness of the evidence that audit could be beneficial to patients and the known difficulty of completing the audit cycle effectively.[55]

53 Following the publication of *'Working for Patients'* new enterprises that could be called 'a healthcare quality industry', emerged, leading to a great expansion of activity. Several quality management systems began to be introduced into healthcare in the UK, including for example the King's Fund *'Organisational Audit'*, BS5750, which was developed as a pilot for organisational accreditation within the UK.[56]

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[54] INQ 0011 0014; *'Medical and Clinical Audit in the NHS'*

[55] INQ 0111 0015; Inquiry Paper

[56] See *'The Reality of Practitioner-Based Quality Improvement'*, National Institute for Nursing, 1995, WIT 0042 0444 Mrs Jenkins, for an account of the development of tools for quality assurance

Systems of Total Quality Management were also developed. In 1990, the Royal College of Nursing (RCN) launched its workbook on the Dynamic Standard Setting System or DySSSy.[57]

Creation of the NHS market

54 On 1 April 1991 the *'Working for Patients'* reforms came into operation.[58]

55 Although the legal framework for a hospital trust established by the NHS and Community Care Act 1990, empowered the Secretary of State, by Order, to establish bodies 'to assume responsibility … for the ownership or management of hospitals … or to provide and manage hospitals',[59] there was nothing in that Act setting out the duties of trust directors in respect of quality or safety. In particular, no guidance on responsibility for standards of safety or quality was given to trust directors.

56 In July 1991, the then Prime Minister, John Major, launched the Citizen's Charter, aimed at promoting good quality services in the public sector. In October 1991, the *'Patient's Charter'* was launched by the DoH.

57 The Charter was described in its foreword as:

> '… a central part of the Government's programme to improve and modernise the delivery of the service to the public whilst continuing to reaffirm the fundamental principles of the NHS.'[60]

One 'right' that was newly established by the Charter was 'to be given detailed information on local health services, including quality standards and maximum waiting times.'[61] The local health authority was to publish annual reports detailing how it was performing against national and local charter standards.

However, the National Charter standards were not legally enforceable. They were described in the Charter as:

> '… not legal rights but major and specific standards which the Government looks to the NHS to achieve, as circumstances and resources allow.'[62]

58 The Government and other bodies undertook further work on the development of audit tools. A series of frameworks were developed centrally for different audit tools. In nursing, a *'Framework of Audit for Nursing Services'* was published by the NHSME. It described an eight-stage approach to nursing audit, broadly consistent with the quality assurance cycle described in DySSSy, but using significantly different terminology.[63]

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[57] See further below at para 117

[58] See Chapter 2 for an introduction to these reforms

[59] NHS and Community Care Act 1990, Section 5

[60] HOME 0001 0003; *'The Patient's Charter'*

[61] HOME 0001 0006; *'The Patient's Charter'*

[62] HOME 0001 0004; *'The Patient's Charter'*

[63] *'The Reality of Practitioner-Based Quality Improvement'*, National Institute for Nursing, 1995, WIT 0042 0444

The introduction of clinical audit

59 By 1993, policy had shifted to recognise that separate medical audit by doctors of medical care and nursing audit by nurses of nursing care was sub-optimal. For audit to be effective, the totality of patient care needed to be studied. All members of a team delivering a particular service should together audit the work that the team was undertaking. This multidisciplinary approach was given the name 'clinical audit'.[64]

60 In November 1992 the first meeting of the Department of Health's new Clinical Outcomes Group (COG) was held. The group was chaired jointly by the Chief Medical and Chief Nursing Officers, and aimed to give strategic direction to the development of clinical audit. It advised upon the development of methodologies to identify and achieve improved outcomes.[65]

61 On 23 April 1993 the NHSME sent out a letter[66] that noted the central development of the clinical audit programme. A policy statement setting out the main strands of the clinical audit strategy had been commissioned by COG and was soon to be published. Whilst funding for medical and nursing and therapy audit was still to be separately identified in 1993/94, an additional allocation of £3.2 million had been made to facilitate the development of multi-professional clinical audit. In 1993/94, Regions were asked to promote the use of the clinical audit programme as part of the purchaser's role in contracting.

62 The letter explained that the NHSME needed to be assured that the appropriate mechanisms and procedures were in place to underpin the development of clinical audit. It required the regional general managers to set out their proposals for achieving this aim in the letters submitting the 1992/93 annual reports.

63 Annexed to the letter was a paper, *'Audit and the Purchaser/Provider Interaction'*,[67] prepared by a working group of the Regional Medical Audit Coordinators Committee and Conference of Colleges Audit Group.[68] The paper was an aid to discussion of clinical audit. It set out the key features of clinical audit, which it was hoped would lead to improvements to the care of patients within five years:

- 'Audit will be largely multidisciplinary (clinical) audit and part of hospital-wide quality management programmes.
- 'Audit will be informed by purchaser/provider and public/patient as well as professional (college) priorities.
- 'The findings of audit will inform service development and purchasing.

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[64] UBHT 0273 0278; (EL(93) 59)NHSME circular, WIT 0108 0047 Dr Roylance, WIT 0120 0378 Mr Wisheart

[65] *'Clinical Audit: Meeting and Improving Standards in Healthcare'*, DoH, 1993, p. 10

[66] UBHT 0028 0014; EL(93)34 NHSME circular

[67] UBHT 0028 0017

[68] Dr Ian Baker, then Consultant in Public Health Medicine at the B&DHA, was a member of the Working Group. He was a representative of the Faculty of Public Health Medicine on the Academy of Royal Colleges Committee on Medical Audit WIT 0074 0037

- ‘Audit will be an integrated part of routine activity and continuing professional education.
- ‘Audit will increasingly demonstrate its effectiveness and cost effectiveness to provider, purchaser and the public.
- ‘Audit will increasingly focus upon outcomes and their relationships to the processes of care.
- ‘Audit will be a shared process bridging primary and secondary care sectors.’[69]

64 Dr Walshe told the Inquiry about the shift from medical to clinical audit during 1991 to 1995. Counsel to the Inquiry asked Dr Walshe whether clinical audit replaced medical audit or whether it was common to find the two operating in tandem. He replied:

> ‘It generally replaced and it was part of the wider shift towards for example more managerial involvement, that there was this move towards a more multi-professional approach to audit and quality improvement. The department had established, back in 1990, a separate nursing and therapies audit programme run by a separate part of the Department of Health, part run by the Chief Medical Officer’s section and part by the Chief Nursing Officer’s section. In 1993 they recognised, as did others, that that division did not make sense and they brought the two together and encouraged Trusts to bring the systems together. What usually emerged within a Trust was a Clinical Audit Committee with a more multi-professional membership, although the membership of those committees tended to be quite medically dominated.’[70]

65 In July 1993 the DoH published a policy document, *‘Clinical Audit — Meeting and Improving Standards in Healthcare’*. It set out a strategy for moving towards multi-professional clinical-audit, with an emphasis on clear definitions, and quality and outcome of care. This document stated:

> ‘A key component of demonstrating quality of clinical care is identifying the benefit of care in terms of improved health, patient satisfaction and reassurance and improved quality of life, i.e. clinical outcome. Clinical outcome usually reflects the consequence of the collective efforts of a number of professionals, consequently while it was necessary, initially, to set up the audit programme on a uni-professional basis, there is now a need to move to a more integrated approach to audit.
>
> ’Therefore while uni-professional audit will continue to be essential, where a mix of professionals are involved in the care of patients, multi-professional audit has

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[69] HAA 0009 0089; *‘Audit and the purchaser provider inter-action’*

[70] T62 p. 51 Dr Thomas

> already become established e.g. Accident & Emergency, Psychiatry and Medicine for the Elderly, as audit on any other basis would have been of limited value.'[71]

Further guidance was subsequently given by the DoH publication *'The Evolution of Clinical Audit'*.[72] It stated that items which would indicate that audit is developing successfully are that it is:

- 'undertaken by multi-professional healthcare teams;
- 'focused on the patient;
- 'performed within a culture of continuing evaluation and improvement of clinical effectiveness focusing on patient outcomes.

> 'The first two aspects are closely related. By making the patient central to the audit process, the professions that need to be involved in the audit will automatically be identified. (There is however still a role for uni-professional audit, where professions can clearly identify their own singular contribution.)'[73]

66 Dr Walshe considered that after the introduction of clinical audit there was no longer a role for a medically orientated form of audit except in some situations:

> 'I think it depended on the specialty, the area and the quality issues that you were addressing, but I think most people would agree that most quality problems do not belong to an individual profession. When you start to examine why a particular problem or difficulty exists, it quickly rolls out, given the complexity of the process of care, into the territory of other professional groups. So clinical audit seemed much better fitted to dealing with the very multi-professional nature of most areas. Clearly there are some specialties who tend to work much less multi-professionally than others, and there was no purpose in having a multi-professional process if the issue simply … affected the anaesthetists. But the default, I think, was meant to be that these processes should be multi-professional, because most of the time that was what was needed.'[74]

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[71] *'Clinical Audit: Meeting and Improving Standards in Healthcare'*, DoH 1993

[72] Circulated under cover of EL(94)20, 28.2.94; HAA 0009 0026. The letter noted that the guidance was prepared by a working group of Regional Audit Co-ordinators and endorsed by COG

[73] *'The Evolution of Clinical Audit'*, DoH 1994c

[74] T62 p. 52–3 Dr Walshe

Changes in funding 1994/95

67 Funding for the national audit programme to 1994/95 was provided as follows:

Table 1: Audit funding allocations[1]

	Medical HCHS[2] (£m)	Primary care (£m)	Nursing/Therapy (£m)	Total (£m)
1989–91	28.0	5.0	–	33.0
1991–92	48.8	12.5	2.3	63.6
1992–93	42.1	12.5	7.2	61.8
1993–94	41.9	12.2	8.2	62.3
Totals	160.8	42.2	17.7	220.7

1. *'Clinical Audit: Meeting and Improving Standards in Healthcare'*, DoH, 1993
2. 'Hospital and Community Health Services'

NB. £3.2 million was provided in 1993/94 to 'pump prime' multi-professional clinical audit

68 On 23 April 1993 the NHSME issued EL(93)34 entitled '*Clinical audit in HCHS: allocation of funds 1993/94'*. This stated that:

> 'Funding for clinical audit from 1994/95 will be included in overall allocations to Regions. Regions will be expected to maintain and develop clinical audit and will be held accountable in this area; specific criteria on which performance will be measured after 1993/94 will be agreed at a later date.'[75]

Thus, the ring-fenced funding allocation for audit was to cease in 1994/95.[76]

69 In the following year, on 28 February 1994, the NHSME issued EL(94)20 entitled '*Clinical Audit: 1994/95 and beyond'*. This contained further advice about the changes in funding arrangements that were to take place in the coming year. It attached guidance upon the funding of audit through the contracting process that had been developed by a working group commissioned by COG. Whilst the advice might come too late for full implementation by many purchasers/providers in the current purchasing round, it was hoped it would assist in the future. The guidance noted that:

> 'From April 1994 funding for HCHS [Hospital and Community Health Services] clinical audit will be included in Regional Health Authorities (RHAs) recurrent funding on a resident population share basis. These monies will be the sum of monies previously set aside for medical and nursing and therapy audit with one major adjustment. Allocations to regions for medical audit purposes, previously calculated on a whole time consultant equivalent basis, will now be allocated on the basis of resident population.

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[75] UBHT 0028 0014; *'Clinical Audit in HCHS'*

[76] UBHT 0028 0018; *'Clinical Audit in HCHS'*

> 'The cessation of ring fencing allows funding to become recurrent, allowing longer term plans for audit to be developed at provider and DHA level. It also allows audit to address more adequately questions of healthcare needs and healthcare effectiveness and to become fully integrated in the mainstream business of provider units/trusts/primary care and health purchasing authorities.[77] The transition of funding should be undertaken in such a way as to enhance the early steps in the evolution from medical to clinical audit.'[78]

The guidance also noted that the recommended approach included:

> '… an agreed contract between the DHA and each service provider for clinical audit, specified in terms of facilities and including some form of indicative workload agreement.'[79]

The role and responsibilities of each group were also set out in the directive. RHAs were to be:

> '… accountable from 94/95 for the maintenance and development of clinical audit. The new NHSME Regional Offices will have a performance monitoring role for both purchasers and providers in the future.'[80]

DHAs and FHSAs were told that their plans:

> '… should indicate the purchasing authority's long term vision for audit and incorporate priorities which have been jointly agreed between purchaser and provider.'[81]

Units and trusts were to:

> '… develop appropriate structures and processes to achieve effective clinical audit.'[82]

70 Thus, in the financial year 1994/95 the funding responsibility for audit moved from RHAs to the purchasing DHAs. Funding for audit became part of the contract between the purchaser and the provider. Furthermore, funding for medical, nursing and therapy audit was no longer separately allocated by the DoH; instead one allocation for clinical audit was made. Figure 7 shows the organisation of clinical audit after April 1994:

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[77] This paper uses the terms DHA and FHSA but recognises the move towards unincorporated associations of DHAs and FHSAs in some regions which will undertake the functions described pending changes in legislation

[78] HAA 0009 0029; *'Clinical Audit; 1994/5 and beyond'*

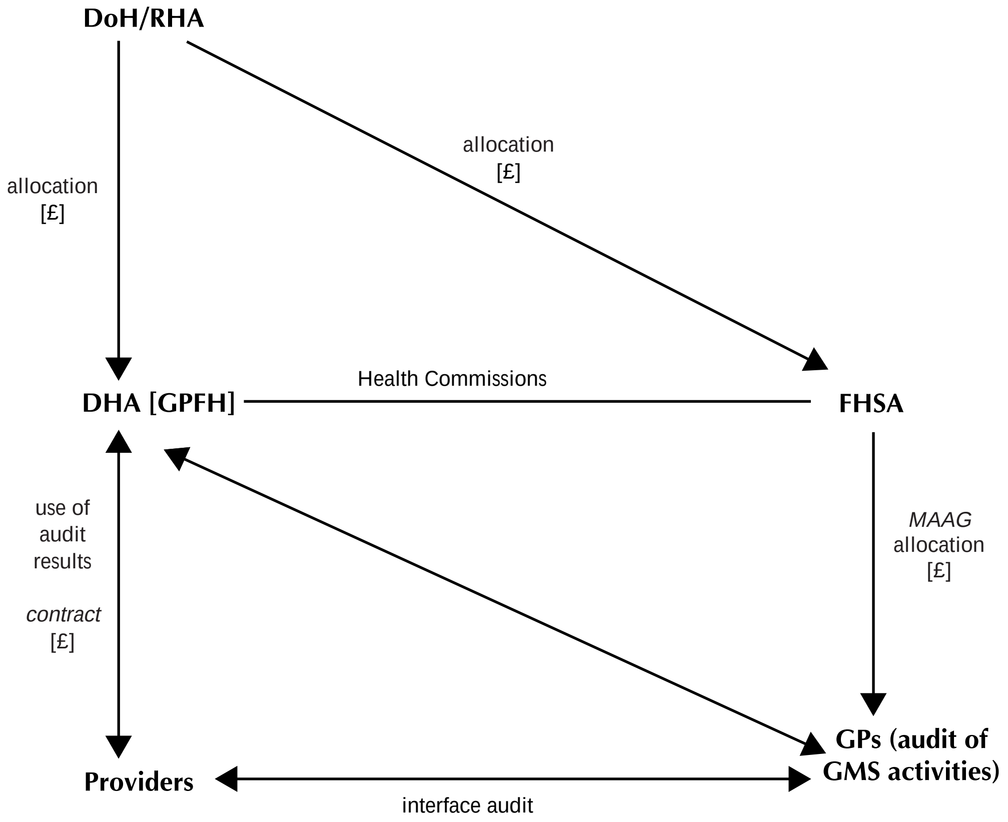
[79] HAA 0009 0030; *'Clinical Audit; 1994/5 and beyond'*

[80] HAA 0009 0031; *'Clinical Audit; 1994/5 and beyond'*

[81] HAA 0009 0032; *'Clinical Audit; 1994/5 and beyond'*

[82] HAA 0009 0033; *'Clinical Audit; 1994/5 and beyond'*

Figure 4: The organisation of clinical audit (after April 1994)[1]



Key

DHA	District Health Authority	GPs	General Practitioners
DoH	Department of Health	GPFH	General Practitioner Fund Holders
FHSA	Family Health Service Authority	MAAG	Medical Audit Advisory Groups
GMS	General Medical Services	RHA	Regional Health Authority

1. Reproduced with the kind permission of the author, Exworthy M. *'Purchasing Clinical Audit. A study in the South West Region'*, University of Southampton, July 1999

Clinical effectiveness

71 Towards the end of the period of the Inquiry's Terms of Reference, the focus of the Government's guidance shifted away from the organisation and monitoring of audit to considerations of effectiveness. An effective clinical audit programme was defined as one which involved balanced topic selection, employed adequate audit processes, secured implementation of audit results and was comprehensive (involving all aspects of healthcare).[83]

72 National policy guidance had shown an increasing emphasis on the improvement of clinical effectiveness since 1993, as shown in Figure 5:

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[83] INQ 0011 0013; *'NHS Executive: The New Health Authorities and the Clinical Audit Initiative: Outline of Planned Monitoring Arrangements'* (EL(95)103) Leeds: DoH NHS Executive 1995

Figure 5: National policy guidance on improving clinical effectiveness[84]

Dec 1993
EL(93)115. The first EL to make explicit reference to clinical effectiveness, it set out the range of initiatives in train to provide information on effectiveness, and recommended guidelines in seven specific clinical areas. Health authorities were asked to report on their progress in using these guidelines in contracting. [1]

July 1994
EL(94)55. Priorities and planning guidance for the NHS for 1995/96. Medium term priority G called on health authorities to '… Invest an increasing proportion of resources in interventions which are known to be effective … reduce investment in interventions shown to be less effective'.[2]

Sept 1994
EL(94)74. Provided an update on the sources of information on clinical effectiveness that were available, but did not ask health authorities and trusts to take specific action. [3]

June 1995
EL(95)68. Priorities and planning guidance for the NHS for 1996/7. Medium term priority C was to 'improve the cost effectiveness of services throughout the NHS, and thereby secure the greatest health gain from the resources available, through formulating decisions on the basis of appropriate evidence about clinical effectiveness'. It called for health authorities to show they had 'strategies to secure sustained and comprehensive improvements in clinical effectiveness'and significant shifts in investment on the basis of effectiveness.[4]

Dec 1995
EL(95)105. Provided a further update on the importance of clinical effectiveness and the growing range of sources of information. Attached a list of interventions being researched and said they should not be used in routine care at present.[5]

1. HAA 0164 0173 – 0182 Guidance EL(90)115
2. HAA 0164 0199 – 0221 Guidance EL(94)55
3. HAA 0169 0136 – 0154 Guidance EL(94)74
4. HAA 0164 0139 – 0144 Guidance EL(95)68
5. HAA 0164 0275 – 0280 Guidance EL(95)105

73 By 1996 audit programmes were no longer seen as the central mechanism for improving the quality of care, as they had been in 1989, but rather as a part of the broader work on improving clinical effectiveness.[85]

The setting of standards

74 Central to the concept of audit, as defined at para 5 above, was the idea that standards of clinical care should first be set; then performance assessed, and possible improvements in practice identified and implemented.

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[84] Reproduced with the kind permission of the authors Walshe K and Ham C, *'Acting on the evidence: progress in the NHS'*, Health Services Management Centre, Birmingham: The NHS Confederation, 1997

[85] INQ 0011 0013

75 Dr Winyard stated:

> 'In the middle and late 80s there was developing interest in more direct and locally based medical audit in which individuals and groups of clinicians would define the standards that they wish to achieve, compare their actual practice with those standards, and institute remedial action where the standards were not being achieved, re-auditing performance subsequently to ensure that the remedial actions had been successful. This process became known as the Audit Cycle and forms the basis of all subsequent medical and clinical audit. In the year before the publication of *"Working for Patients"*, the Department funded a number of the Medical Royal Colleges to develop medical audit projects on this basis. The then Chief Medical Officer also secured the endorsement of all College Presidents that such activity should be an integral part of routine clinical practice. However, at that stage medical audit was very much a minority activity pursued by enthusiasts.'[86]

Increasing pressure developed for doctors' clinical activity to be included in NHS initiatives concerning quality. For example, evidence emerged about unexplained variations in practice related to length of stay, hospital admission rates and variations in outcome. A number of arguments about hospital clinical competence were well publicised. There was an increase in the willingness of pressure groups to publicise information about substandard services.[87]

76 Professor Sir George Alberti, President Royal College of Physicians (RCP), pointed to the difficulty of measuring quality of care and outcome of care and said that comparative information evidencing national standards did not start to emerge until after 1990.[88]

77 Counsel to the Inquiry referred Sir Graham Hart, NHS Management Board Director of Operations from 1985 to 1989 and from March 1992 to 1997 Permanent Secretary at the DoH,[89] to the 1983 *'NHS Management Inquiry Report'* in the following exchange:

> 'Q. In the Griffiths report — we will just have a look at some of the general comments which he made … This comes from Griffiths, it is page 10 of what is acknowledged to be a short but effective report. In paragraph 2, under his general observations, he describes the NHS not having a profit motive but being enormously concerned with the control of expenditure: "Surprisingly, however, it still lacks a real continuous evaluation of its performance against criteria such as those set out above … Rarely are precise management objectives set. There is little measurement of health output. Clinical evaluation of particular practices is by no means common and economic evaluation of those practices extremely rare."

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[86] WIT 0331 0003 Dr Winyard, Medical Director of the NHS Executive and Deputy Chief Medical Officer from 1993 to 1998

[87] INQ 0011 0008; *'Medical and Clinical Audit in the NHS'*

[88] T9 p. 43 Professor Sir George Alberti

[89] WIT 0040 0001 Sir Graham Hart

> ‘Leaving aside the economic and leaving aside the question of output, the number of operations done, clinical evaluation of particular practices is by no means common.
>
> ‘In this paragraph as a whole, what Griffiths appears to be observing, and the implication is, complaining about, is that the NHS had no proper measurement of the quality of the care it was providing in general terms.
>
> ‘First of all, from your own perspective, was he probably right about that, at the time?’
>
> ‘A. Yes. I mean, I would say, I think, what he was saying was that there was no system, if you like. Some of these things happened, but they did not happen in an organised and systematic way. I think that is true. He was spot-on, there.’[90]

78 The opinion of Professor Sir Kenneth Calman, Chief Medical Officer (CMO) for England 1991–1998[91] on the issue was explored in the following exchange:

> ‘Q. … Sir Graham Hart … has told us that, throughout the period of particular concern to this Inquiry, there was no proper measurement of the quality of care which was available within the NHS, looking at the question of the delivery of care by hospitals.
>
> ‘Is that broadly your view?’
>
> ‘A. No, I do not think that would be my view, because for really a very long time, the outcome of the health care has been part of the responsibilities of individual doctors and indeed trusts and before that, hospital boards. It would be impossible to manage a system without knowing what the outcome was. That was done in a variety of different ways over the years, but I think in terms of the outcomes of healthcare, there are difficulties in measuring sometimes the outcome of health care. Mortality is a very relevant way to measure, but once you move into other areas like quality of life, for example, it becomes more difficult to measure, but in terms of the outcome of healthcare, 30-day mortality, wound infection rates have been recorded and reported for a very long time.’[92]

79 Sir Barry Jackson said that the:

> ‘… setting of the standards have created considerable problems in many areas, and in 1989/1991 those standards in most instances were not recognised; therefore to all intents and purposes, they did not exist.’[93]

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[90] T52 p. 34 Sir Graham Hart

[91] WIT 0336 0001 Professor Sir Kenneth Calman

[92] T66 p. 5 Professor Sir Kenneth Calman

[93] T28 p. 92 Sir Barry Jackson

80 Dr John Roylance, Chief Executive of UBHT 1991–1995, was asked about a paediatric cardiology report of March 1992, set out upon the MAC standard form. The 'audit' topic reviewed was paediatric cardiac surgical mortality for 1991. The document contained comparisons with previous years.[94] Dr Roylance gave evidence that he regarded this kind of exercise not as audit but as a review of recent outcomes.[95]

81 Looking at the same document, Sir Barry Jackson agreed with this emphasis upon the centrality of standard-setting:

> 'In the strict meaning of the term, I would agree with Dr Roylance, as I said earlier, because there is no standard set there with which to compare the mortality other than previous years, but there is no acceptance written there that the previous years' figures are the standard to which they were judging the current years' standard.'[96]

82 Sir Barry Jackson further gave evidence that if the standard used was in the form of national indicators of outcomes, drawn, for example, from the cardiothoracic surgeons' register, this was not audit in the formal sense, unless:

> '… it has been defined and agreed initially that that is the standard to which one is aspiring …'[97]

83 Dr Kieran Morgan stated:

> 'I believe Mr Jackson is correct when he has asserted that clinical audit is strictly concerned with setting standards and then auditing activity against those standards. However, there are many preliminaries to a clinical team reaching the stage where they can set standards in an authoritative way and then measure their activity correctly. It is part of the quality assurance concept for providers and commissioners of services to observe that this process is taking place.'[98]

84 Dr Morgan further commented on Dr Roylance's evidence:[99]

> 'Dr Roylance's view in his statement is that true clinical audit was happening rather infrequently and, of course, this depends on the definition of audit. The early definition spoke of systematic, critical appraisal of clinical activity and includes case note review by peers, etc. This kind of activity was not uncommon throughout the Trusts, including the UBHT. However, if one uses a more modern definition of clinical audit – the explicit setting of standards and vigorous measurement of activity to assess the extent to which its standards have been met – then Dr Roylance is right.'[100]

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[94] UBHT 0061 0161; paediatric cardiology report 1992

[95] T25 p. 42 Dr Roylance. He also made the point that audit as he understood it was not only about measuring morbidity and mortality rates for surgical procedures and the like, but also included, for example, the monitoring of the effectiveness of equipment

[96] T28 p. 91 Sir Barry Jackson

[97] T28 p. 91 Sir Barry Jackson

[98] WIT 0307 0018 Dr Morgan

[99] T25 p. 36 Dr Morgan

[100] WIT 0307 0014 Dr Morgan

The nature of audit

85 In 1990 the Standing Medical Advisory Committee (SMAC) wrote:[101]

> 'The essential nature of medical audit is a frank discussion between doctors, on a regular basis and without fear of criticism, of the quality of care provided as judged against agreed standards … It should lead to action where practice has not matched the agreed standards so that the quality of medical care is improved. The principles of medical audit can be compared with those of feed back loop control in which the expected standard of care is defined in whatever terms are agreed to be appropriate, reality is compared with the defined standard and practice is changed in the light of this comparison. This is referred to as the "audit cycle".
>
> 'Although sharing similar objectives with medical audit in respect of medical education and training, the "grand round" or "interesting case" type of clinical meeting does not meet the requirements of medical audit. Medical audit is a systematic structured procedure with the express purpose of improving the quality of medical care. Wherever possible it should be quantified.
>
> 'Medical care can be considered in terms of structure, process or outcome. Structure is concerned with the amount and type of resources available, for example the condition of buildings, the number of beds available and staffing levels. These are easy to measure but are not necessarily good indicators of the quality of care provided. Process relates to the amount and type of activity expended in the care of a patient. Unless resources are severely limited process has more significance than structure and in many circumstances it is the only measure available. The most relevant indicator of quality of care is outcome. … Examples of outcome measures include mortality, such as perinatal mortality and perioperative deaths, residual disability, relief of symptoms and patient satisfaction …'

Types of audit

86 In 1990, SMAC wrote:

> 'There are two main approaches to the practice of medical audit. They are (i) retrospective internal audit within a specialty, hospital, general practice or district community in which records are used to review past events, and (ii) concurrent audit which is a continuous assessment of patient management. In both types of audit results are compared with agreed standards, which may be implicit or explicit, protocols or criteria. We feel that retrospective internal audit is likely to be the most appropriate approach for the introduction of medical audit but these approaches to audit are not mutually exclusive.

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[101] *'The Quality of Care'*, report of the Standing Medical Advisory Committee, DoH, 1990, paras 4.1–4.3

> 'Ideally the basis of audit should be outcome but in practice it is often not. Usually audit of "process" is carried out on the assumption that good process gives rise to good outcome. The subject of audit may include administrative processes (such as medical records, referral and discharge letters), clinical processes (use of drugs, investigations and procedures), clinical condition (classified by diagnostic category) or outcome (return to work, ambulation or unexpected death).
>
> 'Medical audit is now increasingly recognised as a component of medical practice and therefore all doctors should be expected to take part. The main components in the process are:
>
> - 'identification of subject matter to be assessed
> - 'establishment of suitable criteria agreed locally against which to judge performance. Criteria should be based on the best published figures where available or on criteria provided by the Royal Colleges or other appropriate group if such criteria exist
> - 'identification and analysis of any problems
> - 'refining the above criteria in the light of experience
> - 'formulation of recommendations and follow-up action
>
> 'Follow-up action is an absolutely essential feature of medical audit without which the justification for medical audit is lost. Medical audit should lead to changes in the organisation and availability of services, clinical policy and clinical practice with consequent improvement in the quality of medical care as measured by appropriate indicators.'[102]

87 Further, as a national policy upon the introduction of audit developed, guides to the process of audit began to be published.[103]

88 The Quality of Practice Committee of the RCA noted:[104]

> 'Almost any medical activity may be usefully subjected to audit. Included under this heading are:
>
> 'Record keeping
>
> 'Workload and staffing
>
> 'Morbidity and mortality

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[102] *'The Quality of Care'*, report of the Standing Medical Advisory Committee, DoH, 1990, paras 7.1–7.2.1

[103] See, e.g., Shaw C. *'Medical Audit – a Handbook'*, London: King's Fund, 1989

[104] WIT 0065 0596 Professor Strunin, May 1991

> ‘Provision and use of specific services (e.g. operating theatre time, ITU, pain services, etc.)
>
> ‘Education and training.’

89 Dr Baker, in his evidence, noted the debate between the UBHT and the District on the role of measures of process and of outcome. The UBHT wished to concentrate on measures of outcome.[105] He observed:

> ‘By the end of 1995 there was recognition within the medical literature and amongst professional and health service organisations that audit carried out productively to benefit patients was an exacting task, no less so than any other quantified approach to the measurement of quality or resolution of uncertainties. The National Centre for Clinical Audit published *“Good Practice in Clinical Audit”* in 1996 which summarised in particular the difficulties of audit of clinical outcome and encouraged audit of processes of care in relation to explicit criteria. Auditing clinical outcomes requires essentially that cause and effect are well understood in relation to the contributory components of healthcare and their actual relationship to variations in outcomes. In most instances of healthcare this relationship is not well understood.’[106]

The effectiveness of the national audit programme

90 The Inquiry received evidence upon the successes and failures of the Government’s introduction of medical and, subsequently, clinical audit.

91 The Inquiry was also referred[107] to a number of research studies that had been undertaken to assess the impact and effectiveness of the national audit programme.[108]

92 The case study of the implementation of audit in general medicine in four hospitals undertaken in 1991/92 on behalf of the King’s Fund[109] found that:

- ‘audit programmes were formulated by local clinicians on an ad hoc basis and managers had little role in shaping the audit process
- ‘overall attendance at audit meetings averaged two-thirds to three-quarters of all those designated as part of the general medicine audit group

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[105] See para 246

[106] WIT 0074 0040 Dr Baker

[107] Walshe K and Ham C. *‘Acting on the evidence: progress in the NHS’*, NHS Confederation, 1997

[108] These included: Buttery, Walshe, Coles, Bennett. *‘Evaluating Medical Audit: The development of audit – Findings of a national survey of healthcare provider units in England’*, CASPE Research, 1994; Morrell C, Harvey G, Kitson A. *‘The Reality of Practitioner-Based Quality Improvement: A Review of the Use of the Dynamic Standard Setting System in the NHS of the 1990s’*, National Institute for Nursing, 1995; Willmot, Foster, Walshe, Coles. *‘Evaluating Audit: A review of audit activity in the nursing and therapy professions – findings of a national survey’*, CASPE Research, 1995; Buttery, Walshe, et al. *‘Evaluating Audit: Provider Audit in England: A review of twenty-nine programmes*, CASPE Research, 1995; National Audit Office. *‘Clinical Audit in England’*, 7.12.95. Further evaluative studies were assessed in the Inquiry paper on *‘Medical and Clinical Audit in the NHS’*, INQ 0011 0016

[109] Kerrison S, Packwood T, Buxton M. *‘Medical Audit: Taking Stock*. London: King’s Fund, 1993; T62 p. 3 Dr Walshe

- ‘in audit meetings, doctors did not act as peers but rather as consultants and juniors in a hierarchical relationship
- ‘there was very little planning and the entire audit cycle was usually collapsed in a single meeting
- ‘there was often uncertainty about what should happen as a result of audit or who was responsible for taking any action
- ‘audit activities concentrated on the technical aspects of inpatient care
- ‘there was very little use of hospital-wide information technology systems and, in almost all cases, the sample sizes used were small
- ‘most criteria were developed locally with little reference to external guidelines’.

93 The Clinical Accountability Service Planning and Evaluation (CASPE)[110] study of the impact of the medical audit programme[111] surveyed provider units towards the end of 1993. It found:

- ‘Less than a third (29%) of audit programmes were directed by a clinical audit committee, many (31%) had some combination of medical and other audit committees, but 39% had solely a committee for medical audit. The membership of audit committees of all types was dominated by medical staff, particularly from acute specialties. Virtually all audit committees were chaired by a consultant.
- ‘The development of medical audit has been well resourced, almost wholly from centrally ringfenced funding … Most of the resource has been used to establish and staff audit departments to provide information systems and technology.
- ‘It is difficult to assess the effectiveness of resource usage from a survey such as this. Almost all providers had some form of audit department or audit staff. Many audit staff were educated to degree level and a substantial minority held some clinical professional qualification. There was considerable variation between provider units in the titles, grading, qualifications and apparent responsibilities of audit staff.
- ‘The audit process was well established in almost all healthcare provider units, with about 95% of specialties holding some form of audit meetings. However, it was unusual for other clinical professionals (apart from doctors) and for managers to be involved in these review meetings. While much audit activity

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[110] CASPE is an organisation that undertakes research into audit mechanisms for a variety of organisations, including the DoH; T62 p. 4 Dr Walshe

[111] Buttery, Walshe, Coles, Bennett. *‘Evaluating Medical Audit: The development of audit – Findings of a national survey of healthcare provider units in England’*, CASPE Research, 1994

revolved around traditional case note reviews and mortality and morbidity reviews, the survey found a growing use of more systematic and explicit approaches to quality measurement.

- ‘Audit has caused or facilitated change in a wide range of areas, although the extent to which audit has resulted in meaningful change was not clear. In some instances it seems to have influenced clinical practice and management and encouraged the development of written guidelines and protocols. It has also affected the organisation and management of healthcare services, by stimulating organisational change and enabling some service developments and expansion. Moreover, audit was reported to have contributed to changing the culture of healthcare providers, developing a greater sense of clinical accountability, openness, interprofessional understanding and sensitivity to patients’ needs.’[112]

The primary barriers to the development of audit, according to the study, may be summarised as follows:[113]

- ‘The pressure of competing programmes of structural change and other priorities that made it difficult for clinicians and managers to allocate the time and effort needed to establish an effective audit programme.

- ‘Weak links between the medical audit programme and the provider unit in which they were based. In many healthcare providers, medical audit was organisationally, functionally and philosophically quite separate from the service or business of the provider unit itself. This separation in part reflected the way in which the medical audit programme was directed and managed centrally. The emphasis placed on clinical leadership, the linking of audit to professional education, the deliberately limited role of managers, and the ring-fenced funding mechanism used to allocate resources all tended to foster a certain distance and detachment between audit programmes and provider clinical and managerial structures. However, many items of data from the survey seemed to indicate that this situation was changing, and that provider unit Boards and senior managers were becoming more involved in audit.

- ‘Limited investment in the teaching and development of appropriate skills. The potential training needs of clinicians did not seem to have been fully recognised or addressed by many providers. In contrast, a substantial proportion of funds had been invested in information technology systems, with uncertain benefits. In fact, because patient records were far more important as a source of audit data, it might be argued that investment should have been directed to towards improving the reliability and accessibility of those records rather than towards new computer systems.

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[112] Buttery, Walshe, Coles, Bennett. *‘Evaluating Medical Audit: The development of audit – Findings of a national survey of healthcare provider units in England’*, CASPE Research, 1994, p. 1–2

[113] Buttery, Walshe, Coles, Bennett. *‘Evaluating Medical Audit: The development of audit – Findings of a national survey of healthcare provider units in England’*, CASPE Research, 1994, p. 101–7

- ‘The management of audit programmes was poor; many of those involved in establishing and directing audit programmes probably had little previous experience in programme or project management. As a result, the planning of audit programmes was inadequate. Monitoring and reporting arrangements were generally better, but were usually focused on monitoring the process of audit – such as meetings or data collection – rather than the impact of audit on the quality of care. “Moreover, when monitoring or reporting show that particular specialties or departments are not performing as they are expected or required to, most providers have few mechanisms for taking action or intervening to address these deficiencies in the audit process.”

- ‘The choice of audit topics was generally motivated by individuals’ interests or enthusiasms. By choosing the focus of audit projects more carefully, substantial improvements in the resulting yield of changes in practice might be achieved.

- ‘Much audit continued to tread familiar ground, using long-established approaches such as case-note review and mortality and morbidity review. “However, a substantial proportion of providers have begun to use more systematically organised and explicit methods – chiefly the auditing of care against explicit standards or criteria. Since many specialties were already holding regular meetings to review selected cases or to discuss complications in the past, it could be suggested that some relabelling of these existing activities as audit has taken place. It also appears from the survey, that there is now a substantial volume of new activity which is quite different from the more traditional meetings of the past.”’

94 The CASPE study also found that by the end of 1993, clinical, as opposed to medical, audit was not well established:

> ‘It seems that medical audit has become a part of the fabric of practice for almost all medical staff. It would be difficult to find many doctors in the HCHS [Hospital and Community Health Services] whose working life has not been touched in some way by audit over the last four years. While this does not mean that medical staff are all committed to audit, or involved in assessing the quality of their own practice, it is a considerable achievement. Among other clinical professions – such as nurses, therapists, pharmacists, scientists and others – participation is probably much lower. This is not necessarily because members of those professions have not wanted to be involved – they may well exhibit the same spectrum of opinion as medical staff; from enthusiasm to disinterest in audit. Rather, it is because the medical audit programme was led by doctors and was focused on securing the involvement of medical staff – the involvement of other professional groups has often not been welcomed or encouraged. Indeed, enabling these much larger and more numerous professional groups to take part in clinical audit in the future presents some real challenges.’[114]

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[114] Buttery, Walshe, Coles, Bennett. *‘Evaluating Medical Audit: The development of audit – Findings of a national survey of healthcare provider units in England’*, CASPE Research, 1994, p. 105

95 The study noted that: '… for the many clinicians who were participating in audit for the first time, the prospect of sharing potentially sensitive information with colleagues from other disciplines was not appealing, especially at first.'

96 '*Evaluating Audit: Provider Audit in England: A review of twenty-nine programmes'*[115] set out seven 'critical success factors' for clinical audit programmes. These were:

> '**Clinical Leadership** This seemed to be the most important single determinant of an audit programme's success.
>
> '**Vision, strategy, objectives and planning** Providers with successful audit programmes had an explicit vision of what the audit programme was there to do, which had been communicated to everyone and was kept to consistently.
>
> '**Audit staff and support** Successful audit programmes had good audit staff who were recognised as an expert resources for advice and support and valued as important members of the team.
>
> '**Structures and systems** Many audit programmes faltered because they lacked basic structures and systems, e.g. for managing the workload, prioritising, timetabling, monitoring and reporting.
>
> '**Training and education** Few providers had recognised the need for training in audit skills which, despite their professional background, many clinicians did not already possess.
>
> '**Understanding and involvement** As well as good communication, training and leadership, successful participation in audit programmes also depended on resources, time and appropriate incentives and sanctions.
>
> '**Organisational environment** Well-managed providers with good personal and professional relationships among staff and with purchasers were able to establish better audit programmes. Dysfunctional organisations with a history of internal and external conflict and dissent found establishing audit more difficult. Thus the organisations likely to be most in need of audit and quality improvement were probably the least able to make it happen.'

97 In oral evidence to the Inquiry, Dr Walshe criticised the professional guidance from the DoH on the earlier approach of medical audit:

> 'I think it would be true to say that the Department's proposals for medical audit in the NHS at that point in time could be criticised with hindsight as not being particularly directive, not if you like mandating a particular process, not requiring

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[115] Buttery, Walshe, Coles, Bennett. *'Evaluating Medical Audit: The development of audit – Findings of a national survey of healthcare provider units in England'*, CASPE Research, 1994

> the organisations to undertake audit in a particular way and for also perhaps not putting in place particularly strong incentives or requirements for people to engage in this process.'[116]

98 Professor Sir George Alberti told the Inquiry[117] that it appeared that the DoH's focus was more on throughput and waiting lists than on outcome or quality of care and that the lack of guidance given in the area of audit was a reflection of this:

> 'They were not interested in results; they were interested in as many people passing through the system as possible for as low a cost as possible … commercial considerations did seem to enter into it rather strongly.'[118]

99 Dr Ernest Armstrong, the Secretary of the British Medical Association (BMA) from 1993 to date, took the view that audit, be it medical or clinical, had not been successful thus far. He said that evidence showed:

> '… clinical audit has not actually delivered the results that early enthusiasts, and I include myself amongst those, might have expected. We still have a long way to go to change the culture to allow doctors to take part in an open and responsive way in a supportive managerial structure that will ensure that we are not in a punishment mode; that when we find things not as they should be, we do not punish them [*sic*]; we have to put them right.'[119]

100 He said that the evidence also showed that the BMA had encouraged doctors:

> '… to take part in medical audit, in clinical audit, to discuss with peers, not only with medical peers but actually recognising that this involves discussing with peers in the wider health care team, the outcomes of their work, in a situation where, of course, as you would expect, people who do not have a problem turn up and people who do have a problem do not, and do not take part.
>
> 'The question is, how does one encourage people to learn that by taking part they can only benefit, that this is not a threatening or censorious procedure, it is a learning exercise for everyone: one in which the aim is to generate support for something which is not as good or not at the standard that it was supposed to be and to generate a method of putting it right so that the next time you audit it, it is where it is supposed to be?
>
> 'That is very difficult and it is particularly difficult if doctors think that by talking frankly and fully and openly with their colleagues about just why they are not at the standard, the outside standard, however it is measured, that they ought to be, the result is going to be some kind of disciplinary action … and then one, I think,

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[116] T62 p. 6 Dr Walshe
[117] T9 p. 42 Professor Sir George Alberti
[118] T9 p. 42 Professor Sir George Alberti
[119] T20 p. 90–2 Dr Armstrong

> should be able to understand the reluctance of doctors to take part and the need for the BMA in doing as I said earlier this morning, its role of describing what leading edge looks like and where people ought to be in advocating doctors to move closer to the leading edge.'[120]

The constraints (if any) placed on confidentiality and/or the assurance of anonymity[121]

101 The implementation of audit in the late 1980s and early 1990s and, in particular, the development of information technology systems to support it created an accessible collection of data relating to the performance of individual clinicians. The perception was that this information was capable of misinterpretation and was potentially damaging both to individual clinicians and to public confidence in the healthcare system.[122]

102 Clinicians were concerned that data collected could be disclosed to patients or to patients' representatives in court actions for clinical negligence. They were also concerned about disclosure to non-professionals or managers, who might misuse it for 'whatever purpose'.[123]

103 In 1990, SMAC wrote:[124]

> 'Concern has been expressed that any record of the discussions of a medical audit meeting could be subject to legal subpoena. It is important that doctors should not feel that they are under a greater threat of litigation because of their involvement in medical audit. Confidentiality is essential. We recommend therefore that the documentation of audit meetings are [*sic*] provided in an appropriately anonymised form so that the general conclusions of the meeting and recommended action are recorded while the cases used in the discussion are not in any way identifiable.'

104 In May 1991, the Quality of Practice Committee of the Royal College of Anaesthetists advised:

> 'In common with other Colleges and Faculties, the College of Anaesthetists has considered the medico-legal consequences of audit. When data are collected centrally every attempt is made to render its [*sic*] origin unidentifiable and to destroy secondary records as soon as possible.

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[120] T20 p. 90–1 Dr Armstrong

[121] In this section the term 'confidentiality' refers to the basis on which information may be made available which identifies individuals caring for a patient; that is, confidentiality in the context of data that refers to individual clinicians and clinical teams. Confidentiality, in the sense of protecting patients from being identified, was not a contentious issue in the Inquiry although it was an exercise that needed to be carried out to enable the use of data for audit. Dr Walshe confirmed that anonymising patient details was not a bar 'to producing effective medical or clinical audit'

[122] WIT 0323 0031 Dr Thomas

[123] T62 p. 19 Dr Kieran Walshe; T14 p. 104 Professor Strunin

[124] *'The Quality of Care'*, report of the Standing Medical Advisory Committee, DoH, 1990, para 8.5.2, p. 20

> 'Nevertheless, it is the responsibility of all clinicians to keep records of events which involve patients, and it is an offence to alter or destroy such records. The College has been led to understand that all primary records (case notes, anaesthetic records, etc.) are ultimately accessible to patients' relatives and their legal representatives. Secondary data extracted from such records can be rendered anonymous and destroyed.
>
> 'This should not deter clinicians from their responsibilities for performing audit, although it should cause great care to be taken when an opinion is given and recorded as to the cause of any untoward event which may be discussed under the heading of morbidity and mortality.'[125]

105 Although in Dr Walshe's and Sir Barry Jackson's opinion concerns about confidentiality appeared to have waned over time,[126] these concerns were prevalent at the time of the formal introduction of audit in 1990 and, in the opinion of Mr Wisheart, until around 1995.[127]

106 Dr Thomas told the Inquiry that in response to these initial concerns, guidelines and protocols on confidentiality were contained in DoH Working Paper No 6[128] and the 1991 recommendations were contained in the RHA's protocol on confidentiality.[129]

107 Dr Roylance believed that this document, '*Confidentiality of Clinical Audit Information',* was in response

> '… to the concerns of many doctors about the potential access to audit information by managers and it was agreed in Bristol that any requests for audit information, whether from managers or from purchasers, should be channelled through the appropriate Clinical Director.'[130]

108 Dr Walshe told the Inquiry:

> '… Data about individual clinicians would stay within the team and the Clinical Director, so that the Clinical Director had a key role there. That did not mean that if that Clinical Director had concerns about a particular individual, they would not then be able to raise those concerns, and indeed, they would have a duty to raise those concerns with those higher up in the organisation. But it was our kind of pragmatic response to try and find a middle way between the concerns of clinicians and the effectiveness of having an effective audit process.'[131]

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[125] WIT 0065 0599 Professor Strunin

[126] T62 p. 20 Dr Walshe; T28 p. 96 Sir Barry Jackson

[127] T41 p. 86 Mr Wisheart

[128] UBHT 0052 0306; DoH Working Paper No 6

[129] WIT 0323 0027 Dr Thomas; T62 p. 121 Dr Thomas

[130] WIT 0108 0046 Dr Roylance

[131] T62 p. 25 Dr Walshe

International comparisons

109 Dr Walshe described the state of audit in the United States as at 1989. He said:

> '… the United States has had systems for the external accreditation or inspection of hospitals in some form or other since the 1980s, in fairly vigorous form certainly since the 1960s and it first mandated quality assurance, introduced federal legislation that required it effectively in I think 1973. So we would have found a very long history of this kind of work, and lots of efforts with different approaches to attempting to measure quality, different kinds of measures and different ways of structuring and doing this, so a great deal of experience … Every hospital we visited then and indeed now, would have had a well-developed internal quality assurance programme with staff, structures, processors and things like that in place. They would also have had programmes for risk management and utilisation review, looking at the use of resources, and then we would have also found a number of external programmes, payers for healthcare, examining the quality of healthcare provided by hospitals and healthcare providers. I think it would be right to say you would also have found far from a consensus about how useful that very substantial investment had been in bringing about quality improvement and in fact from the late 1980s, the US healthcare system began to move away from its traditional approaches to quality assurance and to embrace what is sometimes called "whole system" approaches to continuous quality improvement and TQM, and that movement in the US has continued.'[132]

110 Dr Walshe said that it would not necessarily be possible to implement the USA model in the UK. First, the system of quality assurance or audit within the USA was largely imposed externally or was required by regulatory systems, and secondly, there was a lack of consensus as to the benefits that had been produced by those approaches.[133]

111 The other difference noted by Dr Walshe was that, in the USA, audit had been required by federal legislation and by payers of healthcare. There were also cultural differences between the way that the US healthcare organisations had traditionally been run compared with British NHS trusts or healthcare organisations. Dr Walshe pointed to the

> '... big differences in the employment status of doctors and the degree of medical involvement in the management of those organisations, and big cultural differences that effect the transference of an organisational approach to quality improvement from their context to ours.'[134]

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[132] T62 p. 9–10 Dr Walshe
[133] T62 p. 10 Dr Walshe
[134] T62 p. 11 Dr Walshe

112 Dr Walshe was asked whether the legal position in the UK, whereby audit data does not attract public interest immunity or any other form of confidentiality within civil litigation, differed from the stance taken in other countries. He told the Inquiry that it did:

> ‘In the United States, something like 47 or 48 of the states have legislation which gives some kind of qualified immunity or privilege to information that health care providers collect for quality assurance purposes. Not all states have that, but the great majority do. Some people pointed to that as an example and said clearly that is needed to allow audit or quality improvement to be established. That has to be seen in the light of levels of litigation for medical negligence which are an order of magnitude higher at least in the US, so a very different situation.
>
> ‘Interestingly, more recently, I think I am right, Australia has introduced some legislation which gives some qualified privilege to information that providers there collect for the purposes of quality improvement.’[135]

He was further asked whether it was possible to assess whether the provision of such immunity made any difference to the effectiveness of the audit process, and replied:

> ‘I do not think we can really answer that question. You could argue in practical terms. It clearly has not been necessary in Canada, it has not been necessary in other European countries and it does not seem to have been necessary here, but we cannot prove the counterfactual, had we had that legislation, things would be different today.’[136]

Nursing audit

The national context

113 In its written statement to the Inquiry, the Royal College of Nursing (RCN) stated:

> ‘The RCN has a long history of supporting developments in the field of nursing quality and audit in the United Kingdom. A dedicated quality and audit unit, the Dynamic Quality Improvement Programme, has focused on developing work, including the following:
>
> - ‘Developing a philosophy and framework for nursing quality evaluation
> - ‘Developing systems for quality evaluation in healthcare
> - ‘Developing specialist guidelines and standards
> - ‘Undertaking research and development.’[137]

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[135] T62 p. 22 Dr Walshe

[136] T62 p. 22 Dr Walshe

[137] WIT 0042 0005; statement of the RCN, submitted by Christine Hancock (former General Secretary)

114 The RCN also provides support, and a forum, for nurses who have concerns about their practice and their profession. As its submission stated:

> 'The RCN provides support for nurses who wish to raise their concerns about the standards of nursing care and other professional issues. The RCN's structure to support nurses who raise concerns about professional practice and standards of care is through the local RCN Branches where concerns can be raised with local management and, if necessary, the Community Health Council and local Members of Parliament and local media. Nurses can also raise their concerns through Forums that can raise the issues at national conferences and also are able to lobby and influence nationally.'[138]

115 The RCN gave evidence to the effect that the nursing profession was progressive in its attitude to standards and audit. The RCN conducted research into these areas in the late 1980s:

> 'Drawing on the specialist knowledge of the membership groups within the RCN, an initial programme of work to develop national standards for particular specialty areas was undertaken during the late 1980s and early 1990s. This resulted in the production of standards for a whole range of specialist subjects, including paediatric nursing, school nursing, radiology nursing, cancer nursing, nursing in older people, and gynaecological nursing.
>
> 'The idea behind these types of specialist documents was that local practitioners could use them as a guide for developing standards within their own clinical area. More recently, however, the focus has moved towards developing evidence-based national guidelines for specific clinical topics, for example, the management of venous leg ulcers, the assessment of pain in children and the assessment and prevention of pressure ulcers. A shift from developing specialist standards of practice to more focused guidelines has been a response to the growing emphasis on evidence-based healthcare, and is aiming at ensuring that national guidance is based on the best available knowledge to promote quality improvement in practice.'[139]

116 The view of the RCN was that:

> 'Changes in managerial structures in the last decade may have had the unintended consequence of weakening the system for identification, monitoring and investigation of untoward incidents. Clinicians (both doctors and nurses) may be inclined to keep matters in their own hands and to resent enquiries by managers. This position may arise out of perceptions of managerial indifference, clinical

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[138] WIT 0042 0028 RCN (Christine Hancock)

[139] WIT 0042 0005 – 0006 RCN (Christine Hancock)

> freedom, unwillingness to admit problems, or even the reluctance to face the death of a patient.
>
> ‘ The organisational culture has a part to play in the reporting of untoward incidents. A combination of high stress levels, clinical inadequacies and punitive, authoritarian culture may provide a background in which not only do mistakes occur but energy is spent on damage limitation rather than open enquiry with a view to future prevention. The RCN has long argued for independent counselling to be provided for NHS staff.’[140]

The Dynamic Standard Setting System (DySSSy)

117 The Inquiry was given details of the work of the RCN in promoting the ‘Dynamic Standard Setting System’ (DySSSy). This was developed by the RCN to enable health-care practitioners to define quality of care locally. The DySSSy involves a group of practitioners, assisted by a trained facilitator, moving around a cycle of describing, measuring and taking action, within a philosophy of continuous improvement in care.[141] It was described as follows in the National Institute for Nursing Report No 124, 1995:

> ‘The Dynamic Standard Setting System depicts both a philosophy and a methodology for developing quality patient care. In terms of philosophy it makes explicit its definition of quality care and most importantly, identifies the organisational culture and values necessary for quality of care to improve and flourish.
>
> ‘The framework for local standard setting was first outlined in 1989 in a publication entitled *“A Framework for Quality”* (Kitson 1989), which outlined a method for setting standards, but located it very clearly within a framework for quality assurance in health care for an entire organisation. The framework also clearly stated the need for a collaborative approach to setting objectives, stressing the importance of interprofessional negotiation.
>
> ‘In 1990 the Dynamic Standard Setting System was launched as a formal workbook, based on the experience of three years of running workshops. It comprised an introductory text and accompanying overhead projector originals (RCN 1990). The workbook focused largely on the mechanics of the system of local standard setting, expounding the quality cycle in some detail. It also described the need for trained facilitators to enable groups of practitioners to move around the cycle, improving care to patients.
>
> ‘The principles underpinning DySSSy were that all activities had to be patient or client focussed. Every standard set should clearly state what level of excellence of

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[140] WIT 0042 0027 RCN (Christine Hancock)

[141] WIT 0042 0451; RCN (Christine Hancock), referring to: *‘The Reality of Practitioner-Based Quality Improvement: A Review of the Use of the Dynamic Standard Setting System in the NHS of the 1990s’,* National Institute for Nursing, Report No 124, 1995

> care a client could expect to receive, relating the standards to client experience rather than diagnostic label or issues of care management.
>
> ‘In addition, DySSSy located the responsibility for the setting, monitoring and improving of standards with practitioners directly involved in client care. Staff must own and control the process of quality improvement, and be fully involved. Finally, standards have to be achievable and all quality improvement activities must recognise the contribution of the entire clinical team.

‘The cycle of quality improvement

‘Improvement

> ‘The Dynamic Standard Setting System is based on a cycle of describing, measuring and taking action, resulting in the continuous improvement of care …
>
> ‘In the describing phase a group of practitioners are helped by a trained facilitator to select their topic for quality improvement, devise a standard statement which reflects the overall intention of the exercise, and identify the elements or criteria necessary for implementation. … These elements can relate to the resources required, the activities undertaken by staff and the anticipated results of the intervention in terms of patients’ experiences. Donabedian (1966) classified these as structure, process and outcome.
>
> ‘Once criteria have been identified, refined and organised, the standard statement is reviewed and edited if necessary. In order to measure practice against the standard, an audit form is then devised by the group from the structure, process and outcome criteria. … A sample is identified, together with data collection methods, a time frame for the collection of data and the individuals responsible ... Implementation and audit dates are then negotiated by the group in consultation with the wider team. …
>
> ‘The final phase of the cycle involves action planning. Data are summarised and brought back to the group to interpret the findings … and decide on what action (if any) is needed. Actions are prioritised and individuals given responsibility for seeing that plans are carried out in an agreed period of time and a date for re-audit negotiated. …
>
> ‘DySSSy shares many common characteristics with other methods for clinical audit and quality improvement. What distinguishes DySSSy from other systems is its unique combination of the following features:
>
> ‘(i) it is clinically as opposed to managerially led, though it must be supported by the organisation;

> ‘(ii)it is locally based, emphasising the full participation of practitioners in all three phases of the cycle;
>
> ‘(iii)it uses small group processes within the local quality improvement team to ensure commitment to developing practice;
>
> ‘(iv)there is a clearly identified facilitator role, guiding and supporting local groups; the facilitator role is undertaken by a skilled and trained member of the team;
>
> ‘(v)it involves the generation of explicit standards, with criteria for implementation developed for structure, process and outcome.’[142]

Comparing DySSSy and Medical Audit[143]

DySSSy	**Medical Audit**
Standards are broad statements of what is to be achieved.	Standards are targets or degrees of compliance.
Structure process and outcome criteria are identified for each standard statement.	Structure, process, outcome is used to classify the topic for audit.
Audit objective is defined after standard and criteria are identified.	Audit objective formulated from the identified topic.
Audit criteria are developed from criteria for the standard. Methods of data collection are developed from the audit criteria.	Methods for audit are chosen from the audit objective, criteria comprise a statement of what is to be measured.
Role of the group facilitator is made explicit.	Role of audit support staff is made explicit.
DySSSy is marketed as a problem-solving approach to quality improvement.	Medical audit is marketed as an educational tool.

118 The overall assessment of the use of DySSSy by the National Institute for Nursing’s Report was that:

> ‘Improvements in patient care were described in all the sites visited, with DySSSy appearing to act as a catalyst. Time to commit to local quality improvement projects was commonly raised as a difficulty…
>
> ‘The lack of information on audit contained within the original DySSSy information was raised as a problem in some places. The involvement of patients in DySSSy has varied, with all standards described as patient centred, although patients were rarely involved.

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[142] WIT 0042 0460 – 0464; RCN (Christine Hancock), referring to: *‘The Reality of Practitioner-Based Quality Improvement: A Review of the Use of the Dynamic Standard Setting System in the NHS of the 1990s’,* National Institute for Nursing, Report No 124, 1995

[143] WIT 0042 0465 Christine Hancock; *‘The Reality of Practitioner-Based Quality Improvement: A Review of the Use of the Dynamic Standard Setting System in the NHS of the 1990s’,* National Institute for Nursing, Report No 124, 1995

'The data suggest that the personality, skills and attributes of the key facilitator are highly influential in the development of a practitioner-led quality programme …

'The lack of training and education in principles and systems for quality improvement and skills in group work and facilitation was raised as a barrier to further development in many areas. The problems appeared to centre around funding for the training itself, and releasing staff from clinical duties. The importance of integrating quality and audit into basic and post-basic education was also highlighted.

'Some of those interviewed felt that the biggest benefit of the purchaser-provider split was that quality issues had been introduced in areas where they had not previously featured. In addition, application for Trust status had helped some organisations draw existing initiatives together into a coherent strategy. This had given DySSSy and local quality improvement initiatives a much higher profile.

'DySSSy appeared to have been most useful in developing patient care in areas where it had become integrated with other issues related to quality …

'A fragmented approach to quality strategy persisted in a large proportion of sites visited. An integrated approach appeared to require not only clear leadership, but also the full commitment of the management team in establishing systems and structures to support the many initiatives.

'DySSSy was being used successfully as a model for multi-professional clinical audit in a few of the sites visited. In other areas it appears that misunderstandings and tribal boundaries between professions persisted, hindering the development of genuinely multi-professional audit.

'… whilst DySSSy continues to provide a useful framework for practitioner-led quality improvement, additional work is necessary to develop the model further for use with multi-professional teams. Mechanisms for involving service users in quality improvement also need continued work.

'Time for quality improvement activities remains a major issue and needs addressing at all levels, by dissemination of innovation at a national level, by recognition of the resource implications at strategic level, and by good planning and prioritising of work locally.

'In addition, it is recommended that to maximise the potential of practitioner-led quality improvement initiatives, they must be firmly integrated within the strategic work of the Trust or provider unit.'[144]

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[144] WIT 0042 0451 – 0452 Christine Hancock; *'The Reality of Practitioner-Based Quality Improvement: A Review of the Use of the Dynamic Standard Setting System in the NHS of the 1990s',* National Institute for Nursing, Report No 124, 1995

Evaluation of the nursing and therapy audit programmes

119 The Inquiry was referred by Mrs Jenkins of the RCN to *'A review of audit activity in the nursing and therapy professions: Findings of a national survey'*, a study conducted by CASPE in the second half of 1994 on behalf of the DoH.

120 The findings were as follows:

> 'The resources available for nursing and therapy audit were almost wholly obtained from centrally ringfenced monies, only 16% coming from other sources, much of that (7%) coming from provider units.
>
> 'Over 70% of the funds available were used to meet staff costs, with information technology using 10% of the resources. Training and dissemination accounted for very little expenditure and were considered to be under resourced. The management of resources seemed to have been effective in most cases …
>
> 'The audit activities surveyed were each led by a named individual. There was a diversity in profession and status of those leading these activities although most were led by directors at board level or by service managers …
>
> 'Whilst the majority of activities were led by nurses, when considered in proportion to the size of the profession, the distribution of leadership across professional groups was reasonably equitable. … Audit leadership was commonly only one aspect of these people's work with the majority spending less than ten hours per week on it, which in most cases was not funded by earmarked audit monies but was a cost borne by the provider unit. … This direct involvement of clinical staff in undertaking audit contrasts with the medical audit programme, where much data collection and analysis was undertaken by central support staff, and may have encouraged a greater integration of audit into routine clinical practice. Most of the audit activities within the nursing and therapy audit programme were multi-professional by nature, with about half involving four or more professions. Only 13% of activities were uniprofessional.
>
> 'The programme achieved a reasonably equitable distribution of activity across different types of provider units and, although not intended at the outset, also included the primary healthcare sector through the involvement of practice nurses in audit. The audit projects funded by the programme tended to look at specific areas in healthcare of particular concern to individual professionals. Not surprisingly, many of the projects focused on areas that had been suggested in national and regional documents. They tended to be selected either because they were of particular interest or concern to healthcare staff, or because there was known variation in clinical practice, they consumed a lot of resources or were considered to be of high risk to patients. Initiatives focused more on establishing the infrastructure for audit and included activities such as identification of audit topics, setting up an audit committee and facilitator role, awareness raising and dissemination as well as undertaking specific audits. The main aim of initiatives

> was recognised, by participants, as encouraging the establishment of audit throughout the unit. There was fairly widespread dissemination of information about activity, within and outside the host units. Written reports were distributed and nearly 70% of activities were reported at externally organised seminars or workshops. There were some difficulties in meeting all the aims set by the audit activities and finishing within set timescales. These were often due to the very limited resources available, but also to a lack of organisational and planning experience in audit.
>
> 'Eighty-three percent of audit activities funded through this programme were claimed to have brought about change. Audit initiatives were felt to have succeeded in raising the level of knowledge and awareness about audit and to have made some contribution to bringing about changes in clinical management and in the quality of communication with patients and other clinicians. It was thought, with rather greater frequency, that projects had also brought about change in these latter two areas and also in the quality of record keeping and patient documentation. However, very few (7% compared to 40%) felt that projects had brought about a change in knowledge or awareness across the organisation. The scale of resources available to audit activities appear to be important in determining its success. Small projects, for example those receiving less than £10,000, had less chance of success than larger activities.
>
> 'The nursing and therapy audit programme was established in order to encourage the development of a framework for audit for the nursing profession and professions allied to medicine within every provider unit. A high proportion of projects funded by the programme had succeeded in encouraging healthcare professionals to undertake further audit projects, but only 15% had led to the development of a more permanent infrastructure for audit within the provider unit. This was not surprising since, by their nature, projects tended to be finite and discrete in their objectives, unlike the wider ranging initiatives that were funded. Indeed, in contrast to projects, 80% of audit initiatives continued, either with or without financial support, after the initial period of funding expired, thus leaving an infrastructure in place to support continuing audit activity.'

The study concluded that:

> '… the nursing and therapy audit programme has been relatively successful in promoting the development of audit, particularly when the modest level of funding available to it is taken into account. It has resulted in a diverse range of both uniprofessional and multiprofessional audit activities, covering all aspects of healthcare; has succeeded in reaching many different professional groups; has resulted in changes in practice, service management and in culture and attitudes; and on the whole has had a lasting effect within provider units. Indeed, its achievements bear comparison with those of the much more generously funded medical audit programme.

> ‘Some problems were commonly encountered by those undertaking nursing and therapy audit activities. Problems encountered as a result of the low level of resources could have been addressed by host provider units if they had decided to commit additional resources to these activities, thus acknowledging that they were an important element of the provider’s business. This might have gone some way towards addressing another issue identified – that of a certain lack of commitment and enthusiasm for audit and its achievements, by those not directly involved in the activity.
>
> ‘Recommendations
>
> ‘Although many nurses and therapists have become involved in audit over the last four years, because of the size of the professions concerned there remain very many clinicians who have had little or no contact with audit activity. As a result, there is still a considerable need to generate awareness of audit, interest and enthusiasm. In order to achieve this, additional support and education is required to provide healthcare professionals with the skills they need to undertake audit, and to enable them to participate in audit activities. This education and support should ideally come from within existing provider audit departments, and should aim to demonstrate to healthcare professionals that audit has the capacity to improve the quality of the care they provide.’[145]

The role of the coroner

121 Thus far, evidence relating to the NHS has been set out. Other individuals and institutions are also concerned with deaths or critical incidents in hospital: for instance, the coroner, the registrar of deaths and the Home Office. The Health and Safety Executive also has a role, but principally as regards the health of healthcare workers and potential accidents to them or others within hospital. In this section we set out the principal evidence received relating to the coroner, the registrar of deaths and the Home Office, as possible monitors of health outcomes from outside the NHS.

The coroner

122 Coroners are required by Rule 54 of the Coroners Rules 1984[146] to maintain an indexed register of all deaths reported to them, with prescribed details.[147]

123 A number of witnesses commented to the Inquiry on whether the coroner’s court is an appropriate means of enabling audit or for identifying local or national trends in mortality.

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[145] WIT 0042 0252 – 0265 Mrs Jenkins

[146] 1984 SI No 552 (as amended by the Coroners (Amendment) Rules; 1985 SI No 1414)

[147] The form of the register appears at *‘Schedule 3, 1984 Rules’* and requires the following to be recorded: date on which the death is reported to the coroner, full name and address, age and sex of the deceased, cause of death, whether the case was disposed of, Pink Form A or Pink Form B or whether an inquest was held, and the verdict at inquest if any

124 Professor Roderick MacSween, the then President of the Royal College of Pathologists, stated that the coroner's court could act as a '… useful unofficial forum for audit …'[148] and that if certain patterns of death emerged in a particular hospital or at the hands of a particular clinician the coroner could comment upon these and draw them to the attention of the appropriate authorities.

125 Mr Robert Clifford, Head of the Coroners Section of the Animals, Bye-laws and Coroners' Unit of the Home Office, told the Inquiry that the system of inquests was designed to look at individual deaths and that there was no requirement on a coroner to look across a range of deaths in a way that would enable trends to be discerned. He identified a number of matters which made such spotting of trends difficult, including: the limited records of previous cases which the coroner is required to maintain; some cases would be dealt with not by the coroner but by a deputy or assistant deputy; there was no one with responsibility to maintain and analyse a database of all the information that came out of individual inquests; such information would in any event exclude deaths that had not been reported to the coroner; and each coroner's jurisdiction is limited to bodies lying within his district.[149]

126 Professor Jeremy Berry, Professor of Paediatric Pathology, stated:

> 'The statutory role of the Coroner is limited to determining the cause of death, and does not extend to monitoring the adequacy of surgical or other services. The pathologist may mention minor deficiencies in treatment in his or her report, but it is generally only major errors that might lead to an inquest (e.g. mis-matched blood transfusion, major equipment failure, or some surgical disaster). The Coroner's system is therefore best suited to recognising individual or repeated gross deviations from normal medical practice … It is not intended to carry out long term monitoring of individual specialised clinical services, which is the function of clinical audit.'[150]

127 The Inquiry heard from Professor Michael Green, Consultant Pathologist to the Home Office and Emeritus Professor of Forensic Pathology, University of Sheffield, that he was aware of only two episodes in the last ten years when the coroners' post-mortem examination system had identified a particular surgeon in a particular specialty within surgery as having a high mortality rate.[151]

128 The Coroners' Society memorandum, *'Coroners and the Investigation of Deaths',* prepared by Mr Michael Burgess, Honorary Secretary of the Coroners' Society of England and Wales and HM Coroner for Surrey, states that: 'The limited nature of the inquest may make it difficult to examine anything other than the circumstances of the single death before the coroner at that time'.[152]

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[148] WIT 0054 0033 Professor MacSween
[149] T42 p. 129–30 Mr Clifford
[150] WIT 0204 0005 – 0006 Professor Berry
[151] T42 p. 101 Professor Green
[152] WIT 0039 0027 Mr Burgess

Records kept by the Home Office

129 Under Section 28 of the Coroners Act 1988 the coroner is required to make an annual return to the Home Secretary giving prescribed details in relation to inquests.[153] The return requires coroners to state the number of verdicts recorded in relation to male and female deaths. It does not require, for example, the age of the deceased or place of death.

130 The Home Office publishes statistical bulletins based on the information contained in the returns, none of which relates to particular identifiable cases.[154]

131 The Inquiry heard from Mr Clifford that the Home Office requirement for statistics relating to the coroners' service was limited and was mainly related to information about case load and did not extend to the circumstances of individual deaths. The Home Office, according to Mr Clifford, does not seek nor receive detailed information regarding post mortems and inquests with a view to analysing, monitoring or acting on the data. It is not a function of the Home Office, Mr Clifford stated, to obtain and use such information beyond ensuring as far as possible that coroners are aware of and observe any requests they may receive to help collect data for other agencies. The Home Office has no involvement in national data in relation to paediatric cardiac surgery.[155]

132 Mr Clifford stated further that, whilst coroners may make reports in the interests of preventing the recurrence of fatalities, such reports are sent to the person or authority which may have power to take action and are not routinely sent or copied to the Home Office.[156]

133 Mr Clifford stated that, since 1993, the Home Office has sought information in coroners' annual returns regarding the length of time taken to complete certain key tasks.[157]

Reports sent to other organisations

134 Although the principle of the 'rider to the verdict' has been abolished,[158] Rule 43 of the Coroners Rules 1984 provides that a coroner who believes that action should be taken to prevent the recurrence of fatalities similar to that in respect of which the inquest is being held, may report the matter in writing to the person or authority who may have power to take such action.

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[153] A copy of the return *'Deaths Reported to Coroners'* was provided to the Inquiry by Mr Clifford at WIT 0043 0091 – 0094

[154] See, for example, Home Office Statistical Bulletin Issue 11/98, 23 April 1998 at WIT 0043 0095 – 0109 Mr Clifford

[155] WIT 0043 0003 Mr Clifford

[156] WIT 0043 0004 Mr Clifford

[157] WIT 0043 0004 Mr Clifford

[158] By the Coroners (Amendment) Rules 1980

135 In certain specified cases, not relevant to paediatric cardiac surgery, the coroner is obliged to report to the Secretary of State.[159]

'Unnatural death' and 'death by natural causes'

136 The extent to which the coroners' system may provide a useful forum for audit in part depends on the interpretation that individual coroners (and others) place on the terms 'unnatural death' and 'death by natural causes' as verdicts open to the coroner.

137 The Inquiry heard from Mr Donald Hawkins[160] that:

> 'During the period 1974 to 1991 I took the view that deaths following operations to correct medical conditions were deaths arising from natural causes and as such only referable to the coroner if the cause of death was unknown, or unknown without a hospital post mortem examination. However, I did require to be notified of deaths that actually occurred on the operating table. When such a death was so referred and the cause of death was known and was natural I dealt with the matter by way of Form A without a post mortem examination.'[161]

138 Mr Paul Forrest, Coroner for Avon who succeeded Mr Hawkins, stated:[162]

> 'You will be aware … that the switch[163] deaths reported to me from 1992 onwards were, following post mortem examination, recorded and registered as deaths from natural causes.'

139 The terms 'unnatural death' and 'death by natural causes', are not defined by statute even though provisions such as Regulation 41(1)(d) of the Registration of Births and Deaths Regulations 1987, and Section 8(1) of the Coroners Act 1988 use the term 'unnatural' in relation to the requirement to investigate a death further.

140 *R v Price* interpreted 'unnatural' as 'a reasonable suspicion that there may have been something peculiar about the death; that it may have been due to other causes than common illness'[164]. A commentator described it as a death which was 'wholly or in part caused, or accelerated, by any act, intervention or omission other than a properly executed measure intended to prolong life.'[165]

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[159] Where a coroner holds an inquest into the death of a person who is proved to have been killed on a railway or to have died in consequence of injuries received on a railway, he must provide details including the cause of death to the Secretary of State, Coroners Act 1988, s11(8). The coroner is required to send notice to the Secretary of State of any inquest into a death following an accident occurring within Greater London or the City of London where it is alleged that the accident was due to the nature or character of a road or road surface or a defect in the design or construction of a vehicle, Coroners Act 1988, s18(1)

[160] HM Coroner for Avon from April 1978 to April 1992

[161] WIT 0348 0002 Mr Hawkins

[162] WIT 0039 0017; letter to the Inquiry dated 31 March 1999

[163] See Chapter 3 for an explanation of this term

[164] *R v Price* (1884) 12 QBD 247

[165] 'Natural and unnatural deaths': Herbert H Pilling, *'Medicine, Science & the Law'*, April 1967

141 In *R v Poplar Coroner ex parte Thomas*[166] the deceased suffered an asthma attack which, had an ambulance arrived sooner, she had a real possibility of surviving. In the event she arrived some 40 minutes later at hospital and could not be revived. The Court of Appeal decided that asthma was a natural cause of death, and that the death was not made 'unnatural' by the late arrival of the ambulance.

142 *'Jervis on Coroners'*[167] suggests that the proper view in that case would have been that the deceased died of 'untreated' asthma, and that if the treatment given seriously departed from the norms for the time, it would be sensible to conclude that this was an 'unnatural' cause of death.

143 In *R v Birmingham Coroner ex parte Benton*[168] it was decided that where a patient was suffering from a potentially fatal condition and the medical intervention (even if wrong) merely failed to prevent the death, then the proper verdict was 'death from natural causes', as it was the underlying condition which had caused the death. If the patient was not suffering from a life-threatening condition but the treatment given for whatever reason caused the death, the proper verdict was accident or misadventure, unless there was a question of unlawful killing.[169]

144 The memorandum *'Coroners and the Investigation of Deaths'* describes the verdict of death by natural causes at Appendix C:

> 'A death is considered to have arisen from Natural Causes if the evidence shows that it is probable (that is, more likely than not) that the cause of death was the result of a naturally occurring disease process running its [full] course.
>
> 'The word "natural" should be given its "usual meaning".'[170]

145 The memorandum then refers to Leckey and Greer, *'Coroners' Law and Practice in Northern Ireland'*: 'It is the *underlying cause of death* rather than the terminal event which is the test as to whether the death is from unnatural causes and therefore properly referable to the Coroner'.[171]

146 In evidence Mr Burgess, in commenting on the decision-making process in respect of a death of someone with a life-threatening condition, who has died during or following surgery, told the Inquiry:

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[166] [1993] QB 610

[167] Sweet and Maxwell, 11th edition at paras 8–20, p. 137

[168] [1997] 8 Med LR 362

[169] With specific reference to death during or after surgery, the determining factor according to the case law, therefore, appears to be whether the deceased would have died from the medical condition in any event, regardless of whether the surgery accelerated the death, rather than the standard of care received, or whether the medical condition could have been survived with appropriate treatment

[170] WIT 0039 0031 Mr Burgess

[171] WIT 0030 0013 Mr Burgess (emphasis in original)

> 'What he [the coroner] is trying to do is maybe simplify what is probably quite a complex and difficult situation: was the death hastened by or brought about by the surgery, or was it that the death arose regardless of the surgery? I think it is often a debate that can quite properly result in well-held beliefs which are totally opposite.'[172]

Records kept by the Registrar of Births, Marriages and Deaths, and the Office for National Statistics

147 The registrar for each sub-district[173] receives reports of all deaths occurring in his sub-district for entry into the register. As with the coroner, his records relate to deaths occurring within his jurisdiction. The registrars would not for example receive reports of deaths occurring following surgery at a hospital lying within his sub-district if the deaths occurred after discharge from the hospital, and in another sub-district.

148 The reports the registrar receives will be from various sources: either the medical practitioner who attended the deceased during the last illness[174] (the medical certificate), or from the coroner. As noted above, the report from the coroner to the registrar may be on Pink Form 100A where the cause of death will be that certified by the deceased's doctor, or on Pink Form 100B where the cause of death will be that disclosed by the pathologist. After an inquest the coroner reports on Form 99,[175] providing the registrar with the particulars required to be registered: the date and place of death, name and surname, sex, date and place of birth and occupation and usual address of the deceased.

149 The registrar delivers certified quarterly returns of all entries in his register to the superintendent registrar who, four times a year, sends copies to the Registrar General.[176] The Registrar General's office, the General Register Office, forms part of the Office for National Statistics[177] and is responsible for the central archive of all registrations of births, marriages and deaths that have occurred in England and Wales since 1 July 1837.

150 The Registrar General annually provides the Chancellor of the Exchequer with a general abstract of the entries for the preceding year, including the number of deaths, which is then laid before both Houses of Parliament.[178]

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[172] T43 p. 19 Mr Burgess

[173] England and Wales are divided into districts and sub-districts for the purposes of registration, by the Registration Service Act 1953, s5(1) as amended

[174] Births and Deaths Registration Act 1953 s22(1)

[175] Coroners Act 1988 s11(7)

[176] Births and Deaths Registration Act 1953 s27

[177] Formed on 1 April 1996 by the merger of the Central Statistical Office of the Chancellor of the Exchequer, and the Office for Population Censuses and Surveys

[178] Registration Service Act 1953 s19

The South West Region and audit

1988–1990 The Regional Hospital Medical Advisory Committee (RHMAC)

151 In 1988, the Regional Medical Advisory Committee (RHMAC) took the responsibility at regional level for promoting the introduction of medical audit.[179] It produced its first report in June 1989. The account set out in this section therefore deals first with the role of the Region in the introduction of audit, before addressing the topics of the District and the UBHT.

152 In January 1989, the Government's White Paper '*Working for Patients; Medical Audit Working Paper 6*'[180] expressed the desire that within two years all hospitals would participate in audit. Funding was announced for the development of medical audit in all healthcare providers, with funds to be distributed by the RHAs.

153 The *'Working Paper 6'* stated that arrangements to support medical audit would need to be made at regional level, through a professionally led 'Audit Advisory Committee'. It further stated that the committee's role was to:

> '… organise audit of the smaller specialties on a regional basis in order to facilitate peer review and to maintain the confidentiality of results.
>
> '… arrange for clinicians to undertake the external peer review of particular problem services in Districts.
>
> '… advise on and support the development of audit across the Region.
>
> 'While this committee will need to be supported and serviced by the RHA, it should be clearly seen as working on behalf of the District committees, enabling them to discharge their responsibility for ensuring that suitable comprehensive audit covers all services. Membership of the Regional committee will need to be determined locally to include a representative of each District committee, chosen to ensure that the main specialty interests are all covered. Whether the remit and membership of this committee should also cover the needs of primary care requires consideration.'[181]

154 The RHMAC was given responsibility for the centrally allocated funds and for reporting on progress to the DoH.

155 At this time it was the prevailing view amongst those seeking to introduce audit programmes that audit was essentially a professional educational activity and that the profession should lead its development. In his written evidence to the Inquiry, Mr David McCoy, Chairman of the RHMAC 1990–1994, stated:

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[179] UBHT 0068 0006; notes to the 1989 RHMAC guidelines

[180] HOME 0003 0124; *'Working for Patients; Medical Audit Working Paper 6'*

[181] HOME 0003 0133; ibid.

> 'Clinical Audit and its importance were recognised, but these were relatively early days and we were concerned with establishing the mechanism of audit. It was understood that the results would remain confidential.'[182]

He also stated:

> 'The picture of audit at its inception was resented by some, and completely clouded by uncertainty of patient confidentiality, and the legal situation, with the risk of action for defamation as the result of published results.'[183]

156 The RHMAC did not delegate the development of audit to a sub-committee as it regarded audit as central to its own professional advisory function. In June 1989, it issued regional guidelines entitled *'The Regional Approach to Medical Audit'*.[184]

157 The RHMAC's report stated that 'There is no need for a separate audit committee to be set up at regional level.'[185] It outlined the programme of work that had already been started. It spoke of the need for district audit committees to advise and implement medical audit procedures.[186] The report further stated that staff in each hospital or group of hospitals should formally agree to accept corporate responsibility for the quality of medical care and the general implementation of audit.[187]

158 The report accepted that audit was essentially a professional and educational activity and that the profession should lead its development. It stated that:

> 'Health authorities and managers are held responsible for the overall running of the hospital service, but they are not competent to make judgments on the technical quality of medical care. They must therefore entrust this function to the medical staff, with an agreed level of feedback and assurance that professional self-review does exist and is effective in improving patient care.'[188]

159 It further advised that:

> 'Clinicians should be provided with the resources required for medical audit. At least one session of any full time consultant's programme may be ascribed to education activities, including medical audit. This should be acknowledged in a formal allocation of sessional time … Current, accurate patient-based data should be available to doctors for medical audit in each specialty. These should include local, diagnostic, operation and mortality listings as well as national data, such as performance indicators for "avoidance of deaths".

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[182] WIT 0436 0002 Mr McCoy

[183] WIT 0436 0002 Mr McCoy

[184] UBHT 0068 0001; *'The Regional Approach to Medical Audit'*

[185] UBHT 0068 0004; *'The Regional Approach to Medical Audit'*

[186] UBHT 0068 0005; *'The Regional Approach to Medical Audit'*

[187] UBHT 0068 0006; *'The Regional Approach to Medical Audit'*

[188] UBHT 0068 0011; *'The Regional Approach to Medical Audit'*

> 'Clerical and computer support should be available to doctors in order to minimise the investment of clinical time in medical audit.'[189]

160 The RHMAC's programme included the appointment of two senior lecturers to the Bristol University Department of Public Health to assist the Committee: Dr Charles Shaw (clinical audit) and Dr D Pheby (clinical computing).[190] The Regional Medical Officer (RMO) was to set their objectives and to meet them regularly to review their progress.

161 Dr Shaw was appointed in January 1989 to a part-time post. Dr Shaw's appointment was also as an advisor to the District Audit Committees, when these were set up. He was responsible on behalf of the RHMAC for preparing the annual audit reports to the DoH to account for how the central funds had been spent. These reports were approved by the RHMAC before submission.[191]

162 Dr Thomas Hargreaves, a member of the RHMAC from 1987 until January 1991,[192] stated in his written evidence to the Inquiry that:

> '… the key issues addressed at local level were: 1) Audit committees had been set up in each district 2) Reorganising support staff into groups supporting clinical unit 3) Introducing audit assistants 4) Training support staff to abstract and code clinical data 5) introducing the clinical workstation/medical data index 6) Improving library facilities.'[193]

163 Medical audit had already commenced prior to the 1989 White Paper. The structures and procedures being put in place were consistent with the directions later to be contained in HC(91)2, *'Medical Audit in the Hospital and Community Health Services'.* Dr Shaw stated:

> 'As in other regions at that time, local audit committees were consultant-led, predominantly medical, and with little direct management involvement. The philosophy was to encourage and support doctors to participate in increasingly systematic evaluation of their own work, to the benefit of patients and of their own professional development.'[194]

Dr Baker stated that, at this stage:

> '… The development of audit locally and nationally was slow in general, individual enthusiasts for audit stood out by exception e.g. radiologists, anaesthetists, surgeons. Funds were spent on audit assistants but co-ordination of the development of audit was difficult at all levels and output was limited. Preparation

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[189] UBHT 0068 0012; *'The Regional Approach to Medical Audit'*

[190] WIT 0399 0002 Dr Alistair Mason, former Regional Medical Officer

[191] UBHT 0068 0006; *'The Regional Approach to Medical Audit'*

[192] WIT 0434 0001 Dr Hargreaves

[193] WIT 0434 0003 Dr Hargreaves

[194] WIT 0437 0001 Dr Shaw

> for the purchaser/provider split and the establishment of NHS Trusts strained the task further.'[195]

Dr Baker told the Inquiry that one of the main obstacles standing in the way of audit

> '… was the feeling that audit was going to become some form of inspectorial management tool of professional practice. I think, in general, the medical profession, and possibly others, closed ranks to some extent to take ownership of this process to try and accept it as something which was educational and related to training and practice in that way, rather than a more general approach to quality assessment.'[196]

164 Dr Shaw stated that:

> 'The Regional Hospital Medical Advisory Committee assumed responsibility for medical audit in 1989, before it became a general requirement in the NHS. Before audit moved from "medical to clinical", committee structures and chairmen were established by the profession and they generally reported to medical staff committees; part of the transition [from medical to clinical audit] was to redesign structures to become accountable to trust boards, such as through the medical directors, and thus to chief executives.'[197]

165 Dr Marianne Pitman[198] saw the role of Region in the audit system as ensuring' … that there was an audit system which was appropriate to each specialty.' [199] She could not say who would select the topics to be audited, because some of the topics were agreed District-wide rather than Region-wide. She told the Inquiry: 'I was not totally involved with the auditing system; I just knew that we had some that were labelled "regional audits"and some which were labelled "hospital audits".' [200]

166 Miss Catherine Hawkins, Chief Executive of the SWRHA from 1984 to 1992, stated in her written evidence to the Inquiry that:

> 'The RHMAC produced the SWRHA first series of service strategic statements in November 1989. This covered 6 specialist services including cardiac services. This report was a strategic statement with input from a variety of cardiologists and cardiac surgeons Region wide. This committee did not identify problems at the BRI unit.
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> 'Item 20 of that report recommends "that the Bristol Centre, while it is the only Unit in the South West[,] be fully utilised by the Districts in the Region and that the London Hospitals only be used to take excess demand". During 1986 the RMO

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[195] WIT 0074 0037 Dr Baker
[196] T36 p. 103 Dr Baker
[197] WIT 0437 0012 Dr Shaw
[198] T58 p. 4; Dr Pitman worked for the SWRHA throughout the period 1984–1995
[199] T58 p. 85 Dr Pitman
[200] T58 p. 85 Dr Pitman

> identified that basic statistics appeared to show less good outcomes from surgery at the BRI than other acute units.'[201]

167 Audit is addressed in the Cardiac Services section of the 1989 Service Strategic Statement where it says:

> '… There is a continuing need to monitor the outcome of established treatments.'[202]

168 In 1990 the RMO assigned a doctor on his staff to the task of promoting the processes of audit in the BRI as the first Acute Unit and then to follow through to all the other Acute Units.[203]

169 In September 1990 the RHMAC published a further document, *'Hospital Audit Update 1990'* [204] summarising the progress to that date.

170 After trust status was introduced in 1991, the BRI moved out of RHA supervision to become part of a trust, the UBHT, and as such was under direct DoH monitoring. According to Miss Hawkins, the residual role of Region in the financing and supervision of audit was from then on only on the basis of devolved responsibility from the DoH. Audit would apply equally to all the units in the geographical area, whether they were trusts or non-trusts. Accordingly, to avoid unnecessary complication and duplication of work, responsibility for audit with respect to the trusts was devolved on to the RHA. [205]

171 This meant that the responsibility of the Region to monitor the quality of services after 1991 changed:

> 'There was a shift of emphasis on monitoring which would move away from the providing of the service to the purchasing of the service, because we would be working through the purchasing DHAs, whereas the performance monitoring of the provider was the DHSS[206] if they were a Trust.'[207]

172 Nonetheless, according to Dr Morgan: 'Throughout the period 1991–1994, the Regional Health Authority maintained a relationship with NHS trusts quite independently of purchaser Health Authorities.'[208]

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[201] WIT 0091 0001 Miss Hawkins
[202] WIT 0091 0016 Miss Hawkins
[203] WIT 0091 0003 Miss Hawkins
[204] HAA 0036 011
[205] T56 p. 115–16 Miss Hawkins and WIT 0091 0005 Miss Hawkins
[206] Or DoH. In July 1988 the DHSS was split into two departments: the Department of Health and the Department of Social Security
[207] T56 p. 125 Miss Hawkins
[208] WIT 0307 0004 Dr Morgan

173 According to Dr Shaw:

> 'The initial clarity of the medical audit programme and its regional structure was reduced by the transition to multi-disciplinary clinical audit (from 1992), the growing independence of the new trusts, devolution of budgets to purchasers, the reduced role of the RHA, and thus the waning influence of the RHMAC.'[209]

The Bristol Clinical Audit Unit

174 The Bristol Clinical Audit Unit (BCAU) was established in late 1992. Dr Shaw summarised the function of the Unit as follows:

> 'The Clinical Audit Unit, on behalf of RHMAC, advised hospital and community units on the preparation of the centrally required annual audit reports, analysed these for compliance with criteria for funding, and included summaries in the composite report from SWRHA to the DoH. These reports, both local and regional, aimed to disseminate effective methods and practical lessons, as well as to account for past expenditure in order to release funding for the following year.'[210]

175 The BCAU was comprised of a director, Dr Shaw, and a manager, together with representatives from the Regional GP Audit Advisory Committee and the Local Hospital Audit Committees. The BCAU contributed discussion documents on methods and resources for audit; training programmes; and, for the smaller specialties, direct support for audit projects.[211] The BCAU tried to promote effective audit through training workshops and direct co-ordination of selected specialty projects. It convened a Region-wide meeting in 1992 of doctors and nurses in paediatrics, surgery and anaesthesia to discuss the recent report of the National Confidential Enquiry into Peri-operative Deaths (NCEPOD) relating to surgery on children. The NCEPOD report developed some general principles and audit measures, for example the availability of paediatric staff and accommodation, accessibility of specialised units and the extent of surgery on children without specialised training. It also showed the weakness of routine hospital data systems for regional monitoring of surgery.[212]

176 The funding and plan of work for the BCAU and for Dr Shaw was agreed annually with the RHMAC and the RMO. Progress and any deviations from the programme were reported to the monthly meetings of the RHMAC.

177 Dr Shaw stated in his written evidence to the Inquiry that:

> '… Late in 1992, RHMAC adopted the collective chairmen of local hospital audit committees (LHAC) as a regional subcommittee to advise on transition from medical to clinical audit. Also the research and development directorate began to take on the role of advising the RHA on the funding and organisation of audit, in

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[209] WIT 0437 0002 Dr Shaw
[210] WIT 0437 0003 Dr Shaw
[211] WIT 0437 0002 Dr Shaw
[212] WIT 0437 0002 Dr Shaw

place of the RMO and RHMAC, and increasing emphasis was put on local management of clinical audit.'[213]

178 In 1993, in preparation for the devolution of audit funding to purchasing authorities instead of directly from the RHA to the provider units, the Audit Unit drafted specifications for effective audit which were to become the basis of future three-way contracts between the Regional Health Authority, purchasers and providers.[214] Under the aegis of the RHMAC and with the agreement of the hospital audit chairman, the same principles guided a series of self-assessments and external validations by a Regional Audit Team. These assessments were aimed to assist the local development of audit, to assess local progress with respect to structure, process and outcome of audit, and to help define contract specifications for 1993/94 funding.[215]

179 The Regional Audit Team was set up to try to encourage the development of audit. Its purpose was to try to develop a source of expertise at Regional level, which would be available to the Districts '… so we were not all inventing the wheel simultaneously.'[216]

180 Up to and including March 1993, the reporting requirements for audit were as stipulated in HC(91)2.[217] The purpose of the report was to account for the funding provided and to report on the progress made. Dr Shaw was responsible, as advisor to the RHMAC, for collating District audit reports to an agreed timetable and structure, and compiling the regional annual report. This report was presented to the RHMAC for approval, and was then distributed to the DoH, the Regional General Manager (RGM) and to the DHA and Trust managers and clinicians within the Region.[218]

181 Dr Shaw wrote:[219] 'During 1993, the reorganisation of the health service (in terms of regional authority and the purchaser/provider split) and of audit shifted the mechanics and accountability. The 1993/94 regional annual report *"Meeting and improving standards of healthcare"* was the first to address "clinical" rather than "medical" audit and to follow the format defined in EL(93)34[220] and 59.'[221]

182 Dr Shaw reported that the final Regional annual report of 1993/94 made no reference to the involvement of or approval by the RHMAC, except that a copy was sent to the chairman of the Committee. But it did declare that it was produced on behalf of the SWRHA.[222]

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[213] WIT 0437 0002 Dr Shaw

[214] The draft contracts were included in the 1992/93 Regional Annual Report, for application in 1993/94; WIT 0437 0013 Dr Shaw

[215] WIT 0437 0002 Dr Shaw

[216] T25 p. 46–7 Dr Roylance

[217] HAA 0164 0023; circular HC(91)2

[218] WIT 0437 0012 Dr Shaw

[219] WIT 0437 0013 Dr Shaw

[220] HAA 0164 0434; circular EL(93)34

[221] HAA 0164 0164; circular EL(93)59

[222] WIT 0437 0013 Dr Shaw. The three-way contracts between the RHA, purchaser and provider, introduced in 1993/94, required the provider units' reports to be sent to the Regional Director of Research and Development, Professor S Frankel; Dr Shaw was not involved in producing the 1993/94 regional annual report

183 According to Dr Morgan: 'There was remarkably little contact between the activities of this [Bristol Clinical Audit]Unit and local District Health Authorities – the relationship appears to have been almost entirely directly with Trust audit mechanisms.'[223]

Effectiveness of the regional audit programme

184 Miss Hawkins was asked by Leading Counsel to the Inquiry whether she, at the level of the Region, had access to what she regarded as full data on the performance of cardiac surgery at the BRI in the period up to 1992–1993. She replied:

> 'Not to my knowledge. Up until the time audit was properly accepted by medical staff, data was not openly and willingly shared. It was particularly difficult around the time of contracting when they had what they called "commercial confidentialities". At regional level, it was extremely difficult to have very specific surgeon/data aligned to one individual. Normally, if data came up, it was in a block scenario so you did not know who was accountable quite for what, so you could have a surgical specialty with subspecialties.
>
> 'It is one of the reasons why – the government did have a push for audit and why we did designate an individual person from Region to actually begin to develop the audit processes within hospitals which would also give us access, as audits came forward, to make good comparisons across regions and on a national basis. But the collection of data was not as it is now.'[224]

185 A letter dated 3 June 1992 from the Deputy Regional Director of Finance concerning medical audit allocations for 1992–1993 stated: '… The fragmentation of funding arrangements and the consequent lack of clarity over the responsibilities of the regional medical audit advisor, local audit committees and the DHAs has led to some confusion.'[225]

186 Miss Hawkins told the Inquiry that this was a reflection of the situation of audit in the early 1990s:

> '… because funding was coming from a variety of sources and each unit either had no audit procedures in operation, or committees, and the one that did had different approaches and there was no common agreement at that stage on how audit should be conducted.'[226]

187 At this stage the medical staff themselves were supposed to be responsible for audit. Miss Hawkins agreed that due to the suspicion and sensitivity from the profession, the prevailing idea during the 1980s was that the most appropriate level from which initiatives on audit should come would be from the RHA. The RHMAC gained the

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[223] WIT 0307 0012 Dr Morgan

[224] T56 p. 14 Miss Hawkins

[225] UBHT 0026 0083; letter from the Deputy Regional Director of Finance to chief executives, 3 June 1992

[226] T56 p. 113 Miss Hawkins

confidence of the consultant staff, and they felt that under the auspices of the RHMAC they would not be made vulnerable.[227]

188 Also influential was the introduction of the audit promoter, Dr Shaw, to assist local units and consultants to develop the process.[228]

189 According to Dr Morgan, RHAs worked directly with the trusts to develop medical audit, allocate funds and monitor progress: 'There was then little contact between the South West Regional Health Authority and Bristol and District Health Authority about these initiatives.'[229]

190 From the financial year 1994/95, the funding arrangement changed and the funding which the Regions had formerly separately identified became part of the general allocation of funding to the DHAs. From then on the districts ensured that audit was part of the standards and processes which they monitored as part of their contracting arrangements, rather than being a matter separately supervised by the RHAs.[230]

191 In preparation for this shift in role, a Regional Working Group had been established in December 1993, chaired by Dr Baker. The Group reported in February 1994.[231]

Audit at district and unit level

Introduction

192 Between 1984 and April 1991, the administration and management of the BRI and the BRHSC were the responsibility of the B&WDHA. Thereafter, they became the responsibility of the UBHT. This chapter gives an account of the evidence charting the development of audit at district level until April 1991, and thereafter at the UBHT. It makes reference, from time to time, to cardiac services and, more specifically, to paediatric cardiac surgical services, while seeking to focus on the more general picture.

193 The systems and practice of the audit of paediatric cardiac surgery have to be seen in the context of systems, practice and policy relating to audit at the level of the unit, which is the subject of this part of the chapter, and, indeed, against the national and regional background which was set out earlier in the chapter.

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[227] T56 p. 113–14 Miss Hawkins
[228] T56 p. 114 Miss Hawkins
[229] WIT 0307 0007 Dr Morgan
[230] T36 p. 101–2 Dr Baker
[231] WIT 0074 0038 Dr Baker

1985–1988 The B&WDHA Performance Assessment Committee

194 In 1985 the B&WDHA formed the Performance Assessment Committee (PAC). The Inquiry was told that the PAC was made up of lay members of the B&WDHA.[232] It was not an audit committee but, by means of examining 'work-related figures', concerned itself mainly with the task of ensuring that the hospitals in the Area functioned as efficiently as possible.[233]

195 Dr Trevor Thomas, Chair of the Medical Audit Committee (MAC) 1991–1993, told the Inquiry that the PAC had, on occasion, been less than tactful in its treatment of information and medical staff. Subsequently, this had adversely affected the introduction of medical audit at Bristol in 1990.[234]

196 One of the functions of the PAC was to monitor the care of patients. To this end it received statistical information from a Medical Information Working Group (MIWG). The MIWG consisted of both clinicians and managers. It seems to have been a sub-group of the PAC and assisted it by interpreting technical and medical information. The Inquiry was told that it was formed following misinterpretations of information and consequent misunderstandings between the PAC and members of the medical staff of the United Bristol Hospitals.[235]

197 Most of the data considered by the MIWG and the PAC was of a general nature, relating principally to bed usage, operating theatre usage, patient throughput and bed occupancy.The PAC received figures such as how many patients each consultant saw and the numbers of operations performed. As regards mortality, the data related only to general mortality statistics.[236]

198 The MIWG was not considered to be a medical or clinical audit committee:

> 'The nature and paucity of the available data, and its relative age, coupled with the cumbersome way in which it had to be assessed, manipulated and reported, through a regional system known as "Centrelink" was not conducive to its being used for audit purposes. This was widely recognised.'[237]

199 In February 1986, B&WDHA agreed that its District Medical Officer (DMO) should 'continue to assess clinical performance in an extended but carefully selected number of specialties'.[238] The difficulties of such assessment were acknowledged in the

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[232] T62 p. 71 Dr Thomas

[233] T62 p. 70 Dr Thomas. He does not define in which sense 'efficiently' is used, but the context is that of workload

[234] T62 p. 68 Dr Thomas

[235] WIT 0323 0003 Dr Thomas

[236] WIT 0323 0003 Dr Thomas

[237] WIT 0377 0016 Mr Alan Carter, former Director of Information Technology and Assistant Director of Operations, UBHT

[238] WIT 0038 0022 Ms Charlwood, Chief Executive Avon Health Authority 1994 to present

Authority's *'Strategy for Neonatal Care 1986–1994'*, adopted in May 1986, which pointed out that:

> 'No separate routinely available information is recorded for the outcomes of neonatal care in relation to neonatal surgery both cardiac and non-cardiac.'[239]

200 In June 1986 the SWRHA required DHAs to provide performance indicators and key indicators. In the view of Pamela Charlwood:[240] '… none was narrow enough to isolate paediatric cardiac surgery and none was concerned with surgical outcomes.'[241]

201 In 1986, the PAC reviewed four of the services provided in Bristol. Paediatric cardiac services was not one of them.

202 Ms Charlwood also told the Inquiry that, in April 1987, the PAC decided that a sub-committee of itself, together with the District General Manager (DGM), should conduct Unit reviews in September or October each year.

203 Consequently, in September 1987, the PAC appointed a Review Group, which reviewed the Central Unit (including the BRI and BRHSC) in October 1987. This Review Group reported to B&WDHA in November 1987.[242] It did not identify paediatric cardiac surgery as an area of concern.

204 Ms Charlwood informed the Inquiry that in August 1988 the MIWG reported that a steering group had been set up under the Chairmanship of Dr Thomas to oversee implementation of 'Medisgrps', a clinical management information system. It was designed to take into account the severity of the patient's condition as it affected the actual outcome of care. It was hoped that it would be applied to data relating to adult cardiology and cardiac surgery. It appears that it was never developed beyond a pilot stage.

205 In September 1988 the MIWG considered cardiothoracic surgery. Ms Charlwood stated that the report '… stressed there were no comparative figures in the form of performance indicators but Mr Wisheart is minuted as having referred to the "national register of cardiac cases".'[243]

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[239] HAA 0128 0033; *'Strategy for Neonatal Care 1986–1994'*

[240] Current Chief Executive, Avon Health Authority (since 1994)

[241] WIT 0038 0022 – 0023 Ms Charlwood

[242] WIT 0038 0023 Ms Charlwood

[243] WIT 0038 0023 Ms Charlwood

206 In summarising developments during this period, Ms Charlwood stated:

> 'By the end of 1988 the DHSS had announced an intention to place greater value on medical audit … Up to that point B&WDHA had
>
> 'i) recognised the need to monitor performance in terms of outcomes for patients;
>
> 'ii) acknowledged the impracticability of assessing all outcomes in all specialties;
>
> 'iii) opted to monitor specific services each year;
>
> 'iv) not seen or heard anything about paediatric cardiac surgery to warrant selecting it for scrutiny.'[244]

207 In October 1988 the PAC received the BRI/BRHSC 1987 *'Paediatric Cardiology and Cardiac Surgery Annual Report on Paediatric Cardiology'*. Mortality rates were described as virtually identical to those obtained nationally as published in the UK Cardiac Surgical Register. The PAC's minute (119/88) stated: 'Members … noted that there were no national performance indicators'.[245]

The District Audit Committee

208 On 6 March 1989 in response to the audit plans set out in *'Working for Patients'*,[246] the PAC asked the MIWG to consider establishing a Medical Audit Advisory Committee. The MIWG considered itself well placed to take the matter forward, and did so in the first instance.[247] The MIWG reported back on 24 April 1989 that its membership and terms of reference were an ideal starting point for an audit committee.[248]

209 Thus the MIWG evolved into the District Audit Committee (DAC). Its function was to oversee the development of a medical audit programme.[249]

210 Dr Thomas stated that:

> 'The Medical Audit Committee was formed as a sub-committee of, and reported to, the Hospital Medical Committee (HMC). Its constitution was discussed by HMC in the autumn of 1990 and the committee met for the first time on 5 December 1990.[250] … The constitution was based on statements contained in the Working Paper 6 (Medical Audit) of the Government White Paper 'Working for Patients' … The main objective of the committee was to establish a formal audit function within

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[244] WIT 0038 0023 Ms Charlwood

[245] WIT 0038 0023 Ms Charlwood

[246] HAA 0165 0145; *'Working for Patients',* Department of Health, HMSO

[247] HAA 0141 0085; report of the PAC 6 March 1989

[248] HAA 0141 0078; report of the PAC 24 April 1989

[249] UBHT 0068 0001; '*The Regional Approach to Medical Audit'*, June 1989

[250] The constitution of the District Audit Committee: WIT 0323 0009 Dr Thomas

the UBHT.[251] It was formed at a time of great change when the United Bristol Hospitals were preparing their submission for trust status.'[252]

211 The terms of reference in the constitution of the DAC were:

> '1. To promote Audit, mindful of national, Royal College and regional initiatives and guidelines.
>
> '2. Facilitate the creation and working of audit groups within individual directorates or other groupings.
>
> '3. Review the reports of the individual audit groups to ensure that effective Audit is being undertaken, within the limitations of suitable confidentiality of individual data.
>
> '4. To notify the Steering Committee of the Hospital Medical Committee of any desirable or proposed changes in utilisation or practice.
>
> '5. To advise local managers as to the adequacy or appropriateness of resources made available for the process of medical audit.
>
> '6. To report annually to the Regional Audit Committee, within the limitations of suitable confidentiality of individual data.
>
> '7. To draw the attention of medical staff to new audit initiatives and facilities that may from time to time occur.'[253]

The approach of the District to audit after April 1991

212 The role and responsibility of the District for audit altered after trust status was conferred on the UBHT and the purchaser-provider split began in 1991. DHAs no longer directly managed hospital units and so their role, necessarily, had to change. Circular HC(91)2,[254] issued in January 1991, required DHAs to ensure a system of medical audit was in place by 1 April 1991.

213 Once the trusts were established, the districts' involvement in audit was through the mechanism of service agreement contracts between DHAs and trusts, and was therefore indirect. These agreements set out audit requirements, and provided that audit information was to be reported to a representative of the purchaser, often the Director of Public Health Medicine.[255]

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[251] The Trust was due to be formed with effect from 1 April 1991

[252] WIT 0323 0004 Dr Thomas

[253] WIT 0323 0009 – 0010 Dr Thomas

[254] HAA 0164 0023; circular HC (91)2

[255] WIT 0108 0046 Dr Roylance

214 Each trust put its own arrangements for audit in place.[256] Thus, the DAC evolved into the Medical Audit Committee (MAC) of the UBHT,[257] and no further audit committee was set up within the District in 1991.

215 The B&DHA's approach to audit through the 'contracting' mechanism was formally agreed on the advice of its Director of Public Health, the lead officer for that area of work.[258] Dr Kieran Morgan, Director of Public Health at Avon Health Authority (Avon HA), stated: 'Immediately after the formal establishment of Bristol and District Health Authority,[259] it began developing approaches to improving clinical quality.'[260]

216 From 1992 to 1995 the B&DHA's approach was to have a quality specification indicating the District's approach to quality which was common to all services, and a separate specification as to the service to be provided for each speciality. The latter specified if there were any additional monitoring requirements for the given year.[261]

217 The B&DHA's specification regarding quality was linked to outcomes in the form of enhanced health, but the guidelines for contracting continued: 'We can also recognise that some measures which on the surface relate to process, rather than outcome, can themselves influence outcome. User involvement is an example of this.'[262]

218 The B&DHA did not have the capacity to monitor all aspects of service quality itself and therefore relied on each trust to report on selected aspects of service delivery according to a quality monitoring schedule which formed part of the service agreement each year.[263]

219 A Medical Audit and Clinical Standards and Outcome Measurement (MACSOM) Working Group was established by the B&DHA in 1993, under the chairmanship of Dr R Kammerling, a public health physician. According to Dr Baker: 'The Committee sought to develop formal relationships with Medical Directors and Chairs of Trusts' Audit Committees for the contracting and funding of audit.'[264]

220 The aim was to agree not only firm contracting arrangements and sound audit processes, but also a limited number of areas for audit which would be recognised as of mutual concern and the findings of which would be supplied to the purchaser. Both process and outcome indicators of clinical quality were regarded by the District as relevant, but Dr Baker stated: 'Dr Morgan advised that UBHT were adamant that they

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[256] T36 p. 100 Dr Baker

[257] See below, para 302

[258] WIT 0159 0038 Ms Evans

[259] In October 1991, in succession to the B&WDHA

[260] WIT 0307 0005 Dr Morgan

[261] WIT 0159 0027 Ms Evans. See, for example, the list of incorporated Schedules in the B&DHA's 1993/94 Service Agreement, WIT 0159 0047 Ms Evans

[262] HAA 0156 0142

[263] WIT 0159 0027 Ms Evans

[264] WIT 0074 0038 Dr Baker

did not wish to generate and stick to clinical process standards and would wish to concentrate on outcome measures only.'[265]

221 In March 1995 Dr R Kammerling wrote a strategy for the Avon HA[266] on the further development of clinical audit. It contained a framework for assessing the development of clinical audit and was accompanied by Schedules of Agreed Audit Topics, agreed with the trusts. At that time, the Schedule agreed with the UBHT did not require an audit of paediatric cardiac services.[267]

The control of audit through the 'contracting' process

222 The minutes of a meeting of the B&WDHA on 16 July 1990 record that: 'Mr Dean Hart confirmed the Hospital Medical Committee's advice that only medically qualified personnel could negotiate, agree and implement contracts.'[268] Clinical directors, rather than general managers, were thus involved in the negotiation of contracts between the Trust and purchasing District.

223 1991–1992 was the first year in which 'contracts' or service agreements between purchasers and providers came into use nationally. The first contract between the newly formed UBHT and the District contained the provision that:

> 'The Providers will have Quality Assurance systems which include elements of quality control, identification of service deficiencies, and mechanisms for correcting and reviewing problems.'[269]

224 The contract also included performance monitoring requirements[270] and provisions relating to audit within the individual contract for each specialty. The contract for cardiac surgical services had separate sections on medical audit, nursing audit and paramedical/support services audit.

225 Medical audit was to:

> '… include audit of outcome, the medical process and the management process … the Cardiac Surgery Unit will set up an audit group to meet regularly and to provide the Bristol & Weston Health Authority with sufficient information for it to ensure that adequate audit is taking place.'[271]

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[265] WIT 0074 0038 Dr Baker

[266] The Avon Health Authority, recently formed

[267] WIT 0074 0039 Dr Baker. Arrangements for a multidisciplinary audit of paediatric cardiac services were subsequently made later in 1995, after the service had received adverse attention and publicity. Results for open and closed surgical procedures from May 1995–January 1996, undertaken by Mr Pawade, were received by Dr Baker, and agreed as a baseline of satisfactory activity

[268] UBHT 0249 0087; minutes of meeting of the B&WDHA 16 July 1990

[269] HAA 0011 0248; service agreement

[270] WIT 0159 0027 Ms Evans

[271] HAA 0010 0094; service agreement

226 In particular, the audit of outcomes was to include measures of 30-day mortality, one-year mortality and one-year symptomatic state. Ms Evans, the Contracts Manager of B&DHA from 1991–1995, expressed the view that those standards had most probably been discussed and agreed with the clinicians although she thought they were regarded as aspirational rather than actual standards to be attained.[272]

227 Before committing the Directorate to the service agreement, Mr Wisheart (as the surgeon who took the leading role on the Working Party which developed the service specification) wrote to Dr Roylance. His letter, of 13 March 1991, contains the following:

> ‘I have been asked to sign this document as the basis for the contract for provision of Cardiac Surgery Services for the year beginning 1st April 1991. As I participated in the discussion which led to the production of this document I am of course in agreement with what it is aiming to do. Lest my signature at the end of this document should be construed as my agreement to the contract for which I am responsible and accountable I must state the following reservations;
>
> ‘1. This service agreement contains no indication of the volume of work to be undertaken or agreed cost and payments …
>
> ‘3. We have agreed that the monitoring and reporting activities reported in Paragraph 18 to 21 should be provided. No resource or provision has been made to do this which may make it difficult or impossible to collect and report all of this data for the coming year.
>
> ‘4. Specific reservations … Paragraphs 15, 16 and 17 – the audit achievement [*sic*] are being established but may not necessarily operate fully from 1st April 1991.’[273]

228 Mr Wisheart gave his view of the concluded contract:

> ‘The early service agreements set out that quality measures, we will say of the management type, and a whole range of them, would be measured, and they were monitored and shared I think on a quarterly basis … Secondly, there was a requirement that audit, that is, medical clinical audit, would be carried out … I think initially the agreement was that they would be assured that it had been carried out, because that was generally the framework within which audit was carried out by clinicians and it was reported to the managers or the Board and they were assured that it had been carried out, rather than providing them with all the detailed information … The third element is the element of the additional agreed topics of audit. That agreement included, of course, the exchange of information because it was actually a collaborative exercise, in essence. So there was full and free exchange of information within that agreed topic.’[274]

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[272] T31 p. 36 Ms Evans

[273] HAA 0011 0254 – 0255; letter from Mr Wisheart to Dr Roylance dated 13 March 1991

[274] T41 p. 99–100 Mr Wisheart

229 The view of the District in relation to the same contract was given by Dr Baker:

> '… Initially, the first specification for contract in 1991/92 did carry a requirement for various aspects of the product of audit, including 30-day post-operative mortality. It was unspecified, but I think it was linked to other matters which suggested that we were thinking about adult activity. Then I think subsequently both in terms of our own reasoning and with advice that we received from others, we realised we had been over-ambitious in what we were asking for in that first contract. Subsequently, those aspects of quality were rephrased in various ways and moved in general terms more to a requirement for audit to be taking place rather than having the expectation that we could be provided with precise information on different aspects.'[275]

230 Dr Baker went on to say that subsequent contracts contained more general requirements that aimed to ensure that a suitable process of audit took place, rather than requiring specific indicators to be provided.[276]

231 The first contract provided that figures relating to outcomes in cardiac surgery should be provided to the DHA. They were to be provided directly to the purchaser, and were not passed through, nor did copies have to be sent to, the MAC. Dr Thomas explained that this was:

> '… because contracts were perceived as following a different route from audit and a sort of schism between the two was quite clear. In the Trust's mind and in I think the Audit Committee's mind as well, the contract negotiations would proceed and would only involve the Audit Committee if the Trust asked the Audit Committee to be a conduit for the passage of information from the directorate to the purchaser'.[277]
>
> 'At that time [1991] there was a clear undertaking being given by cardiac surgery to the purchaser that they would provide, to the purchaser direct, figures of mortality. As far as the Audit Committee were concerned, those figures were passed and we were not given any information that they were not passed. They did not go through the Audit Committee, much to our regret, because we believed that that should be a function of an Audit Committee. We were defeated on this matter by both the purchaser, by the directorate, by the management and so on and so forth.'[278]

232 A quality monitoring schedule having been introduced as part of the service agreement for each year, the 1992/93 B&DHA service agreement contained a 'Quality of Service' Schedule. A statement of 'Key quality objectives' was set out. Rights conferred by the *'Patient's Charter'* were noted and it was stated that providers were

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[275] T36 p. 109 Dr Baker
[276] T36 p. 110 Dr Baker
[277] T62 p. 140 Dr Thomas
[278] T62 p. 79 Dr Thomas

expected to meet patients' rights. Monitoring arrangements were set out. The obligations in the agreement concerning 'professional audit' were as follows:

> 'All Provider Units are required to develop medical/clinical audit programmes whose broad aims are to clarify and improve standards of patient care. These programmes should link with the Provider's overall approach to quality. Bristol & District Health Authority recognises that general features of professional audit will mean that:
>
> - 'Some audit activities will be highly confidential and will be confined to a small group of people. Others will operate under the general levels of confidentiality required by the NHS.
> - 'Some audit activities are best conducted on a multi-disciplinary basis.'

233 There then followed three specific topics for the provider units: hospital-acquired infections; unplanned re-admissions to hospital within four weeks; and pressure sores.[279] A report on audit programmes for medical nursing and Professions Allied to Medicine (PAMs) was required by the end of the year.[280] The agreement also contained a provision to hold a meeting during 1992/93 to review clinical audit.

234 The 1993/94 agreement recognised that there had not been just one meeting during 1992/93 to review audit, but a series of such meetings:

> 'During 1992/93 a series of meetings were held with Clinical Directors and Executives in each Trust to discuss progress with Clinical Audit. Bristol & District Health Authority intend to build on this constructive dialogue to develop our approach to clinical quality.'[281]

235 The agreement went on to state, under the heading 'Professional Audit,' (in recognition of the transition from medical to clinical audit):

> 'Bristol & District Health Authority acknowledge that Clinical Audit is primarily an educational process and must remain under professional control to achieve this goal. The clinical aspects of care are, however, no longer regarded as solely the province of clinicians and the need to develop clinical quality monitoring must be recognised.
>
> 'To ensure that this process has a measurable impact on patient care, it must expand beyond the medical profession to integrate work already taking place within the nursing and the paramedical professions.'[282]

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[279] HAA 0156 0152; service agreement
[280] HAA 0156 0179; service agreement
[281] HAA 0156 0331; service agreement
[282] HAA 0156 0340; service agreement

236 To ensure that audit was taking place, the agreement provided that clinical, nursing and paramedical audit reports were to be provided by trusts to the B&DHA in April 1994.[283]

237 This followed discussions which had taken place with trusts, as a result of which, Dr Morgan stated, the B&DHA had published its own set of principles in *'Medical Audit, Clinical Standards and Outcome Measurement'*[284] and agreed a programme[285] for monitoring clinical quality for 1993/94 onwards. He noted: '… At this time, the principle of [the] Health Authority being able to nominate certain priorities for audit was established for the first time alongside a requirement that each Trust provides a report on its full clinical audit programme on an annual basis.'[286]

238 In the 1994/95 contract, the section on clinical audit was far more detailed than that in previous years. It outlined the aims of audit and the role of the B&DHA, which included:

> '(a) to assure itself that clinical audit is being undertaken
>
> '(b) to facilitate the integration of audit into the routine monitoring process by encouraging audit on topics where it has a specific interest.'[287]

Further:

> 'B&DHA will not attempt to impose a model of audit or define the audit programme. It will, however, look for evidence of well supported audit activity of a high quality.'[288]

239 The annual audit report on the Trust was to be provided to the purchasers.[289]

240 As part of the 1994/95 agreement, the District agreed a Schedule for audit with the UBHT, which identified certain activities that were to be the subject of audit. Some of those activities related to adult cardiac services.

241 From the outset, the contracts with the B&DHA envisaged that clinical directors might seek the advice of the MAC if requested by purchasers to provide information about clinical activity. However, in practice, Dr Thomas told the Inquiry that he could not recall ever receiving requests for information from purchasers:

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[283] HAA 0156 0341; service agreement

[284] UBHT 0028 0155; *'Medical Audit, Clinical Standards and Outcome Measurement'*

[285] One topic was hospital mortality following operations for coronary artery bypass grafting

[286] WIT 0307 0005 – 0006 Dr Morgan

[287] HAA 0156 0429; service agreement

[288] HAA 0156 0430; service agreement

[289] HAA 0156 0430; service agreement. Evidence of the circulation of the UBHT's annual audit reports is to be found at paras 314–17, 364, 378 below onwards

> '… I am casting back in my memory to see whether I can recall any particular figures that came through the Audit Committee and the nearest example I can come to you with is that in, I think, early 1992, our general practitioner representative, Dr Whitfield, came to a meeting and said he felt that the Audit Committee should have a more proactive role.'[290]

242 Dr Black also stated that he could not recall any specific requests from the purchasers to audit any particular aspect of the UBHT's activity during his tenure as a member of the Committee.[291]

243 The contract mechanism thus provided for returns to be made to the B&DHA. The DHA Contracts Manager would receive the returns from the UBHT and either analyse them, or pass them on to colleagues, and then submit an overall comment to the Director in the DHA responsible for monitoring quality.[292]

244 The contractual regime created some difficulties for the provider trust. Ms Evans said that: 'One of the issues was that different purchasers would want to make different quality requirements of the same Trust, and one can imagine that with a Trust like UBHT with 43 purchasers, that would have been difficult.'[293]

245 By 1994/95, she reported, this was a general concern across RHAs throughout the country.[294]

Monitoring and review of performance by the District

246 Ms Evans said that the process within the DHA for dealing with issues relating to monitoring performance and quality 'varied according to the nature of the issue'.[295]

247 In the interim period between the formation of the UBHT in April 1991, and the formation of the Bristol and District Health Authority in October 1991, Dr Baker, then the DMO of the B&WDHA, engaged in discussions with clinicians including local cardiologists and cardiac surgeons, concerning the assessment of trends and attempts to develop outcome measures for adult cardiac surgery.[296]

248 In June 1991 he wrote to members of B&WDHA's Department of Public Health Medicine seeking ideas for items on audit for discussion with clinicians for the 1992/93 contracts. He stated that he had in mind the investigation of treatments that were effective, were applied to a substantial number of patients, and involved

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[290] T62 p. 82 Dr Thomas. Dr Michael Whitfield (Consultant Senior Lecturer in General Practice) produced a paper which suggested a role for the Audit Committee – UBHT 0026 0063

[291] WIT 0326 0004 Dr Black

[292] WIT 0159 0030 Ms Evans

[293] T31 p. 61 Ms Evans

[294] T31 p. 61 Ms Evans

[295] WIT 0159 0029 Ms Evans

[296] WIT 0038 0024 Ms Charlwood

considerable resources. The suggestions received in reply did not concern cardiac care.[297]

249 In December 1991 Dr Baker (by then Director of Public Health for the B&DHA) wrote to Dr Thomas, as Chairman of the MAC, expressing concern over the lack of progress in implementing medical audit.[298]

250 Each year, the B&DHA received feedback in respect of the performance of the provider trusts. Ms Evans stated that in relation to the UBHT the feedback[299] for the first year, 1991/92, drew attention to the fact that in order for the system to work, the Trust would need to take responsibility for setting its own quality assurance framework and for making sure it was reviewing its services against its own framework.[300]

251 The feedback had identified as a weakness that the UBHT did not appear to have an overall approach to quality, nor were there individuals with clear responsibility for it. Ms Evans commented:

> 'I think that in 1990/91/92, which this report is relating to, both the Trusts and ourselves as purchasers were feeling their way in this new world of different responsibilities for quality assurance … The UBHT later established a committee which was chaired by one of their non-executives … I think that one was aimed at looking at marketing issues and so on, but it was certainly a committee which sought out feedback about UBHT services. I was invited to that. I think latterly the Trust also developed a committee which was specifically about looking at quality. So it was an issue which I think they recognised and addressed over time, although, at this point, I think our comment was valid.'[301]

252 Ms Evans drew attention in her written statement[302] to instances in which problems identified in one set of monitoring returns had not subsequently been addressed or followed up. She told the Inquiry:

> 'I think we were very active in quality monitoring. I think probably that if one were to look at other district health authorities we were at least as active as others and probably more active than some. I think in my statement I was also trying to demonstrate that through the iterative process, we were identifying shortcomings and within the UBHT's directorates, they were trying to put them right. I think that is what one would expect to see in any cycle of quality monitoring, that you try and establish your standards and then check performance against them and if you feel they are not good enough, then you take corrective action and go back and re-audit them.'[303]

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[297] WIT 0074 0037 Dr Baker
[298] HAA 0034 0014
[299] HAA 0043 0011; Finance and Contracting Committee report
[300] WIT 0159 0030 Ms Evans
[301] T31 p. 69 Ms Evans
[302] WIT 0159 0190 Ms Evans
[303] T31 p. 74 Ms Evans

253 In 1992, meetings were arranged between the District and each trust within the District. The meeting with the UBHT took place on 11 November 1992.[304] Dr Morgan stated:

> ‘At this meeting (A09796), the Chief Executive of the UBHT, John Roylance, explained that his Trust would not be keen on reporting on audit of process measures but would be happy to work on outcome measures with Bristol and District Health Authority. The Trust agreed to develop proposals for outcomes to be measured in a number of specialties and a list was provided in January 1993 (A09799). This list included adult cardiac surgery – “coronary artery bypass grafting, hospital mortality by pre-operative severity of disease”.’[305]

254 A regional perspective of the extent to which the DHA monitored quality of outcome was provided by Ms Charlwood, referring to the period after 1992:

> ‘… the District Health Authorities do not appear to have used the vocabulary of safety in regard to quality, but they did include outcomes for patients as part of their consideration of quality issues.
>
> ‘From the outset B&WDHA appears from its records to have tried to concern itself with qualitative issues, as distinct from quantitative issues such as the number of operations performed.
>
> ‘However,
>
> ‘(i) the criteria for judging quality appear to have changed from time to time, often in response to changing priorities or emphases on the part of the Government (such as waiting lists and unit costs, or the introduction of the *‘Patient’s Charter’*);
>
> ‘(ii) the criteria chosen, and their indicators, were mostly of a general nature and on a large scale, so did not draw attention to concerns about surgical outcomes in a particular specialty at a particular hospital; and
>
> ‘(iii) much of the information that might otherwise have informed decisions about quality did not differentiate paediatric from other cardiac surgery.’[306]

255 She identified a development of the role from mid-1993:

> ‘From April 1993 onwards, Health Authorities were given a more explicit role in promoting clinical audit, and funding audit through allocations and from 1995 through the “service agreements”. In 1993, B&DHA discussed a joint strategy for clinical audit with UBHT (and the other local Trusts), and negotiated agreement of a

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[304] WIT 0307 0005 Dr Morgan

[305] WIT 0307 0005 Dr Morgan

[306] WIT 0038 0022 Ms Charlwood

> small number of areas for audit on the grounds of shared concerns. Paediatric cardiac activity was not identified by UBHT or the Health Authority as an area of shared concern. These agreements were monitored through review visits by Dr Morgan, the director of Public Health, and the Vice-Chairman of the Authority, Professor Gordon Stirrat, to the Trusts.'[307]

Involvement of the District in nursing audit

256 The reporting of nursing audit activities[308] became a requirement of the contract made with purchasers. Ms Evans told the Inquiry that the DHA saw:

> '… a number of reports which relate either to nursing audit and auditing aspects of the service for children, or to the patients' surveys which took place both in the cardiac surgery ward and in the Children's Hospital, and which sought parent and sometimes children's opinions on various aspects of the service. So there were a number of ways in which we tried to check that the trusts were being active in this area.'[309]

257 Ms Evans cited examples of audit undertaken by nursing staff. In 1992/93:

> 'The nursing staff in cardiac surgery were active … [in] defining nursing care standards and monitoring them. The 1992/1993 Report describes several of these including an audit of cardiac theatres using the National Association of Theatre Nurses audit documents.'[310]

258 Part of this audit referred to departmental organisation. It included the following:

> 'Standard 3 – "The department has an annual quality improvement programme". Although induction programmes had been devised, they were often not put into practice. It was felt that due to a shortage of experienced staff, new members of the nursing staff were often being trained in the practical skills without an all round induction to the entire work of the unit. Staff were not able to express a departmental statement of objectives or philosophy of care.'[311]

259 In the next year, 1993/94, Ms Evans stated that:

> '… the UBHT's monitoring reports begin to report a shift from uni-professional audit … to multi-professional "clinical" audit.'[312]

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[307] WIT 0038 0014 – 0015 Ms Charlwood
[308] For details of the approach of the UBHT to nursing audit, see below at para 379 onwards
[309] T31 p. 52 Ms Evans
[310] WIT 0159 0031 Ms Evans
[311] WIT 0159 0239 Ms Evans
[312] WIT 0159 0031 Ms Evans

260 In the *'UBHT Quality Monitoring Report'* for October 1993 to March 1994 it was noted that:

> 'The move towards multidisciplinary clinical audit described in the Nursing Audit report is welcomed. Discussions are taking place between United Bristol Healthcare Trust and Bristol and District Health Authority on areas for clinical audit in 1994/1995. It is important that nursing staff are involved in this process … It is good to see the positive action taking place as a result of nursing audit, in particular the recommendations from standard four: safety and the environment. The potential for confusion with both corporate standards and local directorate standards is noted.'[313]

261 Ms Evans stated that the report for 1994–1995:

> '… also described work in progress on audit across the nursing teams in the newly established directorate and appends the nursing standards specific to Ward 5 (which includes some standards relating to the care of children).'[314]

262 The report itself stated:

> 'Nursing standards and audit are well established and the emphasis now is to move closer to multidisciplinary audit.'[315]

Reporting of accidents/incidents

263 In 1955 the Ministry of Health issued a Circular, *'Reporting of Accidents in Hospitals'*.[316] The Inquiry was informed, in written evidence, by Mr John Gray, Manager, UBHT Legal Services since 1991, that this document was generally known within the NHS as *'Reporting Accidents and Untoward Occurences'* [317] and was always followed by the UBHT.

264 Before the change to general management, patients' incidents statements generated by nursing staff would normally be considered by a senior nurse before being passed to the hospital administrator. In more recent times there is initial consideration by the clinical nurse manager and a report made to the directorate manager or, in a larger directorate, to the assistant general manager of the directorate. Mr Gray indicated in his statement that 'there was no formal policy in the NHS during the relevant period as to which incident should be reported to the Chief Executive, or what specific action should be taken'.[318]

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[313] WIT 0159 0193 Ms Evans; *'UBHT Quality Monitoring Report'*
[314] WIT 0159 0032 Ms Evans
[315] WIT 0159 0185 Ms Evans
[316] WIT 0137 0032 Mr Gray
[317] WIT 0137 0026 Mr Gray
[318] WIT 0137 0026 – 0027 Mr Gray

265 Mr Gray went on that under the chief executiveship of Dr Roylance:

> 'It was a matter for the professional responsibility and judgment within Clinical Directorates as to what was drawn to the attention of the General Manager by the Assistant General Manager; or in turn by the General Manager exercising discretion as to what matters should be drawn to the attention of the Trust's Chief Nurse Advisor or Director of Operations; and in turn whether those matters needed to be drawn to the attention of Dr Roylance as the Chief Executive.'[319]

266 Mr Gray stated that:

> '… a formal analysis was not usually maintained, although a specific incident or series of incidents might prompt a retrospective analysis.'[320]

267 Mr Gray indicated that he could 'find no written policy relating to the period 1984–1995' on the reporting of accidents and untoward occurrences. Mr Gray's written evidence on the matter was drawn from his own knowledge and after consultation with Ian Barrington, Manager of Children's Services, and Rachel Ferris, Manager of Cardiac Services.

The BRI and the BRHSC pre-1991

268 Before April 1991, clinicians regarded audit as being part of medical practice. Audit activity was undertaken voluntarily by clinicians at specialty level.

269 Audit was:

> '… left to the individual practitioner …'[321]
>
> 'The systems of audit were consciously maintained but they functioned through the commitment and interest of the practitioners.'[322]
>
> 'Some doctors may have kept records of results … but it was certainly not systematic and it certainly did not involve all doctors or all specialties.'[323]

270 Dr Roylance stated that, in 1989:

> 'The guidance emanating from the profession at this time emphasised that it was for doctors to take corporate responsibility for clinical care in terms of outcome measurements, and it was for management to facilitate the conduct of audit and to respond to the conclusions from audit but not to involve themselves in the audit itself. Those conducting audit were required to identify any management action

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[319] WIT 0137 0027 Mr Gray

[320] WIT 0137 0028 Mr Gray

[321] WIT 0097 0322 Dr Joffe

[322] WIT 0120 0406 Mr Wisheart

[323] WIT 0523 0003 Mr Paul Barker, Administrator at the BRI from 1979 to 1985

> that was necessary as a result of an audit and then to inform management. Essentially, audit was seen as a professional activity which should be led by the profession.'[324]

271 'Audit', as defined for the Inquiry,[325] however, was not apparently taking place. Rather, the Inquiry heard evidence of changes in practice being introduced as the result of studying the relevant literature, attending and holding scientific meetings, visiting hospitals and keeping logbooks of operations.[326]

272 There was also some indication that comparisons of practice at the Bristol hospitals were being made with recognised benchmarks or standards. For instance, a comparison of the results for paediatric cardiac surgery at the BRI with national figures is documented in the BRHSC and BRI Annual Reports on Paediatric Cardiology and Cardiac Surgery for 1987,[327] 1988,[328] April 1989–March 1990.[329] The standards referred to related to mortality associated with a particular operation. There were differing views as to whether or not national mortality figures provided a reliable benchmark.

The BRI and the BRHSC after 1991

The involvement of management in audit

273 In April 1991 the creation of the UBHT and the separation of the functions of purchaser and provider meant that the Trust as provider had primary responsibility for the development and implementation of an audit programme within its hospitals. This responsibility was imposed as a term of the 'contracts' with the purchasers.[330] It was also a product of the need to account for the use of 'ring-fenced' funds that, until 1994/95, were allocated by the DoH and distributed locally specifically for the purpose of carrying out audit.[331]

274 The organisation and development of audit within the UBHT differed from that of the other trusts within the region, which were smaller. Consistent with the Trust's policy of decentralisation, the budget for audit and the responsibility for the employment of audit assistants was devolved to directorate level and from there to the specialties. The Trust adopted the philosophy that medical audit should be the responsibility of specialty divisions, or departments, and not necessarily the responsibility of individual directorates.[332]

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[324] WIT 0108 0043 – 0044 Dr Roylance

[325] See para 5

[326] WIT 0352 0025 Dr N Brian Williams, WIT 0084 0022, 0027, 0028, 0031 Mr Dhasmana

[327] UBHT 0055 0009; annual report 1987

[328] UBHT 0089 0023; annual report 1988

[329] UBHT 0055 0068; annual report 1989–1990

[330] HAA 0164 0023; circular HC (91) 2

[331] See above, para 68 onwards, for details of funding made available nationally

[332] UBHT 0273 0007; Medical Audit Committee report 1991. Dr Baker compared this devolved approach with that of other, smaller, local trusts: 'There was a contrast around audit … at UBHT … audit had found its way down to the individual clinical directorates and the individual clinical directorates determined the course of the development of audit largely, with the Audit Committee being I think a fairly low-key committee.' T36 p. 106 Dr Baker

275 Dr Thomas told the Inquiry that this approach was adopted following considerable debate:

> 'From my memory I think that all shades of opinion were voiced. People were, I think, worried or concerned about the prospect of audit being undertaken in a way which did not allow them to guide it or to be the owner, if you wish, of the process and the information.
>
> 'We looked at the Regional Health Authority's pronouncements and the Working Paper 6 for guidance and it seemed to us that if we were to reassure colleagues and actually persuade them to pursue audit and gain the benefits from it, that we had to actually allow them to build their own audit process within their specialty. That, we felt, would assuage their concerns quite considerably, but there is no question in my mind that concerns continued for the whole of my time as the Chairman of the Audit Committee, and there was a constant need to reassure people [individual clinicians] that confidentiality would be protected …'[333]

276 The NHS Working Paper No 6 had stated that:

> 'The [audit] system should be medically led, with the local medical audit advisory committee chaired by a senior clinician. The overall form of audit should be agreed locally between the profession and management …'.[334]

277 The Working Paper envisaged that management should be aware of audit results:

> '… the general results of [medical audit] need to be made available to local management so that they may be able to satisfy themselves that appropriate remedial action is taken when audit results reveal problems'.[335]

278 There was neither definition nor further explanation of what the phrase 'general results' meant.

279 The Working Paper also envisaged that management had a role in ensuring that effective systems of audit were in place:

> 'While the practice of medical audit is essentially a professional matter, management too has significant responsibility for seeing that resources are used in the most effective way, and will therefore need to ensure that an effective system of medical audit is in place.'[336]

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[333] T62 p. 67–8 Dr Thomas

[334] HOME 0003 0130; NHS Working Paper No 6

[335] HOME 0003 0130; NHS Working Paper No 6. See also the 1989 guidance from the Royal College of Surgeons, WIT 0048 0116 Sir Barry Jackson

[336] HOME 0003 0130; NHS working paper No 6

280 Furthermore, the draft Health Circular *'Medical Audit and the Hospital and Community Health Services'*[337] suggested that there was an obligation on the Audit Committee from the outset to provide regular reports to management as well as medical staff on the results of any audit being carried out:

> 'These may, for example, include:- a broad outline of the aggregate result, together with any national, regional or other comparisons available.'[338]

281 The NHS Management Executive's later report entitled *'Clinical Audit'* also described the Government's expectations of managers. On the one hand, the Government encouraged managers to be involved in audit and, on the other, they recognised that parts of audit were best left to the professions. The document stated:

> 'Managers need … to be actively involved in the audit process, this being particularly important as deficiencies revealed by audit relate more often to the running of the organisation than to poor quality professional practice. The more managers are involved in the audit process and its organisation the more likely they will be committed to securing the necessary improvements in care.
>
> 'For their part managers must recognise that some aspects of audit are best carried out in complete confidence by the professions concerned, thus ensuring that more sensitive issues are not avoided.'[339]

282 In relation to the role of the chief executives of trusts the report continued:

> 'The Chief Executives of provider units have overall responsibility for the quality of care provided for patients and must therefore have confidence in the local audit programme.'[340]

283 However, no evidence was put before the Inquiry of any formal indication as to what information was to be circulated to management. It was primarily for the clinicians to determine what information was passed up the chain in order to support a case for particular changes to be made within a hospital.[341]

284 Dr Morgan stated that it was fair to say that there were no clear guidelines about which audit results could be passed on to management within trusts and health authorities. He reported that in the early 1990s the clinicians were, in effect, in a position to choose what was reported to management and the health authorities. He stated in his written evidence to the Inquiry that this began to change later in the 1990s 'and is still evolving'.[342]

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[337] UBHT 0058 0134; draft health circular

[338] UBHT 0058 0138 – 0139

[339] UBHT 0271 0391; *'Clinical Audit',* NHS Management Executive, undated

[340] UBHT 0271 0391; *'Clinical Audit',* NHS Management Executive, undated

[341] T28 p. 102 Sir Barry Jackson, President of the Royal College of Surgeons of England

[342] WIT 0307 0019 Dr Morgan

285 Mr Graham Nix[343] also agreed that it was a matter for the clinicians involved in a particular area to keep abreast of their relative performance. He told the Inquiry that the senior management within the Trust kept abreast of relative performance for things such as waiting times and the outcomes of the Trust's services compared with others, but that there was no information on outcomes and no other 'top management' mechanism for monitoring relative performance of any particular specialty in the Trust.[344] Had there been such a mechanism, Mr Nix indicated that it would have fallen within the jurisdiction of the Deputy Chief Executive for clinical issues (Mr Wisheart),[345] since he (Mr Nix) was concerned only with financial and administrative matters.[346]

286 Dr Roylance stated that regular reports were made to the RHA for the purpose of demonstrating that audit was taking place, which subjects were being reviewed and what, if any, action was being taken to improve the quality of care. However, he went on, detailed results of audit were not communicated to the District or the RHA, because to have done so might have threatened the process and co-operation of clinicians.[347]

287 With respect to the role of management, he stated:

> '... the primary responsibility of management was to ensure that audit was being introduced and conducted and that the requisite resources were made available. It was clear from both Regional and national guidance that managers were not to be directly involved in audit and that the actual audit figures were to remain confidential to those providing the service, i.e. the clinicians. Indeed, it was thought that any attempt by the management to become directly involved in audit or the results of audit would seriously inhibit the development of the audit process. Instead, those conducting audit were responsible for identifying any areas which needed management intervention and then for informing management of what intervention was required. Implementation of the process of audit was overseen and monitored by a Trust Audit Committee which reported through the HMC to the District [Regional] Medical Officer.'[348]

288 Sir Barry Jackson told the Inquiry that the attitude within many hospitals, in the late 1980s and early 1990s, was that management should not be a party to audit. He said that there was widespread opinion that audit was a confidential matter between the clinicians concerned.[349]

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[343] T22 p. 124 Mr Nix, Deputy Chief Executive and Director of Finance, UBHT, since 1993
[344] T23 p. 24 Mr Nix
[345] A post created in 1993, according to Mr Nix T23 p. 97
[346] T23 p. 97 Mr Nix
[347] WIT 0108 0044 Dr Roylance
[348] WIT 0108 0019 Dr Roylance
[349] T28 p. 92 Sir Barry Jackson

Devolution of responsibility

289 Dr Roylance had a policy of devolving responsibilities for audit to the specialty level. This devolution was a consequence of the Trust's philosophy of decentralisation generally.[350] He stated:

> 'Audit took place on a specialty basis, with each specialty committee or division taking responsibility for deciding how audit was to be arranged and the resources required in terms of clinical time, clerical and secretarial support, information technology and training and education.'[351]

290 Referring to medical audit, which was subsequently superseded by clinical audit, Dr Roylance explained that it was controlled professionally rather than managerially:

> '… medical audit was introduced on the professional network from the Regional Medical Officer [RMO] and his Regional Hospital Medical Advisory Committee to the consultants within the staff, through the Medical Committee and their divisions; it was not through the management process; it did not come from the Regional General Managers.'[352]

291 This meant that audit was introduced directly to the consultants by the RMO, and it stayed at divisional level within the directorate when the clinical directorate structure was introduced and stabilised in the UBHT, and when medical audit was being changed to clinical audit.[353]

Views expressed on the devolutionary approach

292 Dr Thomas expressed the view that the devolutionary model worked well. It was, he told the Inquiry:

> '… a very logical way to proceed. It maintained the contact between like clinicians who had similar problems and could therefore explore them. One of the problems of audit was always how does a single-handed practitioner audit, and that was always difficult to do and had to be done on a cross-district or cross-region or whatever basis. So if you bring people together with a common area of interest, then that is perceived as concentrating your skills into a group that can improve its practice, can identify problems and so on and so forth.'[354]

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[350] T25 p. 49–50 Dr Roylance

[351] WIT 0108 0044 Dr Roylance

[352] T25 p. 24 Dr Roylance

[353] T25 p. 26 Dr Roylance

[354] T62 p. 112–13 Dr Thomas

293 Dr Baker referred to what he saw as both the strengths and weaknesses in the UBHT's approach:

> 'I suppose the counter-weakness … was that where one wanted co-ordination of competition for limited resources for audit assistants, some perhaps prioritisation of areas for audit, then there was not a ready mechanism for that taking place.
>
> 'The counter would be to say that in my experience of some audits with other Trusts, where the Audit Committee masterminded arrangements more so, at least from a purchaser point of view that could seem to be over-controlling and exclude to some extent our ability to make contact with clinicians to talk about audit areas.'[355]

294 Dr Walshe, as one of the Inquiry's Experts, told the Inquiry:

> '… I think it might be helpful to refer to some of the research and evaluation that we did here. One of the things that we looked at in our survey of all Trusts in 1993 was whether Trusts had devolved the process to directorates and devolved the resource as well to directorates, or whether they had a central function. I think we found from memory about ten percent of Trusts had chosen to devolve the process wholly or largely to directorates. The great majority had established some kind of central audit function, quite often with a link then to directorates, so individual audit staff would serve particular directorates, for example. In that report … we argued that the devolved model was not a good way to go, for a number of reasons: because it fragmented the resource across areas, it made it much more difficult to do anything across directorates; it was hard to monitor and there was some evidence from our survey that directorates did not necessarily use the resource for clinical audit as it was intended to be used, and it led to some very isolated audit and quality improvement staff. So we felt that a centrally led model, particularly in the early days of clinical audit, was much more appropriate.'[356]

295 Dr Walshe confirmed that Bristol was not one of the trusts involved in the research. However, he pointed out that:

> '… we looked at some very large acute Trusts and also some smaller acute Trusts. We looked at community Trusts and combined Trusts that combined medical health and acute services.'[357]

296 Dr Walshe acknowledged that he was:

> '... quite cautious about imposing a particular shape to the process on a Trust, because one of the things the research suggested was that it was very dependent on

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[355] T36 p. 107 Dr Baker

[356] T62 p. 34–5 Dr Walshe

[357] T62 p. 37 Dr Walshe

> the local context; it was hard to prescribe that "this is the best way" of organising and auditing an organisation.'[358]

297 Mr McKinlay stated that although the structure kept the confidence of the consultants it also presented many opportunities for variations in procedures.[359]

298 Mr Hugh Ross,[360] currently the Chief Executive of the UBHT, told the Inquiry that a properly monitored institutionalised system of audit was lacking.[361]

299 Dr Jill Bullimore, Chair of the Clinical Audit Committee 1995/96, noted that the lack of central co-ordination also resulted in difficulty in obtaining information for audit reports.[362]

300 Mr Ross said that he recognised a problem in the lack of ownership for audit when he succeeded Dr Roylance in 1995. He said that no one was:

> '… actually managing and gripping it [audit] in a way that I felt was necessary.'[363]

301 One consequence of devolution was that any money allocated by the Trust for audit activities was distributed to the directorates for their use. Consequently, the Audit Committee had no resources of its own.[364]

Audit committees

302 Dr Thomas informed the Inquiry that the existing District Audit Committee (DAC) became the UBHT's Medical Audit Committee (MAC) in 1991:

> 'I was … the Chairman of the District Audit Committee of the Bristol & Weston Health Authority which was subsequently renamed the United Bristol Healthcare Trust Medical Audit Committee.'[365]

303 The membership of the MAC was identical to that of the DAC, save that Mr Dean Hart was replaced by Dr M Whitfield, a GP representative. Dr Thomas remained as the Chairman.[366] The constitution of the two committees was identical.[367] After the end of his formal three-year term of office, Dr Thomas remained the Acting Chairman until mid-1994.[368]

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[358] T62 p. 37 Dr Walshe
[359] WIT 0102 0009 Mr McKinlay
[360] WIT 0128 0001 Mr Ross
[361] T19 p. 63 Mr Ross
[362] UBHT 0016 0006; notes of Patient Care Standards Committee, 7 November 1995
[363] T19 p. 89 Mr Ross
[364] UBHT 0030 0024; CAC Minutes 2 March 1994; T25 p. 29–31 Dr Roylance; T41 p. 102 Mr Wisheart
[365] WIT 0323 0003 Dr Thomas
[366] UBHT 0025 0156; constitution of the DAC and UBHT 0058 0149; constitution of the MAC
[367] UBHT 0025 0158; constitution of the DAC and UBHT 0058 0156; constitution of the MAC
[368] UBHT 0024 0076; report of the Regional Audit Team's visit to the UBHT 10 March 1994

304 Dr Thomas stated that:

> 'It was a time of great concern and considerable controversy and new initiatives tended to be viewed with suspicion by both medical staff and management. To set up audit at this time was particularly difficult. It was essential to reassure consultant staff that they could "own" the audit process and the data which they accumulated.'[369]

305 Dr Thomas took the view that the MAC was there to 'establish a formal audit function within the UBHT'.[370]

306 He also expressed the view that it was the role of the MAC to:

> 'ensure funding for audit was spent on audit, but not to scrutinise outcome figures or mortality statistics so as to be able to determine whether or not those were acceptable but rather whether the process of audit was being carried out.'[371]

307 Dr Roylance said that the MAC's purpose was: '…To facilitate and monitor development of an audit process.'[372] And to: '…obviously have a role in advising the Trust Board, probably via the Medical Director.'[373]

Its role, he said: '… would be a supportive one to Directorates' because in future, clinical audit will form an important part of contracts …' because Dr Roylance 'agreed that it was the Clinical Director's role to run the Directorate and the Audit Committee's role was to monitor audit.'[374]

He recognised that there was: '… a requirement for the development and nurturing of acceptable outcome measures …' and accepted that: 'It was clear that members had some concerns that the Committee had no specific resources and that its influence on the conduct of audit would necessarily be an indirect one.'[375]

308 Dr Roylance said:

> '… the Chairman of the Audit Committee was clearly responsible for informing me as the Chief Executive, directly and urgently if necessary, if any management action was required for the introduction [of audit] … and in theory, to deal with any adverse result of audit, although that was necessarily some time in the future.'[376]

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[369] WIT 0323 0004 Dr Thomas
[370] WIT 0323 0004 Dr Thomas
[371] T62 p. 139 Dr Thomas
[372] T25 p. 53 Dr Roylance
[373] T25 p. 31 Dr Roylance
[374] UBHT 0030 0024
[375] UBHT 0030 0024
[376] T25 p. 67 Dr Roylance

309 Further, he told the Inquiry that he considered that it was the responsibility of the Chairman of the MAC to satisfy himself that the process of audit was being carried out:

> '… it was very much divorced from me. This was a function that consultants were charged with pursuing, overseen and monitored by a committee which was a committee of consultants and at that time a subcommittee of the Medical committee. My role was to respond to any management action that arose thereby. It would have been quite counterproductive for me to monitor audit.'[377]

310 Dr Roylance said that if, for example, a Unit failed to carry out the process of audit, that would not be a management issue which would involve him:

> 'No, it would not and quite specifically not, but if the Chairman of the Audit Committee required my assistance, he was charged with asking for it and he did on a number of issues. You … appear to be inviting me to jump into a position whereby management at that time had direct responsibility for audit. Curious as it may seem at this stage, it did not.'[378]

311 These issues were addressed in the Chairman's remarks in the 1993 MAC report itself:

> 'The devolutionary process which has lain at the heart of the Trust's operational philosophy has, in the past, made it quite difficult for the Audit Committee to influence and record audit activities. As the Regional Audit Team observed, the Audit Committee has no budget and is not made up of clinical directors. … It seems likely that these parameters and limitations will also be a frame within which the new Clinical Audit Committee will work. The new Committee may well wish to establish a role in the co-ordination of audit projects across the Trust. It may also wish to play some part in the assessment of the quality and effect of audit projects. These objectives are highly desirable but will remain difficult to achieve unless some agreement can be made between senior management and the Clinical Audit Committee as to the future of audit in the UBHT'.[379]

312 Audit activities were organised at the clinical directorate level, and were monitored and co-ordinated by the MAC. The MAC prepared an annual report based on the returns from all the specialties, which was then submitted to the RHMAC and to the Chief Executive of the Trust.[380]

313 The MAC's terms of reference included the requirement that it '…notify the Steering Committee of the Hospital Medical Committee of any desirable or proposed changes in utilisation of practice.'[381] The Chairman of the MAC, or another representative in his absence, attended and reported to the Steering Committee meetings. In addition,

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[377] T88 p. 137 Dr Roylance
[378] T88 p. 138 Dr Roylance
[379] UBHT 0058 0309; MAC report 1993
[380] WIT 0108 0045 Dr Roylance
[381] UBHT 0058 0157 MAC constitution

the constitution of the MAC provided for its 'ex officio' members to include the Chairman of the Hospital Medical Committee (HMC) or his/her deputy.[382]

314 Dr Roylance stated that:

> 'An Annual Report was prepared by the Committee, based on returns made from all the specialties, and submitted to the Regional Hospital Medical Advisory Committee. I was also sent a copy of the report and I considered it essential that I should see something of that nature that was going to be seen outside the Trust.'[383]

315 Dr Roylance, as Chief Executive, stated that he did not receive copies of minutes of audit meetings. He explained that this was because of the perception that management should be seen to be outside the audit process and because he was reassured by Dr Thomas, having talked with him a great deal '… about the implementation and development of audit within UBHT and beyond. He kept me informed of the problems that were being faced and overcome and I was satisfied that he would come to me if he needed my help.'[384]

316 It was not customary for the Trust Board, as distinct from the Chief Executive, to receive or to discuss MAC's Reports, as Mr McKinlay stated:

> 'In UBHT it was not the custom to circulate these reports to the Board or discuss them at Board Meetings. The only report which I saw [was] in the second quarter of 1995 … I formed the conclusion that the audit process was in its infancy and the Board was not seen as being part of the monitoring process.'[385]
>
> 'Control of individual situations was in the hands of the clinical teams and the Trust executive management. A yearly audit report covering clinical performance was produced by the Medical Audit Committee under a senior consultant. In my time, it was not practice in UBHT for this report to be seen by the Board or the Board Committee.'[386]

317 Dr Roylance agreed with this recollection, although he noted that later the Reports did become available, from around October 1995. Dr Roylance said:

> 'The Audit Report was initially introduced along the provisional line from Region down to District and then became Trust. I was anxious that what was being reported outside the Trust should be made known to people responsible for the Trust, but I had to move very gently and delicately, because at this time the reassurance given to the staff is that it was nothing to do with management … there certainly was a difficulty initially as to whom the audit report, which was a report about the process

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[382] UBHT 0058 0156 MAC constitution

[383] WIT 0108 0045 Dr Roylance

[384] WIT 0108 0045 Dr Roylance

[385] WIT 0102 0023 – 0024 Mr McKinlay

[386] WIT 0102 0011 Mr McKinlay

> of audit and not of audit, should be made available and I think we have seen before, Dr Thomas' view that anything out of the Audit Committee could only go where he said.'[387]

318 The extent to which reports and information obtained by the audit process were made available was the subject of further examination by the Inquiry. Evidence was heard that purchasers requested information upon the work of the MAC, but that the Committee was reluctant to provide that information. In particular, Dr Thomas was referred by Counsel to the Inquiry to the MAC meeting of 10 June 1992[388] where there was a discussion about purchasers' access to audit information:

> 'Q. You are minuted as referring to the constant pressure from the purchasers to have some access to audit information, but you were reluctant to accede to their request, particularly their suggestion that they should receive copies of the committee's annual report.
>
> 'Why was that a request that you were reluctant to accede to?
>
> 'A. I cannot answer your question. I do not know because the annual report had a very wide circulation and went across the Region. I suppose that I was responding to their wish as purchasers to have free access to information which the Audit Committee did not have and had it had that information, it might not have chosen to share it with the purchaser. A provider, fine, because that is within the envelope of the organisation the philosophy within the Health Service had changed quite markedly from a service to a business. Part of that change of culture involved a change of attitude towards many things, including information. Information then became commercially sensitive. This was one of the reasons why I, and I think the UBHT, were resistant to sharing processed information.
>
> 'It was, if you like "What is the recipe for Marmite, because if we know what it is, we might be able to make it cheaper". That is the commercial view. That was the sort of attitude that was beginning to creep into those discussions, and information was regarded as sensitive and not to be shared in a way that would make it accessible to competitors.'[389]

319 It was Dr Thomas' impression that purchasers were receiving mortality statistics for the whole of cardiac surgery, but he was not able to confirm whether they received them. Dr Baker told the Inquiry that they were never received.[390]

320 Dr Morgan stated that: 'Trusts submitted annual reports to the Region which the purchaser Health Authorities were not shown at that time.'[391]

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[387] T25 p. 65 Dr Roylance

[388] UBHT 0067 0083; MAC meeting

[389] T62 p. 115–16 Dr Thomas

[390] T62 p. 137 Dr Baker

[391] WIT 0307 0004 Dr Morgan

321 Mr McKinlay expected that concerns about standards of practice or care within the BRI would reach the Board through the Clinical Director, or the Medical Director, and the Chief Executive. Referring to concerns about paediatric cardiac surgical services, he said:

> 'I would have envisaged that the Clinical Director would go to where the source of the problem lay. We are talking here about consultant anaesthetists having concerns, so the Clinical Director in anaesthesia, in a very logical system, goes and talks to the Clinical Director in paediatric cardiac surgery. … Then I think the logical next step is to the Medical Director … The Chief Executive is the next step, possibly with the Chairman of the Hospital Medical Committee being somebody that might be consulted on the way. … [the next step would be] From the Chief Executive to the Board.'[392]

322 Mr McKinlay stated in his written evidence to the Inquiry:

> '… clinical outcomes and adverse events … were fundamentally a matter for the audit meetings of the particular services involved … were not as a matter of course reported to the Board.'[393]

323 The Clinical Audit Committee[394] (CAC) was responsible in succession to the MAC for encouraging and monitoring the introduction of the process of audit. It produced reports that were sent to Region to say how the development of audit was progressing.[395]

324 Dr Roylance was asked what use was made of the CAC and its deliberations within the Trust since the reports from the CAC, as with those of the MAC, did not go to the Board:

> '… the report … went to the Region and was … processed with all the others … If you say what function did the Audit Committee have, I think I told you: the Audit Committee was charged with encouraging and monitoring the introduction of the process of audit … these were very early days and I cannot really discuss sensibly what we did with the outcome of audit because there was very little outcome of audit at that stage, it was only the process of audit we were concentrating on, but the Chairman of the Audit Committee was clearly responsible for informing me as the Chief Executive, directly and urgently if necessary, if any management action was required for the introduction … of audit, and in theory, to deal with any adverse result of audit, although that was necessarily some time in the future.'[396]

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[392] T76 p. 37–8 Mr McKinlay
[393] WIT 0102 0011 Mr McKinlay
[394] Which succeeded the MAC in 1994
[395] T25 p. 66 Dr Roylance
[396] T25 p. 66–7 Dr Roylance

Audit co-ordinators and audit assistants

325 Following the introduction of the Government's paper *'Medical Audit Working Paper No 6'*,[397] medical audit co-ordinators were appointed for each service to co-ordinate and report to the MAC. Audit assistants were provided, although the use that was made of them differed widely at the outset, from specialty to specialty.[398] The audit co-ordinators reported to the Audit Committee through one of its members.[399]

326 The introduction of audit assistants went some way to rectify earlier problems in developing medical audit, summarised by Dr Stansbie, Vice Chairman, UBHT Medical Audit Committee (1990–1994), in his written evidence to the Inquiry as including:

> '… a lack of secretarial and clerical support, a lack of an adequate audit database and a lack of time to prosecute audit, particularly in the case of single handed consultants in small specialties.'

He noted that:

> 'The provision of audit assistants with computers, who were trained to use word processing and spread sheet packages, went someway to dealing with these needs and were largely in place by 1992.'[400]

327 Ms Sheila Wilkins, Audit Assistant 1991–1993, set up a system whereby clinical information needed for the medical audit of services within the Directorate of Surgery could be recorded. The system used by the Directorate was the Medical Database Index (MDI) which was already in place in the South West Region:

> 'Part of my role was to train clinicians, including junior doctors, in the use of the system and identifying the importance of accurate data recording.
>
> 'As Audit Assistant within the Directorate of Surgery the specialties I supported were general surgery, urology, orthopaedics and Accident & Emergency. I understood that they submitted their data to the National Audit Registry. Paediatric services had their own audit assistant at the Bristol Children's Hospital. I did not know the input clerk of cardiac services. As well as preparing data for monthly audit meetings for the Directorate, my duties included instructing the house officers on rotation into the use of the MDI system used for audit purposes. …
>
> 'Examples of the types of information that were entered onto the MDI system for the Directorate of Surgery were the bloods used; drugs given; procedures undertaken; the reason for death, (if it occurred and when); the length of stay in hospital, (pre and post operatively); if a catheter was inserted and for how long…

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[397] HOME 0003 0124; *'Medical Audit Working Paper No 6'*

[398] WIT 0108 0045 Dr Roylance

[399] T62 p. 74 Dr Thomas

[400] WIT 0324 0002 Dr Stansbie

> ‘My work included planning and implementing audit projects. Medical staff in the Directorate of Surgery would identify an audit subject and, if the data was not already captured, I would liaise with the Information Technology Department to ensure that that specific data was captured.
>
> ‘Monthly meetings were held between Audit Co-ordinators and Assistants throughout UBHT. … They were well attended by both the Audit Co-ordinators and Audit Assistants representatives of the various Directorates, for example from Surgery, from the Eye Hospital and Medicine and sometimes from the Children’s Hospital.
>
> ‘In addition to the monthly meetings, Audit Assistants often met with others doing the same sort of work, throughout the region in a group called SWAANS (South West Audit Assistants Network Services). Meetings took place once every 3 months. As many Audit Assistants from UBHT as possible would go to every meeting. The objective of these regional meetings of Audit Assistants was to obtain clear agreement, on a regional basis, on how the government guidelines on audit should be implemented. … Representatives from Trusts in other areas in the region or elsewhere came to speak to the Group … The purpose of the meetings was to discuss systems and statistics, not individual cases.’[401]

328 Ms Wilkins also commented that there was concern among audit assistants ‘… that they had no representatives on the [Audit] Committee’ and ‘… no knowledge of what decisions the Committee was making on the implementation of audit. …’[402]

329 Ms Wilkins described the experience of the audit co-ordinators and audit assistants:

> ‘Audit Assistants throughout the Trust were using the MDI system in different ways. We nevertheless found it helpful to meet to discuss the problems we were encountering and the ways we were implementing the government guidelines. Meetings took place between ourselves and staff from the Information Technology Department. Although our use of systems within Directorates and specialties were different, many of the problems we encountered were the same and, in principle, solutions were similar…[403]
>
> ‘… annual reports prepared by Audit Assistants and submitted to Clinical Co-ordinators were in standard format, so as to ease identification and comparison of material in the report. This was, I believe, a result of Dr Thomas’s initiative. He sought to ensure that reports on the functioning of audit, from each Directorate, used the same format. I have already identified that the audit data itself was not in the same format, and that different systems were in place within each directorate, but yearly reports were to use the same layout.’[404]

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[401] WIT 0396 0002 – 0003 Ms Wilkins
[402] WIT 0396 0003 Ms Wilkins
[403] WIT 0396 0004 Ms Wilkins
[404] WIT 0396 0005 Ms Wilkins

Role of the clinical director[405]

330 The *'Regional Audit Team Report'* of 1994[406] observed that the control of audit lay ultimately with the clinical directors.

331 Dr Thomas agreed:

> 'Effectively they had the responsibility, they had the resource[s], and therefore it was their control that dictated what could or could not be done.'[407]

332 The role of the clinical director and the relative powerlessness[408] of the Audit Committee may have been a product of the uncertainty and change evident in 1991 when the Trust was set up. Mr McKinlay stated:

> '… there was a strong suspicion in the Consultant group that this [the creation of the Trust] was the ultimate take-over by the administrators and that their freedom to make clinical decisions would be seriously curtailed. In order to combat this fear, the Trust was set up with 14 Clinical Directorates with a Consultant as the Clinical Director in each case.'[409]

333 The Report said that because the MAC was not constituted of clinical directors it was relatively powerless. It said:

> 'There was direct admission from a representative of the management team that issues for audit which they (the managers) feel need to be addressed or are asked to address by purchasers, tend to [be] implemented via the clinical directors rather than by any central overview from the Audit Committee.'[410]

334 Dr Roylance was asked about this view expressed in the report in the following exchange:

> 'Q. …That would be consistent with your explanation, as I understand it, that it was for the Clinical Directors to run the directorate and the Audit Committee's role was not to control audit but to monitor it?
>
> 'A. Absolutely. I mean, people who, like, spin on it a direct admission, that always implies that they did not want to let it be known but eventually released it.
>
> 'Q. Leave aside the spin. What it indicates is that the author of this document from the region, the Regional Audit Team, envisaged audit in a very different way from the way in which it was in fact being delivered?

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[405] The role of the clinical director generally is dealt with in Chapter 8
[406] UBHT 0024 0076; *'Regional Audit Team Report'* 1994
[407] T62 p. 110 Dr Thomas
[408] UBHT 0024 0076; *'Regional Audit Team Report'* 1994
[409] WIT 0102 0009 Mr McKinlay
[410] UBHT 0024 0077; *'Regional Audit Team Report'* 1994

> 'A. No, that is quite wrong. That is quite wrong. He actually attended the Audit Committee, and he was reflecting the view of some of the Audit Committee. I talked to him directly. I talked to the audit group directly, from Region. I spent a lot of time ensuring that audit was set up.'[411]

335 Dr Walshe was of the view that putting clinical directors on the Audit Committee would not have made much difference:

> '… I do not know, but I suspect that it would have made little difference … Because I think that the directorates viewed the resource as theirs and at any meeting to discuss what audit was to be done, that would have coloured people's judgment … given the devolved structure and the fact that the money was going to devolve anyway, I think having the Clinical Directors there would have made little difference to what was done.'[412]

336 Mr Wisheart expressed the view that the clinical director had a responsibility to see that audit was carried out within the directorate, a responsibility for the organisation of the clinical work and a responsibility if there had been any complaints of any sort, to deal with them. It was his opinion, however, that the clinical director was not responsible for the individual work of an individual clinician.[413] Mr Wisheart was asked about the 1990 application from the UBH for trust status which stated, in relation to quality of service, that:

> 'Within the Trust each contract will be the personal responsibility of a Clinical Director supported by a Manager. Quality of service will therefore be their responsibility.'[414]

337 Mr Wisheart did not regard this as meaning that the clinical director was directly responsible for the work of individual clinicians. He said that part of the issue turned on the definition of what 'quality of service' meant:

> '… One has to ask what the "quality of service" means. There are two broad areas under which it could be considered there. There is the area of quality in the sense of the management of the organisation, the waiting times, the promptness with which letters were sent out, the adequacy of the food and so forth and so on. Then secondly, there is the quality of the clinical service, which would be dealt with in a general way within the directorate, within additionally medical audit and later clinical audit.'[415]

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[411] T25 p. 54 Dr Roylance

[412] T62 p. 112 Dr Walshe

[413] T41 p. 1 Mr Wisheart

[414] UBHT 0060 0041; *'Application for NHS Trust Status'*

[415] T41 p. 2 Mr Wisheart

The shift from medical to clinical audit

338 In early 1994, the MAC was reconstituted as the Clinical Audit Committee (the CAC). This change was consequent upon the introduction, in 1993, of the requirement by the Government that clinical audit be carried out. At a Committee meeting, Dr Thomas reported:

> '… there was concern that medical audit will be marginalised under the pressure from clinical audit. The Chairman [Mr Wisheart] pointed out that we must be perceived to be carrying out the national guidance lest we lose audit monies. We must also maintain medical audit as a valuable educational and peer review activity.'[416]

339 When asked about the relationship between medical and clinical audit, Dr Thomas said:

> '… the answer to your question is that the short history of medical audit set up a system which was being used as an educational system, and that the new form of audit, clinical audit, was going to be a much more widely-based type of audit; it was not going to be limited to educational purposes, and it was going to address problems of resource allocation, throughput and so on and so forth in a much wider sense and with a different emphasis.'[417]

340 In Dr Thomas' opinion there were indications that medical audit still had a role and should continue alongside clinical audit:

> 'I believed that … there were indications — … in I think both the government documents of the time that medical audit should indeed continue. I think that there were substantial reservations about the progress that had been made because – and I speculate here you understand – I believe that in Government circles they had anticipated that progress would be much more rapid than it was.'[418]

> '… they also anticipated that medical audit would embrace the wider sphere of information-gathering, which I suspect was sought in the first place. I think that those anticipations of rapid progress were ill-founded and had the government chosen to listen to advice, it would have realised that setting up such a system as they had proposed in the White Paper was actually going to take a substantial amount of time, and not just a couple of years. It was not just a simple thing to put in place.

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[416] UBHT 0098 0013, 0017; meeting of the Steering Committee with Chairmen of Divisions, held on 5 January 1994

[417] T62 p. 99 Dr Thomas

[418] T62 p. 99 Dr Thomas

> ‘There was, among most of the documents at the time, an emphasis on bringing non-medical paramedical, whatever you wish to call them, members of the hospital staff, the teams and so on, into the audit process. It is my memory that we had already done that to a limited extent in the directorates, not in the audit committee, but in the directorate. But that was a another aspect of clinical audit.’[419]
>
> ‘Q. … at a directorate level, some overlap had been taking place?
>
> ‘A. Yes.
>
> ‘Q. Some participation amongst non-medical staff in the audit process?
>
> ‘A. Yes.’[420]

341 Dr Thomas was not able to say how widespread this participation was, except that:

> ‘… the directorates that spring to my mind, as directorates where I was aware that that was happening, were medicine in general, although that was made out of separate subgroups, but general medicine, rheumatology and so on, ophthalmology and the dental services.’[421]

342 There was also a concern that by widening the parameters of medical audit to include other specialties, there would be a dilution of the effectiveness of audit.[422] Dr Thomas commented:

> ‘It is not a question of letting other professional groups into the process, it is a question of how people perceive the time and the opportunity. So, for instance, I might, as I said this morning, wish to explore the complications of epidurals in pain relief. On the other hand, if you enlarge the group beyond me as a medical person and bring in somebody who may, perhaps, manage the resource of the Trust, they might be more interested in how I was going to use the money that they were prepared to let me have to buy kits or whatever.
>
> ‘So the emphasis within the meetings was going to change and that might well have damaged educational processes, I thought.’[423]

343 However, Dr Thomas confirmed that by 1995 medical audit evolved into clinical audit.[424]

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[419] T62 p. 100 Dr Thomas

[420] T62 p. 101 Dr Thomas

[421] T62 p. 101 Dr Thomas

[422] WIT 0120 0405 Mr Wisheart

[423] T62 p. 102 Dr Thomas

[424] T62 p. 103 Dr Thomas; WIT 0323 0007 Dr Thomas

344 This move towards clinical audit resulted in the re-constitution in early 1994 of the MAC, which, as set out above, became the CAC. Dr Thomas stood down as Chairman of the Committee shortly before 22 June 1994. Mr Wisheart then chaired the Committee for six months.[425] Dr Thomas stated to the Inquiry that the transition from one form of audit to the other was completed by the end of 1994.

345 In January 1995, Dr Jill Bullimore, consultant clinical oncologist, took over as Chair of the CAC.[426]

346 Dr Roylance explained a change in reporting structures: the multidisciplinary CAC reported through the Patient Care Advisory Committee to the Trust Board.[427]

347 Dr Roylance described the change from medical to clinical audit:

> '… before medical audit was up and running and in any sense robust, it was changed to clinical audit, and even with clinical audit, it was not expected to produce anything effective, anything that you could rely on as audit, for another five years.'[428]

348 Dr Joffe stated that with the change to clinical audit, the emphasis was placed on shared care of patients by a broad range of carers, including doctors, nurses and professions allied to medicine. Dr Joffe expressed the view that the shift to clinical audit appeared to make the sub-specialties even more marginalised.[429]

349 At about the same time, funding for audit was transferred from regional to district control. Dr Morgan stated that because: '…This change was signalled late during 1993/94 … a contract between Bristol and District Health Authority and the Trusts (including the UBHT) was not agreed until November 1994.'[430]

Collation of audit material by the Audit Committee

350 There was no reference in the *'Annual Audit Report'* to audit activities in paediatric cardiac surgery or in paediatric cardiology in 1992 or 1993.[431] Dr Thomas confirmed that the MAC was aware of this omission. He said that he tried to persuade audit co-ordinators to file a report and sent reminders:

> '… I think we probably sent out one, probably two reminders to audit co-ordinators that they had not yet filed their report with us.'[432]

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[425] UBHT 0024 0267; CAC minutes, 11 January 1995
[426] WIT 0108 0048 Dr Roylance
[427] WIT 0108 0019 Dr Roylance
[428] T25 p. 45 Dr Roylance
[429] WIT 0097 0319 Dr Joffe
[430] WIT 0307 0004 Dr Morgan
[431] T62 p. 148 Dr Thomas
[432] T62 p. 125 Dr Thomas

351 However, Dr Thomas' only means of seeking to ensure that the reports were made were persuasion and exhortation:

> '… I had no big stick with which to beat people into giving me a report.'[433]

352 Failure to provide a report to the Committee did not produce any adverse effect for the department concerned in terms of sanctions except for 'embarrassment', as Professor John Farndon, the Audit Co-ordinator in Surgery in 1992, said:

> '… I had to chase some groups more vigorously than others to get returns, and others found it difficult or impossible. The accident room, I think, found it particularly difficult because of staff shortages to initiate the process. Orthopaedics was gradually getting up to speed. And I would chase and encourage as much as I could, but it was as much as I could do to have responsibility for general surgery… There would be an embarrassment that there was no return from orthopaedic surgery, if that were the case, and it would appear in the Report.'[434]

353 The link between the Audit Committee and cardiac surgery was through the Audit Co-ordinator in Surgery, as described by Dr Thomas:

> 'The route to cardiac surgery from the Committee would have been via the co-ordinator for surgery. That was Professor Farndon. The reason that that was the route was because we had a specific number of members of the Committee and to have divided the major specialties into their integral sub-specialty groups would have produced such a profusion of co-ordinators for the committee members to liaise with that it was not practicable.
>
> 'So Professor Farndon was our contact point with surgery. Certainly, he would have received the letters that went out asking for reports and he would have received the reminders. However, I would make two comments about cardiac surgery: I, as a Chairman of the Committee, and Mr Wisheart as committee member, had a conversation on a couple of occasions in which I pointed out that we had not yet received the report from cardiac surgery. In my memory, as I recall, he said "Well the quality of patient care is improving in cardiac surgery". I said "Well, in that case that makes it even more important that a report is received so that throughout the Region people will know that that is the case".
>
> 'However, we did not receive a report and I regretted the fact that they had been unable to produce one for us. There was some reassurance, I felt, in that we knew that cardiac surgery were carrying out basic audits on mortality outcomes as part of their contract with the purchaser and that they were returning figures to the Central Cardiac Surgery Registry, the national registry.

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[433] T62 p. 127 Dr Thomas

[434] T69 p. 84 Professor Farndon

> ‘So although I regretted the fact that they had not been able to produce a report, I was reassured that audit was in fact being done, and I believe that that is the case: it was being done.’[435]

354 In a letter dated 22 March 1993 to Dr David Stansbie, Professor Farndon wrote:

> ‘The major problem with Cardiothoracic Surgery is that this is a highly specialist group working in isolation with no other similar group within the region. They, too, are establishing their own audit system which, I understand, will interface with other cardiothoracic units at national level.’[436]

355 Data concerning cardiac surgery did not reach Professor Farndon and was not included in his report to Dr Thomas:

> ‘… I do not remember Dr Thomas wanting me to pursue this issue further. I think that I and the audit committee were happy that the cardiac unit were submitting to a national comparative audit. I felt that this was logical because of the highly specialised nature of cardiac surgery. It is a speciality[specialty] that does not compare easily to any other sub-speciality[specialty]. We knew that audit was taking place and at the time the focus was on getting audit carried out across the whole Directorate and in every sub-specialty of surgery.’[437]

356 As has been noted, Mr Wisheart’s view was:

> ‘… The actual figures that went to the register were never submitted to the Audit Committee, that was not part of the process as it existed … So what I would have wanted to see … were the appropriate reports that the meetings had taken place, which they had, and of course I knew they had taken place but the reports never reached the committee for those two years.’[438]

357 Professor Farndon stated that his understanding of cardiac surgical procedures in general and, in particular, paediatric cardiac surgery, and their associated morbidity and mortality, was very limited:

> ‘… I would not have known the bench-marks that the cardiac surgeons should have been achieving. Few other surgical sub-specialties have mortality and morbidity to match that of cardiac surgery. It is a very technical, high risk, area with no comparisons to general surgery. I knew that the cardiac surgeons were submitting data to a national audit where comparisons with other units would be made. The process should have identified problems and corrections to allow closure of the audit loop. When reporting to the Medical Audit Committee I informed them that cardiac surgery were submitting externally. I felt that this national arena was the

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[435] T62 p. 126–7 Dr Thomas

[436] UBHT 0027 0282 ; letter to Dr Stansbie from Professor Farndon dated 22 March 1993

[437] WIT 0087 0003 Professor Farndon

[438] T94 p. 141 Mr Wisheart

> most appropriate way of dealing with cardiac surgery and provided a secure mechanism.'[439]

358 Professor Farndon agreed that the Committee received such information, through him, as people within the directorate chose to send and that his function was much like that of a 'post box'.[440]

359 Professor Farndon told the Inquiry that he had heard of the external register to which the cardiac surgeons submitted their returns but he did not know any detail of it nor the nature and scope of the returns, nor did he ever see them.[441]

360 Dr Thomas confirmed that, as Chairman of the MAC, he thought that the cardiac surgery department was conducting adequate audit in 1991:

> 'We believed it to be so at the time: we knew that audit meetings were occurring and we knew we were assured that returns were being made to the National Registry.'[442]

361 Dr Thomas recalled that it might have been Mr Wisheart who reassured him that returns were being made.[443]

362 Professor Farndon told the Inquiry that he could not ever recall Dr Thomas ever seeking such reassurances from him,[444] although in his written statement to the Inquiry he stated that, when submitting his report to the MAC, he informed them that cardiac surgery were submitting data externally.[445]

363 Dr Thomas told the Inquiry that he could not recall any question as to the acceptability of results within the department of paediatric cardiac surgery ever being brought to the MAC's attention.[446] Dr Thomas said that he had no knowledge of the Bolsin-Black 'audit'[447] nor did either of them raise concerns with the MAC at any time.[448] Dr Black was a member of the CAC from its inception in June 1994.[449]

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[439] WIT 0087 0003 – 0004 Professor Farndon
[440] T69 p. 84 Professor Farndon
[441] T69 p. 74 Professor Farndon
[442] T62 p. 140 Dr Thomas
[443] T62 p. 141 Dr Thomas
[444] T69 p. 81 Professor Farndon
[445] WIT 0087 0004 Professor Farndon
[446] T62 p. 138 Dr Thomas
[447] T62 p. 143 Dr Thomas
[448] T62 p. 141 Dr Thomas
[449] UBHT 0024 0267; CAC meeting, 22 June 1994

Summary of annual Audit Committee reports

364 The MAC report for 1991 was published in March 1992. Specialties were required to report on a quarterly basis to the Audit Committee on a standard form. An annual precis was also requested from the specialty which was included in the report. The annual reports of the specialties were included in the report.[450]

365 In summary, the annual report for 1991 recorded the following:

- ‘Paediatric cardiology held five audit meetings in 1991. The annual audit of surgical intervention; the annual audit of non-surgical intervention; and multi-disciplinary meetings (morbidity and mortality) with cardiologists, surgeons, pathologists, radiologists, and anaesthetists were recorded. One new standard was reported as having been adopted: to operate more on patients under 1 year, in particular those with Atrio-Ventricular Septal Defect.

- ‘The audit co-ordinator was Dr Martin.

- ‘Cardiac Surgery held 12 meetings but attendance was not shown. The co-ordinator was noted as being Mr Hutter. Much of the commentary related to adults.’

366 The Bristol & District Health Authority’s (BDHA’s) assessment of the MAC’s 1991 report was that audit, in the sense of standard-setting, was not always being described. However, it noted that some changes in clinical practice had been introduced and that some of these were being audited. It was not clear whether others would be reviewed.

367 The report for 1992[451] was more comprehensive. However, it was circulated to internal UBHT and Regional officers only, not to the DHAs.[452]

368 The Chairman’s introduction stated:

> ‘The main purchaser of health care from the UBHT is the Bristol and District Health Authority. A meeting was held between the Trust and the purchaser in order to review audit activities during 1992. During that meeting the responsibility of the Trust and its Medical Audit Committee for the process and prosecution of audit was restated unequivocally. It was agreed however that we would be able to act in concert with the purchaser in assessing some measures of outcome following treatment within the Trust. Audit Co-ordinators in a number of specialties responded most constructively to a request for suggestions of measurable and verifiable outcomes, six of which are being pursued by the Trust and the purchaser in partnership.’[453]

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[450] UBHT 0063 0336; *‘Annual MAC Report’* 1991
[451] UBHT 0066 0107; *‘Annual MAC Report’* 1992
[452] UBHT 0066 0106; *‘Annual MAC Report’* 1992
[453] UBHT 0066 0111; *‘Annual MAC Report’* 1992

369 The introduction also noted that difficulties arose because of the low priority that was still accorded to audit by a minority of consultants.

370 The report contained a return from the Department of Anaesthesia but noted that the Department of Child Health did not submit its report in the correct form, so that nothing from that department was included. No report was submitted by cardiac surgery (or paediatric cardiac surgery) nor by paediatric cardiology.

371 The report for 1993[454] reproduced the Regional Audit Team's report criticising the fact that power in relation to audit lay with the clinical directors, who were not members of the MAC. The MAC was by-passed, according to the report, when managers wished issues on audit to be addressed or were asked to address issues by purchasers. The report also noted the need to ensure that traditions of audit and audit methodology in other clinical fields were recognised by the (previously medical) Audit Committee.

372 Again, the 1993 report did not include a report in respect of paediatric cardiac surgery, nor did it explain its omission to do so.

373 The Regional Audit Team report stated that:

> 'This tight directorate structure and approach operates at all levels and for most issues and has, therefore, led to a confusion for the Audit Committee over its role.'[455]

374 Dr Thomas told the Inquiry that he rejected the idea that there was any confusion in this regard and indicated that the MAC had no incentives nor sanctions at its disposal:

> 'I do not think there was any confusion in our minds about what we might be able to achieve. We had … no budget, no staff and therefore the only way in which we could influence people was by persuasion, by cajoling them into doing things which we thought were valuable. Sometimes they agreed with us, sometimes they did not. We knew that we would be able to influence people over such things as hardware, staffing and training, because the members of the Audit Committee had information which was not available easily to the Clinical Directors. So we could pass that information on to them and persuade them to take the steps that we thought were wise.
>
> 'There was, I suppose, the other element to the equation, and that was that they knew at the end of the year they would have to account for how they had expended their money. Certainly when things started the Audit Committee was required to put its seal on those items of accounting and say, "Yes, that is what happened."'[456]

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[454] UBHT 0058 0301; *'Medical Audit Report'* 1993

[455] UBHT 0024 0076 *'Regional Audit Team Report'* 1994

[456] T62 p. 111 Dr Thomas

375 The Regional Audit Team observed that the directorates were able to undertake effective audit in their own specialties, but that decentralised audit functions meant that they were less able than a central body to manage cross-specialty audit, to maintain consistent methodology, to disseminate lessons learned, or to develop and make best use of the audit staff who became isolated.[457]

376 In dealing with what it saw as the bypassing of the MAC, the Regional Audit Team report stated:

> 'The devolutionary process … has made it quite difficult for the Audit Committee to influence and record audit activities … the Audit Committee has no budget and is not made up of clinical directors. It seems likely that these parameters and limitations will also be a frame within which the new clinical Audit Committee will work. The new Committee may well wish to establish a role in the co-ordination of audit projects across the Trust. It may wish to play some part in the assessment of the quality and effect of audit projects. These objects are highly desirable but will remain difficult to achieve unless some agreement can be made between senior management and the Clinical Audit Committee as to the future of audit in the UBHT.'[458]

377 The report for 1994/95[459] was the first report of the CAC. Again, it did not contain reports in respect of paediatric cardiac surgery or cardiology, nor did it explain the omission.

378 The annual reports of the Audit Committee were sent to the SWRHA. Dr Roylance commented on the RHA's use of these reports:

> 'They summated them [audit reports], had a look at them and they issued an encouraging document … to say "Look what has been happening across the region and please, would other people like to do a similar thing", but it was a report on the introduction of the process of audit with a few encouraging notes to say, "and we have found something we can improve on"'.[460]

Nursing audit in Bristol

379 Until the introduction of clinical audit, nursing was audited separately from medical services.

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[457] WIT 0437 0003 Dr Charles Shaw

[458] UBHT 0058 0309; *'Annual MAC Report'* 1993

[459] UBHT 0058 0217; *'Clinical Audit Report'* 1994/95

[460] T25 p. 65–6 Dr Roylance

380 Mrs Margaret Maisey, Director of Operations and Nurse Advisor at the UBHT, was responsible for the audit of nursing. She described her primary concern as being that:

> '… nursing care was of the highest standard, that nurses were trained and had available to them all that they required to carry out their duties correctly and in accordance with our professional standards. I tried to ensure that proper records were kept and that nursing administration was efficient, so that nurses spent as much time with patients as possible, delivering high quality care and constantly looking for ways to improve what they were doing.'[461]

381 Mrs Maisey described her role as being:

> '… to keep up with the standards of the day and ensure systems were in place so that nursing audit happened in UBHT.'[462]

382 She stated that she led the introduction of audit:

> '… firstly as Chairman and later as facilitator on the District Nurse Advisory Committee. … I led my colleagues in the introduction, consultations, discussions and eventual implementation of various nursing processes across the Trust as a whole. One of these processes was nursing audit.'[463]

383 Mrs Maisey stated that she had introduced the notion of nursing audit first through the Nursing Committee of the District, from 1989, then the Trust:

> '… For example, I recall proposing that nurses should ensure that their staff were recording that they had checked on bedfast patients during their period on duty, to ensure that the patient was not left in soiled linen: an apparently minor point but essential to patient care and positive nursing attitudes. Nursing records are traditionally of a higher quality than medical notes. Accurate contemporaneous reports are recognised by all nurses as vital to their proper patient care. I was very concerned to maintain this principle from the time I arrived in Bristol and never failed to make this point at every appropriate opportunity.'[464]

384 Mrs Maisey stated that she ensured that appropriate structures were set up to report on audit measures:

> 'Within the Trust and the Trust Nursing Advisory Committee (TNAC), I worked to produce the forum in which nursing audit, nursing procedures, and policy advice in such matters from the centre, was discussed, adapted and implemented by those nurses with the relevant managerial and professional roles in the Trust. From TNAC, I took their views and decisions to the Regional Trust Nurses Group where such

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[461] WIT 0103 0078 – 0079 Mrs Maisey

[462] WIT 0103 0071 Mrs Maisey

[463] WIT 0103 0071 – 0072 Mrs Maisey

[464] WIT 0103 0073 – 0074 Mrs Maisey

> things were discussed and information given which might assist others and the centre as to what each Trust was doing.
>
> 'Similarly, within the TNAC, following the introduction of a contractual requirement by the Avon Purchasers, annual nursing audit reports were produced. I think I took these reports to the Trust Board or one of its Committees. Clearly, over time, these reports and procedures became far more sophisticated and wide-ranging, as we all learned more about the audit process as a consequence of carrying it out, but also as a result of receiving more and more information from the centre, other Trusts, and the clinical areas, including what other professions were doing.'[465]

385 At the meetings of the TNAC and District Nursing Advisory Committee (DNAC):

> '… each senior clinical nurse reported back on their clinical area of responsibility. Issues raised were debated by the meeting and the greater experience of the group as a whole brought to bear. Subjects discussed at the DNAC/TNAC meetings included Department of Health circulars, UKCC consultative proposals, RHA and Regional Nursing Officer/RGM letters and similar documents, DHA matters, developments in nursing, nursing audit and nursing standards. Various aspects of nursing policy for the Health Authority/Trust as a whole were discussed and agreed upon at the meetings.'[466]

386 Annual nursing away-days were also organised to discuss issues in more depth and to consider standards, research and advanced nursing practice.[467]

387 Nursing audit was reported on a yearly basis:

> 'A Nursing Audit report was prepared annually and sent to the Avon purchasers and to the Trust. These reports were written by the Nurse Advisors for each part of the Trust. The reports evolved over time. They were designed to set standards, measure attainment against those standards, and lead to changes in nursing practice where changes were appropriate. The reports from the Children's Services written in 1995 for the Annual Report 1994/5 is typical of the period and reflects the confusion in the minds of many as to exactly what was expected of us in the matter of 'audit'. To resolve this situation was one of the key tasks of the Trust Nurses'Advisory Committee. It must be understood that until very recently, "audit" was something that was medically driven and nurses were still feeling their way.'[468]

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[465] WIT 0103 0071 Mrs Maisey

[466] WIT 0103 0073 Mrs Maisey

[467] WIT 0103 0073 Mrs Maisey

[468] WIT 0103 0074 Mrs Maisey

388 Mrs Maisey noted that with the commencement of trust status there was much change:

> '… many … relationships were changed; some of them disappeared altogether, while others became more at arm's length, while yet others followed the same patterns as previously but with different players. From being a general manager with general management responsibilities, I became a facilitator and enabler to the managers. As before, I continued to give ethical and professional guidance to the nurses and to give nursing advice to the Trust Board. The Nurse Advisory [TNAC] Committee continued to set standards. These were monitored and later reported as part of the nursing audit process.'[469]

389 Mrs Maisey commented on the evolution of audit in respect of her involvement with the MAC and CAC. She stated:

> 'At Bristol, I attended meetings of the Medical Audit Committee and its successor the Clinical Audit Committee. … At the outset, the meetings of the Medical (later Clinical) Audit Committee which I attended dealt with funding, with the possible processes of recording audit events, the mechanical process by which the annual report would be generated … . The meetings never discussed outcomes. They certainly did not discuss relationships between practitioners, or clinical performance in any way.
>
> 'Generally, these Committees were considering management matters related to clinical practice … We would see summarised "audit"reports. We were aware that certain specialities [specialties] with common interests and concerns met to discuss specified topics, but we were not party to any of their debates, only to the agreed outcome of the debates and what future actions had been decided.'[470]

390 Fiona Thomas, a Sister at the UBHT, described the following difficulties in conducting nursing audit:

> '… a level of expertise was required to undertake audit; diploma or degree nurses may have had these skills. Difficulties arose in conducting audit due to constraints of clinical work or other roles, which led to difficult decisions about what came first. Sometimes nursing staff were so busy caring for patients, it was difficult to find time or spare pairs of hands to carry out audit.'[471]

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[469] WIT 0103 0077 Mrs Maisey

[470] WIT 0103 0078 Mrs Maisey

[471] WIT 0114 0055 – 0056 Fiona Thomas

391 Ms Sarah Hoyle, Directorate General Manager for Women's and Children's Services (and, at one point, Mrs Maisey's assistant in Bristol), stated that:

> '… nurses were always willing to support the development of clinical audit, involving all healthcare professionals.'[472]

Attitudes towards the formal introduction of audit 1990–1993

392 Mr David McCoy, Chairman of the RHMAC, stated that:

> 'The picture of audit at its inception was resented by some, and completely clouded by uncertainty of patient confidentiality, and the legal situation, with the risk of action for defamation as a result of published results.'[473]

393 Dr Morgan stated:

> '… there was much suspicion and a great deal of sensitivity from the professions….'[474]

394 Mrs Liz Jenkins, Assistant General Secretary, RCN, told the Inquiry:

> 'I can think of examples, not necessarily from my own organisation, but … meetings that I went to … across the country, where doctors would not even want medical students to take part in the clinical audit meetings in case the medical students actually really found out what the results were. I mean there was real fear and anxiety about it, and I have to say a lot of lip-service paid to it.'[475]

395 Dr Thomas' view was that:

> '… the profession were wary of the White Paper in general, and I suppose, therefore; any components of it. That was the sort of ambience within which we were working.'[476]

396 As has been seen, Mr McKinlay stated:

> '… there was a strong suspicion in the Consultant group that this was the ultimate take-over by the administrators and that their freedom to make clinical decisions would be seriously curtailed. In order to combat this fear, the Trust was set up with 14 Clinical Directorates with a Consultant as the Clinical Director in each case.'[477]

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[472] WIT 0527 0007 Ms Hoyle

[473] WIT 0436 0002 Mr McCoy

[474] WIT 0307 0011 Dr Morgan

[475] T34 p. 79 Mrs Jenkins

[476] T62 p. 85 Dr Thomas

[477] WIT 0102 0009 Mr McKinlay

397 Dr Roylance expressed this view:

> '... a strong feeling within the medical profession that audit was going to be used as yet another management tool and I felt that its introduction to the formal structure of Bristol and Weston Health Authority, as it was at that time, and then the UBHT, needed to be handled very carefully in order to encourage doctors to participate. (This was a great change in the NHS generally and there were already strong feelings and a great deal of sensitivity about the increasing role of managers in healthcare.)'[478]

398 Dr Thomas told the Inquiry:

> '… the profession was perhaps less enamoured, less convinced, than professional bodies and organisations. That is reflected in some of the papers recruited from individual clinicians, saying "Whilst we sign up to the aims of this, we are not sure it is really going to work and deliver improvement".'[479]

399 Dr Brian Williams, consultant anaesthetist at the BRI since 1977, stated:

> 'Senior management and most Associate Directorates of surgery were initially resistant to the idea of formal audit being conducted in our Directorate [anaesthesia] during in-service hours. They were of the opinion that the disadvantage of the inevitable interruption to elective surgery throughout the Trust would outweigh any possible advantages.'[480]

400 Dr Sally Masey, consultant anaesthetist and Anaesthetic Audit Convenor, explained that the use of clinical time to hold audit meetings was a problem:

> 'As it was considered to be a contractual requirement to be involved in audit the Department of Anaesthesia would ask for all routine operating to cease on those 8 half-days a year so as many anaesthetists could be involved as possible. An emergency anaesthetic service was maintained. Understandably, this met with considerable resistance from surgeons, and the Trust management was also not receptive to the cancellation of routine lists, despite it being clearly stated in the NHS [Management] Executive document *"The Evolution of Clinical Audit"* that adequate time had to be set aside for audit activities. However, we were able to establish this pattern of cancellation of routine working with moderate success by stressing the contractual obligation to audit.'[481]

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[478] WIT 0108 0043 Dr Roylance

[479] T62 p. 17 Dr Thomas

[480] WIT 0352 0025 Dr Williams

[481] WIT 0270 0012 Dr Masey

401 These attitudes persisted after 1993. On 23 February 1994, the minutes of a meeting of the B&DHA recorded that Dr Morgan presented a paper on *'Clinical Audit and Outcome Monitoring'* which stated: 'A significant problem was the feeling of clinical professions that clinical practice was not the concern of the Purchaser'.[482]

Views as to the relative responsibility for aspects of audit

402 Dr Roylance was recorded in the minutes of the clinical audit review meeting of the B&DHA on 11 November 1992 as commenting that: '… the way that care is carried out is the responsibility of the Trust, but the outcome is Bristol & District's domain …'[483] He explained that in placing contracts with the UBHT or other trusts, the B&DHA could not disassociate itself from the benefits those contracts were achieving for patients, and that the District should be concerned with the *value* of the process to their patients, in terms of clinical outcome, and not just the process itself.[484]

403 Ms Evans stated that the District's view of responsibility for outcomes and clinical quality was that:

> '… the primary responsibility for outcome and clinical quality of service lay with Trusts. That was one of their key roles, one of their main jobs, and they reported to the centre through the regional health authorities and later what was called the "regional outpost"of the NHS Executive about quality and about financial matters. So that was their province. I think, at the beginning of the period at any rate, audit was seen as being a professional activity. I think it was seen as being educative about learning and reviewing things, and I think it was seen, therefore, as not being the province of managers and not being the province of purchasers … I think initially it was regarded as being purely professional and not something that Trust managers should be involved in the detail of, other than to know that it was happening. I think that changed over the period between 1991 and 1995.'[485]

404 She added that, in 1991, the role of the District was limited to satisfying itself that audit was taking place.[486] Further:

> 'It was the Trust's responsibility to make sure that it had appropriate frameworks and processes in place for quality assurance, both in terms of clinical audit and in terms of what perhaps might be described as "processes of care".
>
> 'In addition to that requirement, health authorities had specifically laid upon them certain national requirements, many of which came under the Patient's Charter, and these were requirements that we should monitor certain aspects of patient care processes, notably waiting times in Accident and Emergency departments, waiting times in outpatient clinics, between patient arrival and seeing a consultant,

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[482] HAA 0145 0375; minutes of the meeting of the B&DHA, 23 February 1994

[483] UBHT 0271 0020

[484] T25 p. 20 Dr Roylance (emphasis added)

[485] T31 p. 27–8 Ms Evans

[486] T31 p. 63 Ms Evans

> cancellation of operations, and, of course, waiting times for inpatient and outpatient appointment from GP referral.'[487]

In terms of monitoring the standards and outcomes of care:

> '… the primary responsibility was laid on Trusts and their reporting was through the Region to the Centre. I think the Health Authority had a role, and I think a recognition of the Health Authority's role evolved over time, so that, by I think about 1995, it was recognised – and in that encouraged – by the Department of Health that health authorities should have the right to nominate certain audit topics that Trusts would undertake. But that was very much towards the end of the period and I think we saw our role as being to encourage the development of audit and to work with our Trusts, all of our Trusts, on specific audit topics, particularly those which, like the work we did on heart attacks, seemed to be important in terms of illness within our population, and health care for our population.'[488]

405 With regard to collecting data and conducting audit, Sir Graham Hart, Permanent Secretary at the DoH from March 1992 to November 1997, was clearly of the view that it was Region's responsibility after the introduction of trust status:

> 'I would certainly expect the contact with the UBHT to be from regional level.'[489]

He continued in the following exchange:

> 'Q. They should obviously have done the job and collected the data. On the assumption that they did not, as appears to be the case, they are part of the District and the District is part of the Region. What role or function would the District play in this?
>
> 'A. No, I do not think post-1991, I mean, this is a Trust now.'

406 If trusts were not collecting data or making it available, he went on, this was not something which districts could address:

> 'The District obviously has, or a number of Districts have a relationship with the Trust, but it is not such that you could really expect the District to put this right.'[490]

407 Overall responsibility for audit was separated from those who were expected to put it into effect. Ms Charlwood stated:

> '… from 1990 right through to 1996, while the DHA was encouraging monitoring and audit, it was the SWRHA that was primarily responsible for monitoring clinical

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[487] T31 p. 61–2 Ms Evans

[488] T31 p. 62–3 Ms Evans

[489] T52 p. 85 Sir Graham Hart

[490] T52 p. 85 Sir Graham Hart

> audit activity in the NHS Trusts in the South West. I have no evidence available to me showing that SWRHA raised with the DHA any issues which it required the DHA to pursue regarding monitoring of clinical audit. Actual implementation largely lay with the professionals in the NHS Trusts, who organised the clinical audit resource and arranged audit of specific clinical activity.'[491]

Audit of infant and neonatal cardiac surgical services: role and responsibility of the District [492]

408 From April 1984 to March 1994 paediatric cardiology and cardiac surgery for neonates and infants under 1 year old was designated a supra regional service.[493]

409 Ms Evans and Dr Baker told the Inquiry that, as a result, the District was not responsible for monitoring the performance of paediatric cardiac services for the under-1-year-olds.

410 Ms Evans expressed her view in the following exchange:

> 'Q. … it is right, is it, that we must bear in mind that your detailed involvement was with services for the over-1s rather than the under-1s?
>
> 'A. Yes. That is right, and that was because the service for the under-1s was purchased by the NHS Executive because it was designated as a supra regional service for part of the period until the service was de-designated.'[494]

411 Dr Baker explained, in the following exchange:

> 'Q. … in terms of your overall planning function, did you have any responsibility to check that the service for either the under- or the over-1s was producing an acceptable outcome?
>
> 'A. Yes, certainly in terms of children over 1, they were part, obviously, of our overall planned or later commissioned services. Within the breadth of our responsibilities for understanding whether we were getting the services we wanted to, that would have been generally the case.
>
> 'Q. And in relation to the under-1s?
>
> 'A. Not in relation to the under-1s. My understanding always was that the supra regional service was supervised through their own arrangements.'[495]

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[491] WIT 0038 0014 Ms Charlwood
[492] The role of the DoH, Supra Regional Services Advisory Group, Royal Colleges and others is examined in Chapter 7
[493] Designation as a supra regional service is considered in Chapter 7
[494] T31 p. 6 Ms Evans
[495] T36 p. 74–5 Dr Baker

412 When paediatric cardiac surgical services for the under-1s were de-designated with effect from April 1994, commissioning of the service became the responsibility of purchasing DHAs. There was no communication from the NHS Executive to these authorities on the nature or scope of any monitoring of quality that should be established for the service, despite the complexity or specialised services involved.[496]

The audit and review of the paediatric cardiac surgical services in Bristol

413 The Inquiry heard evidence that, during the period of the Inquiry's Terms of Reference, various types of meetings were held in Bristol in order to review results in paediatric cardiac surgery.

414 Mr Wisheart stated:

> 'The practice of audit within paediatric cardiac surgery was set up by the clinicians in that area and it was done on the basis of their interest, enthusiasm and commitment, not because of any management requirement … The practice evolved and developed from the years prior to 1984 and throughout the period [of the Inquiry's Terms of Reference]'.[497]

415 These meetings fell into four main categories: cardiac surgical audit, departmental audit, clinico-pathological meetings and evening meetings.

Cardiac surgical audit meetings

416 Mr Wisheart explained:

> 'Cardiac Surgical Audit was formally instituted in 1990/91 in response to the White Paper. However, it evolved from pre-existing activities which had been labelled educational but which did involve a significant element of audit. All the cardiac surgical staff, junior and senior, attended this meeting which occurred once a month in term time. … To begin with there was no minute of the meeting; a record of the meeting was made by the Sub-Directorate Audit Convenor which was submitted to the Trust Audit Committee.'[498]

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[496] WIT 0159 0035 – 0036 Ms Evans

[497] WIT 0120 0392 Mr Wisheart

[498] WIT 0120 0392 – 0393 Mr Wisheart

417 Mr Dhasmana explained that:

> 'During the eighties and early nineties the records and data were collected by the Registrar/Senior Registrar working with the respective surgeons and presented to the meeting under the supervision of the senior registrar … Things changed with the establishment of UBHT and organisation of an Audit structure in 91/92. Mr Jonathan Hutter was our first audit co-ordinator, who started collection and storage of these data.'[499]

418 Mr Wisheart stated that:

> 'The most common method of presentation of data [at the meeting]was for each consultant's registrar to present the work of the previous month and to draw particular attention to any patients where there had been death or serious complications. This led to a discussion of those events which sought to establish whether any modification of clinical practice would be beneficial. Specific topics were also audited such as wound infection. The annual statistics were usually presented to this meeting for discussion.'[500]

419 Mr Wisheart pointed out that the meetings focused on the review of individual cases, although series of patients were reviewed when 'topics' were audited, or annual statistics presented.[501]

420 Mr Dhasmana stated that prior to 1992 the meetings were attended by members of the Department of Cardiac Surgery although: 'After 1993/94, when the audit was better organised, the attendance increased to include nurses, anaesthetists and adult cardiologists.'[502]

421 Mr Alan Bryan, consultant cardiac surgeon since July 1993, stated that he produced minutes of the meetings which were held at the end of 1993 and in early 1994. He went on:

> 'In 1994 my role in relation to audit was formalised in that I was asked to be audit convenor for cardiac services. This formalisation of my role in 1994 was part of a Trust-wide move to formalise audit procedures. Prior to this my involvement had been on my own initiative … It is worthy of note that there would have been no need to do this immediately upon my appointment [in July 1993] if a regular organised programme of audit was in operation.'[503]

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[499] WIT 0084 0017 Mr Dhasmana

[500] WIT 0120 0393 Mr Wisheart

[501] WIT 0120 0393 Mr Wisheart

[502] WIT 0084 0017 Mr Dhasmana

[503] WIT 0081 0021 Mr Bryan

Audit meetings, paediatric cardiac surgery and paediatric cardiology

422 Regular audit meetings, bringing together those involved in paediatric cardiac surgery and paediatric cardiology, commenced in 1990. Dr Robin Martin, consultant paediatric cardiologist since 1989, was the co-ordinator of these meetings. He explained in his letter of 18 December 1989 to colleagues:

> ‘At a recent meeting it was suggested we ought to hold regular clinical audit meetings and I have volunteered to help co-ordinate these. The purpose of these meetings would be to discuss clinical cases, complications, post-operative management and other relevant problems in the Paediatric Cardiology and Cardiac Surgery Unit.’[504]

423 Mr Dhasmana stated that the meetings were held monthly, initially on Monday mornings, but later (from 1992) on Wednesday lunchtime or in the early afternoon, in the seminar room attached to the cardiac catheter laboratory at the BRHSC.[505]

424 As to attendance at these meetings, Mr Dhasmana stated:

> ‘The meeting was open to all members of staff concerned with the care of children with congenital heart defects … However this was mostly attended by members of paediatric cardiac medical and surgical staff and also by nursing and technical staff from the catheter lab. Dr Peter Wilde the consultant cardiac radiologist and/or his staff and Mrs Helen Vegoda from the paediatric cardiac family support services also attended these meetings from time to time. Others like anaesthetists and junior members of surgical staff were not able to attend these meetings on a regular basis because of their clinical commitment elsewhere in the same hospital or at BRI.’[506]

425 Dr Bolsin told the Inquiry that it was ‘probably’ right that anaesthetists were invited to and did on occasions come to these meetings, but that there were difficulties in attending.[507] Dr Masey told the Inquiry that, because of timetabling difficulties: ‘We did not find that we were able to frequently meet with our surgical colleagues.’[508]

426 There was evidence that these meetings had lapsed before the beginning of 1992. Dr Martin wrote to Dr Jordan on 3 January 1992: ‘I think it is very important that we recommence our audit sessions in 1992 and after discussion I think we ought to hold these monthly on the fourth Wednesday of each month. …’[509]

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[504] WIT 0084 0035; letter from Dr Martin to colleagues dated 18 December 1989. Mr Dhasmana refers to these meetings as ‘monthly paediatric cardiology/cardiac surgery audit meetings’(see WIT 0084 0019), but Dr Martin’s letter is headed ‘Departmental Audit Meetings’

[505] WIT 0084 0019 Mr Dhasmana

[506] WIT 0084 0020 Mr Dhasmana

[507] T81 p. 25 Dr Bolsin

[508] T74 p. 29 Dr Masey

[509] UBHT 0061 0153; letter from Dr Martin to Dr Jordan dated 3 January 1992. Mr Wisheart confirmed that although the letter is headed ‘audit of paediatric cardiology’ it was referring to audit which embraced both paediatric cardiology and paediatric cardiac surgery, see T41 p. 75

427 Dr Martin commented on the lapse of these meetings:

> I think it is difficult in a busy clinical programme sometimes making the time to get people to come to these meetings … That is not to say that people were not interested, it is just the pressure of clinical commitments often makes it very difficult … it was the hurly-burly of clinical work that makes it much more difficult and I am sure it was a problem more clinicians face, to get a regular audit programme going is very difficult ... I think it is probably fair to say the switch [split] site arrangement did not particularly help us to get an adequate number of people together. … Since they moved the open heart surgery up to the Children's Hospital, we have got more people on site and it has been easier to get good consensus and a group of people together, but it is not easy.'[510]

428 These meetings lapsed again during 1992. Mr Wisheart stated that: 'Following the publication of the contents of a paediatric cardiological audit in *"Private Eye"*, this audit programme lapsed for a time.'[511] Mr Dhasmana stated that: '… the confidentiality of the data was broken at least on two occasions, when figures relating to Tetralogy of Fallot and Arterial Switches appeared in the media (*"Private Eye"* 1992). This did have some negative effect on the conduct of these meetings.'[512]

429 A number of witnesses commented on the specific effect of the publication in *'Private Eye'* on 3 July 1992 of an article concerning data about paediatric cardiac surgery in Bristol.[513]

430 Mr Dhasmana told the Inquiry that following the publication of the article: '… I felt the best thing would be really to explain myself to my medical colleagues … so I was continuing with my audit in a similar manner … it did not stop me from presenting our data to the department or monthly audit or anything like that.'[514]

431 Dr Joffe commented in the following exchange:

> 'Q. Mr Wisheart, when he spoke to the GMC, said that the effect of the *"Private Eye"* article … [was] that the audit process of paediatric cardiology was very seriously set back, and really did not occur thereafter for quite some time … How accurate is that?
>
> 'A. I think it is accurate in the sense that the audit process that Dr Martin had developed at the end of the year before and during that year 1992 was to a degree certainly interrupted by the reaction to the *"Private Eye"* article. There were meetings I believe, but they did not follow the same format as the previous ones.'[515]

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[510] T76 p. 159–60 Dr Martin

[511] WIT 0120 0393 Mr Wisheart

[512] WIT 0084 0020 Mr Dhasmana

[513] SLD 0005 0002; *'Private Eye'* 3 July 1992

[514] T86 p. 131 Mr Dhasmana

[515] T90 p. 124 Dr Joffe

432 Dr Martin commented:

> ‘Around that time – I think it was around July or August 1992 – we were quite concerned about a report that appeared in *“Private Eye”* at that stage which seemed, appeared to include what appeared to be data from our audit meeting directly. I am sure it had an effect on audits after that, certainly for the surgical results. I think we carried on having some audit sessions for individual catheters, maybe foetal, you know some of the different sub-specialties that we also feel important to audit, but I do not remember that same format being used for the surgical results. …’[516]

Clinico-pathological meetings

433 Clinico-pathological conferences were held when a patient had died. Mr Dhasmana stated that they were held to review individual cases: ‘in order to confirm the pre-operative diagnosis and to re-examine the operative procedure.’[517]

434 Mr Dhasmana explained that the meetings were organised by Professor Jem Berry and scheduled to take place once a month, but on occasions were postponed or reorganised due to a lack of cases for presentation.[518]

435 Mr Wisheart stated:

> ‘The Clinico-Pathological Conference was instituted in the early to mid 80s and it almost certainly coincided with the arrival of Dr, later Professor, Jem Berry.[519] Cardiologists, surgeons, radiologists, anaesthetists as well as pathologists were welcome at such meetings. Up until the arrival of Dr Ashworth in 1993[520] no record whatsoever was kept of these meetings and in particular there were no minutes or definitive reports of findings. As far as I am aware the occurrence of these meetings were not reported to the Trust Audit Committee.’[521]

436 Mr Dhasmana described that at these meetings:

> ‘The clinicians concerned with the case, medical and surgical, would present the clinical details, echo. catheter and angio-graphic findings, the operative procedure and post operative course/events. The pathologist would demonstrate the specimen, describing the autopsy findings. Most of the times the surgeon would also join in the study of operative findings and the technique. The discussion used to centre around the post-mortem findings and if an explanation could be found for the post-operative course and the sad outcome.’[522]

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[516] T76 p. 163 Dr Martin

[517] WIT 0084 0022 Mr Dhasmana

[518] WIT 0084 0022 Mr Dhasmana

[519] Professor Berry was appointed consultant paediatric pathologist at the BRHSC in 1983, see WIT 0204 0002

[520] Dr Michael Ashworth was appointed consultant paediatric pathologist at the UBHT in 1993

[521] WIT 0120 0395 Mr Wisheart

[522] WIT 0084 0022 Mr Dhasmana

Evening meetings

437 The Inquiry heard evidence about informal evening meetings held at the homes of consultants, from the early to mid-1980s.[523]

438 Mr Wisheart described these as 'multi-disciplinary evening meetings' and explained that they 'were attended by cardiologists, surgeons, anaesthetists, radiologists and pathologists' and took place two to four times a year.[524] Mr Dhasmana referred to these meetings as meetings of the 'paediatric club'.[525]

439 Mr Wisheart stated that the agenda of these meetings:

> '… was not limited to audit, but it did include review of the annual statistical summaries and occasional series of patients, particularly before other more formal audit activities began in 1990-1991. The clinical series reviewed included Fallot's tetralogy repair in 1991, VSD closure in 1988 or 89 and the prevention and management of pulmonary hypertension. Thus the emphases was on a series of patients, rather than the individual patients.'[526]

440 Mr Dhasmana stated that at the meetings:

> '… some important issues in the management of postoperative problems were discussed and recommendations implemented. For example an important guideline was formulated for the management of postoperative pulmonary hypertension in patients with complete AV canal and in some cases of Tetralogy of Fallot following this [a] meeting in 1989/90. The issue of Arterial Switch in older children was reviewed in one such meeting in December 1994. Similarly Dr Hayes chose to discuss the topic of Protocol and Review of correct practice in paediatric cardiology in one of these meetings in June 1994.'[527]

441 Dr Masey stated that the meetings:

> '… would quite often be chaired by the person in whose home the meeting was being held … I felt it was a very good opportunity to talk to people because the environment was moderately informal, and … there were also meetings where more people were usually able to attend because they were out of the normal working day.'[528]

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[523] WIT 0120 0396 Mr Wisheart

[524] WIT 0120 0396 Mr Wisheart

[525] WIT 0084 0023 Mr Dhasmana. Although Mr Dhasmana referred to these meetings by a different name, he described them as taking place three to four times a year at the home of one of the consultants (in rotation)

[526] WIT 0120 0396 Mr Wisheart

[527] WIT 0084 0023 Mr Dhasmana

[528] T74 p. 75 Dr Masey

442 Dr Bolsin believed he was 'obstructed' in carrying out audit of paediatric cases. He expanded on that in the following exchange:

> 'A. I think that there was another incident when I produced minutes of one of the informal evening audit meetings and I was told that they were not acceptable outside of the meeting. So that not at the time, when the minutes were being considered to be accepted at the meeting, before the next meeting was arranged I was told: "these minutes will not be circulated, this is not how we do things, I do not want you keeping minutes again". That to me could be construed as obstruction. I probably brought that in as "obstruction" in my statement.
>
> 'Q. We have been told by Mrs Masey [*sic*] that it was her who said that to you, and we have been told by Mr Wisheart and from comments he has made that he did not say that to you. Are they right or are they wrong?
>
> 'A. I think Dr Masey is right, she did say it. Mr Wisheart may be wrong. I believe he also said that to me as well.
>
> 'What surprised me was that here was a concerted attempt by two members of the meeting, not to correct the minutes when they are presented at the next meeting, which is the usual way things are done, but actually to say "You are not to circulate these or keep minutes again".'[529]

443 Dr Joffe told the Inquiry:

> 'We had a very small, close-knit group of five or six people and I think our thorough airing of the situation with a conclusion that we had come to at the end of it was sufficient for all of us to then take on whatever policy changes we had decided upon, and all of us would stick to them. So there was no problem in not having minutes for that kind of discussion.'[530]

444 Mr Dhasmana explained that: 'Since it was an informal meeting, records were not kept regularly,…'.[531] Dr Jordan stated: '… these meetings were not minuted.'[532]

445 Dr Joffe stated that the discussions at these meetings were mainly focused on issues related to paediatric cardiology and surgery. He stated that anaesthetists did not come to every meeting, 'But there were some issues that some anaesthetists did attend to discuss where their presence was certainly very important.'[533]

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[529] T80 p. 14–15 Dr Bolsin

[530] T90 p. 130 Dr Joffe

[531] WIT 0084 0023 Mr Dhasmana

[532] WIT 0099 0019 Dr Jordan

[533] T90 p. 130 Dr Joffe

Other meetings

446 In addition to the four types of audit meeting set out above, Mr Dhasmana pointed out that weekly departmental teaching sessions took place on Friday mornings, and joint cardiac and thoracic surgical meetings took place on Wednesday evenings. Although these meetings were mainly used as teaching sessions for junior members of surgical staff he stated that: '… on some occasions, case reviews, both individual and of series, were presented and unit figures were audited. On occasions specific post-operative problems in case management were also audited at these meetings. Most of these related to adult cardiac surgery.'[534]

447 Mr Wisheart stated that some reviews of series of clinical cases were carried out on an ad hoc basis: 'Some of these reviews took place within the format of the multi-disciplinary evening meeting, some within the paediatric cardiological audit programme and others at ad hoc meetings.'[535]

448 Mr Wisheart also stated that: 'Reviews of series of patients were carried out with the intention of communicating the findings to scientific meetings or publishing them in peer review journals'; for example, in respect of the Mustard and Senning operations, and that 'These might be regarded as being outside the audit process, the findings were usually also presented at an audit or educational meeting within the Department.'[536]

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[534] WIT 0084 0024 Mr Dhasmana

[535] WIT 0120 0397 Mr Wisheart

[536] WIT 0120 0397 Mr Wisheart

Chapter 19 – Statistics Relating to the Clinical Performance of Paediatric Cardiac Surgical Services in Bristol Compared with Other Specialist Centres during the Period 1984 to 1995

Introduction: purpose and scope of the chapter

This chapter sets out the evidence received by the Inquiry on statistics relating to the clinical performance of paediatric cardiac surgical services in Bristol relative to other specialist centres.

In this chapter, the term 'clinical performance' means the activity (the type and volume of operations or procedures carried out) and outcomes (in terms of post-operative mortality and morbidity) of paediatric cardiac surgical services in Bristol. Bristol's particular clinical performance may be assessed by examining its own results over a period of years and by comparing them with the contemporaneous performance of other centres.

'Statistics', for the purpose of this chapter, means figures of any kind relating to clinical performance.

The statistics fall into two main categories:

- statistics relating to clinical performance that were available to clinicians in Bristol during the period 1984 to 1995 (the clinicians' *contemporaneous* statistics);
- statistics relating to clinical performance presented to the Inquiry as expert evidence (the Inquiry's *retrospective* statistical evidence).

As regards the clinicians' contemporaneous statistics, the main sources of statistics relating to clinical performance available to clinicians in Bristol during the period 1984 to 1995 were:

- the clinicians' own clinical logs and computerised information systems;
- external sources, including the Society of Cardiothoracic Surgeons' UK Cardiac Surgical Register ('UKCSR'); the reports of national working parties on neonatal and infant cardiac surgery; ad hoc external audit reports; and professional meetings, contacts and journals.

As regards the Inquiry's retrospective statistical evidence,[1] Experts were commissioned to review, analyse and synthesise the six principal sources of data that existed at the relevant time. These were: the national Hospital Episode Statistics (HES); the UKCSR; the UBH/T's Patient Administration System (PAS); the clinical records of children whose treatment fell within the Inquiry's Terms of Reference; the surgeons' logs; and the South West Congenital Heart Register.[2]

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[1] The Experts' statistical reports appear in full in Annex B

[2] The log kept by the perfusionists in Bristol and the mortality records of the Office for National Statistics were also used by the Experts, for the purpose of testing the accuracy of the data derived from the main sources

The statistical investigations described in this chapter make comparisons with other centres. They do not seek to draw conclusions as to the reason(s) for any difference which may be found to exist between Bristol and other centres providing similar treatment. Rather, they seek to establish, on a statistical basis, whether there is such a difference, and how significant that difference is. The experts in their investigations examined a number of suggested causes of such differences as are identified, and expressed their view that some of these proposed causes may be eliminated or discounted. They did not advance any reason for the differences which they identified.

The statistical evidence received by the Inquiry must be distinguished from the Clinical Case Note Review (CCNR), reproduced in Annex B. The CCNR was a clinical audit by experts which focused on the quality of care delivered in a sample of cases in Bristol, as judged by reference to the case notes. The CCNR examined a representative sample of case notes, with a view to generalising from the conclusions drawn from the sample to the whole. The conclusions are derived from what the notes show about the care provided at the different stages of a child's treatment. The experts' views as to what might have been expected elsewhere informed their conclusions, but formal comparison of Bristol with other centres formed no part of the CCNR exercise.

The chapter is divided into two main parts. The first part sets out evidence received by the Inquiry concerning the nature of the statistics relating to clinical performance available to clinicians in Bristol during the period 1984 to 1995, and the views of the Inquiry's experts on the interpretation of these statistics. The second part sets out the principal conclusions of the retrospective statistical evidence received from the Inquiry's experts relating to the activity and outcomes of paediatric cardiac surgical services at Bristol relative to other specialist centres, and the views of the Bristol surgeons and of the experts on the reliability and validity of this statistical evidence.

Section one: statistics relating to clinical performance available to clinicians in Bristol during the period 1984 to 1995

Statistics relating to clinical performance produced by the clinicians in Bristol

1 The sources of statistical data available to the clinicians in Bristol included the clinicians' own logs (handwritten, typed and computerised logs compiled contemporaneously by surgeons, cardiologists, anaesthetists and perfusionists).[3] From these, data were derived for annual statistical summaries, Annual Reports on paediatric cardiology and cardiac surgery from 1987[4] onwards, ad hoc sheets of figures produced for audit[5] and other professional meetings,[6] and Bristol's returns to the UKCSR and to the Supra Regional Services Advisory Group (SRSAG) surveys.

Logs

2 As regards the surgeons, Mr Wisheart stated in his written evidence to the Inquiry that he kept a log of his open-heart operations from 1975 until the end of his consultant career.[7] The log contained information about each patient and in particular about the outcome of the procedure(s) carried out. Mr Wisheart told the Inquiry that he used his log for the purpose of carrying out his own personal audit[8] and stated specifically:

> 'The log was an immediately accessible source of information about the patients on whom I had operated, and was used for such purposes as:
>
> 'a) the preparation of the annual statistical summary;
>
> 'b) the preparation of my contribution to the Department's returns to the UKCSR from 1977 onwards;
>
> 'c) the preparation of any other report of work done, which was requested from time to time;

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[3] Further sources of data that were kept by clinical staff included the Theatre Register (see WIT 0341 0039 – 0040 Dr Pryn), Helen Stratton's register of the cases that she dealt with (see WIT 0341 0040 Dr Pryn), and the Nurses' Ward Admission Books

[4] T90 p. 13 Dr Joffe; 'The 1987 report [UBHT 0055 0009] was the first one'

[5] See Chapter 18

[6] Such as the meeting on the evening of 11 January 1995 before the operation on Joshua Loveday; see Chapter 30

[7] WIT 0120 0255 Mr Wisheart

[8] T41 p. 66–7 Mr Wisheart

> ‘d) the purposes of formal or informal audit, or review, of any group or sub-group of patients.’[9]

3 Mr Wisheart confirmed that he would use his log book to monitor his own performance.[10] He stated :

> ‘It [the surgeon’s log] had the advantages of being within my possession, (i.e. in my hospital office), accessible, highly reliable and because of the way that it was set up it was both functional and effective.’[11]
>
> ‘I believed that the log was [as] complete and accurate as possible. … I believe that the quality of the data in the log is high but I would never claim that it is perfect. … I would regard entries concerning death and autopsies as extremely reliable. … In summary – although the log is not perfect I believe it has been a very high quality resource for the purposes identified earlier [set out in para 2 above].’[12]
>
> ‘For me it [the log] has proved to be an excellent system, which provided accessible and reliable information …’[13]

4 Mr Dhasmana described his surgeon’s log in his written evidence to the Inquiry:

> ‘The main purpose of the Logbook was to provide a quick reference for the personal audit of the open-heart operations carried out by me in the Hospital, as an ongoing process. This helped in recognition of problems at an early stage. The Logbook provided figures, which helped with preparation of various audits [*sic*] reports including compilation of data in the U.K. Cardiac Surgical Register. These figures also helped to prepare for various committee meetings concerning [*sic*] with the development of facilities at the unit and also with the development at the Children [*sic*] Hospital.’[14]

5 Mr Dhasmana stated:

> ‘I never treated my Surgeon’s Log as a complete record. As mentioned before, this was intentionally made simple and brief for the ease of filing. For me it served as a quick reference book for the purposes mentioned [set out in para 4 above] …’[15]

6 Mr Dhasmana went on:

> ‘I was also maintaining a folder (YearBook) of my surgical activity at the hospital. This would contain a copy of operation notes, discharge summary and autopsy

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[9] WIT 0120 0256 Mr Wisheart

[10] T41 p. 62 Mr Wisheart

[11] WIT 0120 0255 Mr Wisheart

[12] WIT 0120 0259 – 0260 Mr Wisheart

[13] WIT 0120 0262 Mr Wisheart

[14] WIT 0084 0001 – 0002 Mr Dhasmana

[15] WIT 0084 0004 Mr Dhasmana

> report where relevant, of individual patient, adults and children, operated during that year in an alphabetical order. This yearbook usually provided more detailed information on the individual patient and was used for validation of entries in the Surgeon's Log. Individual case notes were also checked from time to time for the same purpose.'[16]

7 As regards the anaesthetists, Professor Prys-Roberts told the Inquiry that he regarded the keeping of an anaesthetist's log as: 'proper medical practice'.[17]

8 Referring to the log which she kept, Dr Susan Underwood stated:

> 'The purpose for which data was logged in my diaries was as a personal record of the cases I had undertaken. …
>
> '… Some of the data recorded by me is incomplete and it is quite possible that I have failed to record some cases altogether. In any instance where death occurred it was recorded in my log if it occurred in the hospital and I was aware of it. …'[18]

9 Dr Sally Masey stated:

> 'The purpose for which the data were logged in my diaries were [*sic*] for personal interest, to have a record of cases performed. …
>
> '… The data are, as far as I am aware, complete for my practice, except for 1988. … The record of in-hospital deaths may not be complete, as some deaths may have occurred about which I was unaware.'[19]

10 As regards the perfusionists, Mr Richard Downes, Clinical Perfusionist at the BRI from 1992[20] and Chief Clinical Perfusionist from 1994 (still in post in June 1999),[21] stated that:

> 'The function of the Perfusionist's Log was to provide a record in the form of lists, of the type and number of open heart surgery cases the perfusionists had carried out over the years. That information was limited to the cumulative number of patients operated on, surgeon's initials, patient name, age, operation type and date of operation …'[22]

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[16] WIT 0084 0003 Mr Dhasmana
[17] T94 p. 5 Professor Prys-Roberts
[18] WIT 0318 0001 Dr Underwood
[19] WIT 0270 0001 Dr Masey
[20] WIT 0169 0002 Mr Downes
[21] WIT 0169 0004 Mr Downes
[22] WIT 0169 0015 Mr Downes

Accessibility, availability and use of logs

11 Mr Wisheart stated:

> '[My] log was not disseminated in any routine way nor was it disseminated unprocessed. It was however, known to exist amongst my colleagues, i.e. my surgical, anaesthetic and cardiological colleagues, both junior and senior, and a significant number of them used it as a resource. … Information derived from it was disseminated, usually within the paediatric cardiological and cardiac surgical group, but also to other groups as well.'[23]

12 He stated further that he regarded his log as being:

> 'At the time in Bristol … a unique source of information.'[24]

13 Mr Dhasmana stated:

> 'The Surgeon's Log and Year Books were always kept in the department's office with secretaries. They were easily available to members of the department. Similarly other clinicians could also have an access to these books through our secretaries. Junior doctors were often using it for a quick reference before starting on any clinical research and also during their preparation for presentation of figures to the monthly mortality and morbidity (audit) meeting in the department. However this function ceased once the computers became more established in the department in the early 90s.'[25]

14 Dr Underwood stated:

> 'There was not any arrangement for the dissemination of the data I recorded. …
>
> 'In my opinion my diaries provided only an individual record for myself. I did not consider that consultants were obliged to keep a log and I therefore consider that there is no recognised system in place and no standard against which to compare.'[26]

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[23] WIT 0120 0260 Mr Wisheart

[24] WIT 0120 0260 Mr Wisheart

[25] WIT 0084 0004 Mr Dhasmana

[26] WIT 0318 0001 – 0002 Dr Underwood

15 Referring to her log, Dr Sally Masey stated:

> 'There was no dissemination of data.
>
> '… No practical applications or uses were made of the data. …
>
> '… There is no system for the keeping of anaesthetic logs by consultants. My record was personal. Therefore I cannot comment on any system as none is specifically in place for consultants.'[27]

16 Referring to the uses made of the perfusionist's log, Mr Richard Downes stated:

> 'Apart from the despatch of information to the UK Heart Valve Registry I do not believe there were arrangements for routine data analysis until after 1995 or for its dissemination. Aside from its use as a record of work undertaken, appropriately indexed by operation type, and for stock records there were no other practical applications or use made of the data in the Perfusionist's Log.'[28]

17 In respect of the perfusionists' log, Mr Donald Caddy stated:

> 'I note Mr Downes' comments about the information in the perfusionists' log being of limited use on its own and would remind the Inquiry, as set out in my first statement, that the detailed records for each individual patient made by the perfusionists at each operation were kept in my department during the period when I was Chief Perfusionist. I understand that those records are now kept with each patient's individual medical records instead. However, the point is that during my day, whatever the perceived deficiencies of the logbook, we always had available the full details of every patient who had been perfused in the department as these were contained in the patient's perfusion records kept in my office. Therefore, the perfusionists' logbook was of less relevance at that time, save as a record of the numbers and types of procedures we had carried out.
>
> 'Indeed, when the detailed audit was undertaken by Dr Stephen Bolsin it was to the individual patient's perfusion records, rather than to the logbook, that he turned for the detailed information that he was looking for.'[29]

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[27] WIT 0270 0001 – 0002 Dr Masey

[28] WIT 0169 0018 – 0019 Mr Downes

[29] WIT 0143 0041 Mr Caddy

Annual statistical summaries

18 The numbers of operations carried out and of deaths, of both adult and child patients, were compiled in respect of each cardiac surgeon in Bristol into an annual statistical summary.[30] Mr Wisheart explained:

> 'A. … This did not happen right at the beginning, but it began early on and evolved to the point where each year I published an annual – what I have called a "statistical summary". So in the preparation of that, I would have reviewed the cards[31] in the Children's Hospital and used that information.
>
> 'Q. Was that a statistical summary for yourself, or for the service?
>
> 'A. It was for the service, so my colleagues, or colleague, whatever was the situation at the time, provided their information to me, and I collated it.
>
> 'Q. Do I understand that the information was, with odd exceptions … aggregated rather than broken down by surgeon?
>
> 'A. The summaries that I am referring to were aggregated and I continued to produce those up until, I think, 1992.'[32]

19 In most of the categories of operations detailed in Chapter 3 there were a very small number of patients in each year. Mr Wisheart stated in his written evidence to the Inquiry that:

> 'Attempts were made to overcome this in two ways. First, for patients over one year an attempt was made to aggregate operations into groups under the heads of simple, moderate and complex. This aggregation was essentially arbitrary and has not proved to be particularly helpful. The second step which was taken was to include in the report the results for each operative category, not only for the year in question, but also for the previous four or five years. This in principle was a much more satisfactory step and was much more helpful.'[33]

20 A copy of the data was sent to individual consultant cardiac surgeons working in the cardiac unit.[34] These figures also appeared in the Annual Reports of the paediatric cardiology and cardiac surgery services for the years 1987, 1988 and 1989 (discussed below). For the years 1993 to 1994 and 1994 to 1995, copies of the annual data were also submitted to the audit co-ordinator for the particular year.[35]

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[30] WIT 0084 0024 Mr Dhasmana

[31] Handwritten cards (known as the Cardiologists' Card Index System), recording basic information on all patients seen by the paediatric cardiologists at Bristol, were kept by the secretaries in the Cardiology Department at the Children's Hospital throughout the period of the Inquiry's Terms of Reference

[32] T41 p. 63 Mr Wisheart

[33] WIT 0120 0394 Mr Wisheart

[34] WIT 0081 0019 Mr Bryan

[35] WIT 0084 0024 Mr Dhasmana

21 Mr Wisheart stated that the statistics relating to clinical performance in Bristol which were available consisted of:

> '… total numbers of paediatric cardiac surgical procedures. These numbers may most easily be obtained from the annual statistical summaries which are available for each year from 1984-92 inclusive and for the years 1992-93 and 1994-95. My own files do not appear to have a summary for 1993-94, but those figures are contained within the following summaries:
>
> '1. Tabulated summary for all procedures for the years 1990-95 drawn up by Mr Dhasmana (within which the 1993 figures may be identified).
>
> '2. The UBHT published results for all cardiac procedures from 1990-95 (January 1996).
>
> '3. The figures submitted to Dr Hunter and Mr de Leval by Mr Dhasmana and myself on the 10th February 1995.'[36]

The Annual Reports on paediatric cardiology and cardiac surgery

22 During the period of the Inquiry's Terms of Reference, the clinicians in Bristol produced a series of three Annual Reports on paediatric cardiology and cardiac surgery in Bristol:

> (i) Annual Report on Paediatric Cardiology and Cardiac Surgery at Bristol Royal Hospital for Sick Children and Bristol Royal Infirmary, 1987;[37]
>
> (ii) Annual Report on Paediatric Cardiology and Paediatric Cardiac Surgery at Bristol Royal Hospital for Sick Children and Bristol Royal Infirmary, 1988;[38]
>
> (iii) Annual Report on Paediatric Cardiology and Paediatric Cardiac Surgery at Bristol Royal Hospital for Sick Children and Bristol Royal Infirmary, 1989/1990.[39]

23 The Reports contained tables of the results of open and closed surgery for congenital heart disease in patients under 1 year of age and those aged over 1 year, and showed the numbers of deaths, and the rate of mortality. Leading Counsel to the Inquiry asked Dr Joffe about the distribution of the Annual Reports in the following exchange:

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[36] WIT 0120 0285 Mr Wisheart

[37] UBHT 0166 0001 – 0014; *'Paediatric Cardiology and Cardiac Surgery – Bristol Royal Hospital for Sick Children and Bristol Royal Infirmary – Annual Report 1987'*

[38] HAA 0138 0003 – 0012; *'Paediatric Cardiology and Cardiac Surgery – Bristol Royal Hospital for Sick Children and Bristol Royal Infirmary – Annual Report 1988'*

[39] UBHT 0133 0073 – 0086; *'Paediatric Cardiology and Cardiac Surgery – Bristol Royal Hospital for Sick Children and Bristol Royal Infirmary – Annual Report 1989/1990'*

‘Q. … The [1988] annual report[40] was obviously produced for someone; who got it?

‘A. The idea was to send the reports to the then District Health Authority, both the local one and peripheral centres, particularly to the paediatric paediatricians [*sic*] around the region with whom we were related, so to say, by virtue of the peripheral clinics that we held at these various centres and we wanted them to have a view of what we were doing and of our figures and our enterprises.

‘Q. It would follow, I suppose, that they, if they had kept the reports from one year to the next, would have seen the same comparison figures as you might if you had done that exercise, or others within the unit might?

‘A. Yes, I believe so.

‘Q. Within the unit, what circulation did the report have?

‘A. It was freely available to the members of the cardiology team. I think on the first page of each of those annual reports there is a list of the people who make up the totality of the cardiac unit … Those[41] are the individuals who would have received copies and, indeed, others who requested copies who might not be on the list would have received them too. There was no sense of restricting access to this report, it was meant to be open.

‘Q. … Did anyone who was occupying a management role in the Health Authority at this time receive a copy, the District General Manager —

‘A. Yes, certainly.

‘Q. You say the idea was to send the reports to the then District Health Authority, both the local ones and the peripheral centres. That was what you described as the idea; was it also the reality or not?

‘A. Yes, we sent them out.

‘Q. Do you know whether they went to individual paediatricians who might refer cases to Bristol?

‘A. I believe so. I really cannot recall exactly how the mechanism worked, but I believe my secretary or a secretary within the cardiology department would have been asked to send these reports to these people plus the referring paediatricians.’[42],[43]

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[40] UBHT 0055 0022; *‘Paediatric Cardiology and Cardiac Surgery – Bristol Royal Hospital for Sick Children and Bristol Royal Infirmary – Annual Report 1988’*

[41] Listed at UBHT 0055 0023 for 1988

[42] T90 p. 16–17 Dr Joffe

[43] Referring clinicians were specifically asked by the Inquiry to address whether they had seen or requested a copy of the Annual Reports. Their written evidence is set out in Chapter 11

24 Dr Jordan told the Inquiry of his recollection of the distribution of the Annual Report after 1987 in the following exchange:

> 'Q. … It is right, is it not, that the cardiac unit at Bristol produced an annual report from the late 1980s onwards?
>
> 'A. My recollection of this has been helped by the fact that I have found a copy of what I think was the first annual report we produced, which was for 1987. I think that was stimulated by the fact that of course that was the first year that we had a catheter laboratory at the Children's Hospital and really had anything physically, if you like, that could be called a paediatric cardiac unit. We did try and produce an annual report – not actually quite of the same size as that one – subsequently.
>
> 'Q. For whose consumption was the report produced?
>
> 'A. The consumption was basically internal and it went I think to the management of the Children's Hospital and to the various people concerned; that is a fairly wide number of people, not just the cardiologists, the cardiac surgeons, it would include people like Sister Wakeley, I think the secretaries had a copy, that sort of thing.
>
> 'Q. It was not disseminated externally? It was not sent, for example, to referring paediatricians?
>
> 'A. I think we did actually send the one in 1987 out much more widely. I think we just wanted to do a bit of advertising then, but my recollection is that we did not send subsequent ones out.'[44]

The Inquiry contacted a number of paediatricians who referred children to Bristol. Sixty-five clinicians replied, of these 64 said, with varying degrees of certainty, that they had not seen the Annual Reports. Some were sure that they had not seen copies, but a number made the point that they were now relying on their memories of events up to 13 years ago.[45]

Statistics produced for audit and other meetings

25 Apart from the basic statistics relating to clinical performance produced by the clinicians in Bristol for the purpose of Annual Reports, figures were also produced on an ad hoc basis for presentation at audit and other meetings. For example, referring to the audit meeting of 19 March 1990,[46] Mr Dhasmana stated:

> 'In order to explain the rise in mortality there was a detailed breakdown of operations and analysis of risk factors.'[47]

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[44] T79 p. 140–1 Dr Jordan

[45] See Chapter 11

[46] UBHT 0061 0126; minutes of audit meeting, 19 March 1990

[47] SUB 0010 0009 – 0010 Mr Dhasmana

26 As a further example, Mr Dhasmana stated[48] that he presented the results of a detailed audit of the results of his Switch operations carried out on older children, at a meeting open to all clinicians involved in paediatric cardiology, held on 3 June 1992.[49] He further stated that results of open-heart operations carried out between January 1992 and January 1995 were submitted to the external review of paediatric cardiac services in Bristol conducted by Mr (later Professor) de Leval and Dr Hunter in 1995.[50]

27 Mr Wisheart stated that from time to time reviews of results in particular areas were carried out:

> 'On occasions we believed that the results of the work in a particular area might not be as good as had been hoped for. We examined that area in order to try to find out what were the reasons for the disappointing results and then took whatever steps were necessary to improve our practice. Such reviews were carried out for the Fontan operation, for VSDs in the late 80s, for the complications of pulmonary hypertensive problems in the post-operative period, for the results of the Fallots operation in 1990-91, for TAPVD and for the results of the arterial switch operation. Some of these reviews took place within the format of the multi-disciplinary evening meeting, some within the paediatric cardiological audit programme and others at ad hoc meetings.
>
> 'Reviews of a series of patients were carried out with the intention of communicating the findings to scientific meetings or publishing them in peer review journals. Such reviews were carried out for the Mustard and Senning operations, for the Fontan operation, for the results of our work in Pulmonary Atresia with Intact Ventricular Septum and on a range of topics relating to surgery for Coarctation of the Aorta during the period of the Inquiry's review. These might be regarded as being outside the audit process, but of course the findings were usually also presented at an audit or educational meeting within the Department.'[51]

28 A report[52] entitled *'Analysis of Paediatric Cardiac Mortality Data from UBHT 1990 –92'* was produced which contained the results of statistical analyses of data relating to mortality following paediatric cardiac surgery (omitting the Arterial Switch operation) in Bristol for 1990 to 1992, and comparisons with the rest of the UK for the 'National Average Year' of 1991. It showed that, for certain operations, mortality in Bristol was significantly worse than the rest of the UK. The availability of these statistics to clinicians in Bristol during the period 1990 to 1995 is set out in detail in Chapter 20 to Chapter 30.

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[48] SUB 0010 0012 Mr Dhasmana

[49] UBHT 0061 0165; *'Hospital Medical Committee – Audit Committee Medical Audit Meeting Report – Paediatric Cardiology'*, 3 June 1992. Further details of this meeting and its content appear in Chapter 18

[50] INQ 0045 0118 Mr Dhasmana

[51] WIT 0120 0397 Mr Wisheart; see Chapter 3 for an explanation of these terms

[52] UBHT 0061 0080 – 0102; *'Analysis of Paediatric Cardiac Mortality Data from UBHT 1990 –92'* (also referred to as 'the Bolsin/Black audit')

29 Further statistical information on mortality following paediatric cardiac surgery at the BRI was produced within the Department of Anaesthesia at the BRI. Dr Pryn stated that he compiled figures from a variety of sources on paediatric cardiac outcome data for the chronological year ending 31 December 1993.[53] The figures were discussed at the audit meeting on 20 January 1994. This meeting is described in further detail in Chapter 29.

The returns made to the UKCSR

30 Bristol submitted returns to the UKCSR annually from 1977 onwards. They were compiled from the surgeons' logs, and submitted by Mr Wisheart's secretary. The figures submitted in the returns related to acquired heart disease (adults) and congenital heart disease (children). For congenital heart disease, the number of open and closed operations and number of deaths, for patients under the age of 1 year and those aged over 1 year, were presented in different categories.The categories related to diagnosis rather than the type of operation carried out.

31 The data provided a point of comparison within the Bristol service, year by year, by reference to the figures produced by the clinicians in Bristol for the preceding year and years. It was also possible for Bristol to compare its data with the aggregated data from other specialist centres in the UK, albeit that by the time the UKCSR aggregated data was published it was 18 months to 2 years old.

32 Mr Alan Bryan stated:

> 'It has always been accepted in cardiac surgery that there was a professional commitment to supply accurate data to the UK cardiac surgical register throughout the period in question.'[54]

33 Mr Dhasmana told the Inquiry about the circulation within the Bristol service of the figures submitted to the UKCSR in the following exchange:

> 'Q. If anyone within the department had said, "Janardan, what are the figures?" would you have given them a copy of the returns to the register?
>
> 'A. Copies were always sent to my surgical colleagues, so they all had a copy.
>
> 'Q. What about cardiological colleagues?
>
> 'A. Paediatric cardiologists would have had a copy, but it would not have gone to adult cardiologists and I do not think, you know, we were sending copies to anaesthetists in a way, but if somebody would have come and asked, yes, they would have got a copy.

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[53] WIT 0341 0039 – 0041 Dr Pryn
[54] WIT 0081 0017 Mr Bryan

> ‘Q. Why were paediatric cardiologists given the figures but not anaesthetists?
>
> ‘A. Because we were closely working together; we were discussing problems, and we had audit meetings called in paediatric and Children’s Hospital and anaesthetists were called. If they were not coming to the audit meetings, how would I know they were so much interested about the figures, unless they kept bringing their presence into the meeting? They never did that.’[55]

34 Mr Dhasmana was asked by Leading Counsel to the Inquiry about whether the figures, if presented at audit meetings, were circulated to all those entitled to attend the meetings, in the following exchange:

> ‘A. … I do not think any of these papers you saw, except for the minutes or the summary, the figures itself, I do not think they were circulated, no.
>
> ‘Q. Why not?
>
> ‘A. I do not know. You ask Dr Martin [who ran the audit meetings].
>
> ‘Q. For your part, you did not circulate the results because you thought the anaesthetists might not have been interested?
>
> ‘A. No, I did not circulate because it was not my job, but at the same time, anaesthetists, if they were conspicuous by their absence, I do not think they could really complain that they were not getting minutes. They never attended any of those audit meetings.’[56]

35 Dr Joffe discussed the distribution of the UKCSR figures within the Bristol service in the following exchange:

> ‘Q. You tell us in your statements that there were figures which were available year on year from, certainly from 1986 onwards but relating to the period 1984 through to 1995. Did you yourself see the figures produced by the unit in terms of mortality rates in the different categories, the under 1s, the over 1s, open and closed for each year as each year fell?
>
> ‘A. They were certainly available year on year. … the figures were made available to all the cardiologists. Access to those figures is by the surgeons only, that is the UK national register, so that we could only respond to those figures as they were shown to us by the surgeons.

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[55] T86 p. 146–7 Mr Dhasmana

[56] T86 p. 148 Mr Dhasmana

> 'Q. You got the figures for the unit which were collective figures?
>
> 'A. Yes. …'[57]

The South West Congenital Heart Register

36 The cardiologists also developed a system[58] for keeping records of all children seen by them with a congenital heart defect. Dr Jordan stated[59] that the system had a long history, as records had moved from books containing notes onto various early computer systems (from 1973 onwards), until the Bristol and South West Children's Heart Circle purchased a computer which was capable of holding a database of information. Dr Jordan engaged his son to write a software application to make the system more 'user-friendly'. A small research grant from the South West Regional Health Authority (SWRHA) paid for a part-time secretary to input the data. Any patient from the South West seen by the cardiologists who was considered to have organic heart disease, had details of the clinical diagnosis entered on the computer. Some 96 items were recorded for each patient. The uses of the database permitted identification of all patients by multiple parameters; for example, all patients with Down's syndrome or AVSD,[60] the first operation under 1 year of age, and the particular surgeon.

37 Dr Jordan explained:

> 'In general, while the system probably sounds to be amateurish and was by no means perfect, it was better than most units had in place. Clearly it would have been better if we had had more clerical and computer staff, but we had no finances to pay for this. … Even with the system as it was, I could have made much more use of it if I had had more time.'[61]

The METASA System and the Patient Analysis and Tracing System

38 Mr Jonathan Hutter described in his written evidence to the Inquiry the efforts made to introduce computerised data collection in the Department of Cardiac Surgery.[62] He stated that in 1990 Mr Wisheart:

> '… was negotiating to buy hardware and software from the METASA company for the purpose of developing a database of patients having cardiac surgery in order to facilitate research and audit. … This was purchased from Mr Wisheart's fund, which had been donated by patients who wished to express their gratitude by making a monetary donation to the fund run for this purpose by Mr Wisheart.'[63]

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[57] T90 p. 9–10 Dr Joffe

[58] This is distinct from the 'Cardiologists' Card Index System', referred to earlier, which was kept by the cardiologists' secretaries at the Children's Hospital

[59] WIT 0099 0001 Dr Jordan

[60] See Chapter 3 for an explanation of this term

[61] WIT 0099 0003 – 0004 Dr Jordan

[62] WIT 0096 0002 Mr Hutter

[63] WIT 0096 0002 Mr Hutter

39 Mr Hutter explained that Mr Wisheart correctly anticipated that computerised audit would become essential and was keen to be at the forefront of its development. Mr Wisheart's fund provided the finance for the purchase of both the METASA system and, later, the Patient Analysis and Tracing System (PATS).

40 Mr Hutter stated that he developed a data set of questions designed to assist audit, or 'retrospective research projects on analysis of results (the old name for audit)'.[64] The intention was to develop two data sets, one for adults and one for children. However, as someone who operated on adults, he stated that he decided to concentrate on developing the adult system first: '… with the intention of assisting in the development of the paediatric data set once the adult system was up and running satisfactorily'.[65]

41 Mr Hutter stated that problems were experienced, such that the PATS system never produced data complete enough to be useful, and never functioned effectively during the period of the Inquiry's Terms of Reference.[66]

Statistics relating to clinical performance at other specialist centres (for the purpose of comparison) available from external sources

42 During the period of the Inquiry's Terms of Reference, statistics relating to the clinical performance of other specialist centres, as well as the Bristol service, could be derived from three main external sources:

- the data from the UKSCR, made available to the cardiac surgeons in Bristol by the Society of Cardiothoracic Surgeons;
- the Department of Health's and Royal Colleges' national working parties on supra regional units for neonatal and infant cardiac surgery in England and Wales;[67],[68]
- externally produced ad hoc reports on the clinical performance of the paediatric cardiac service (PCS) in Bristol relative to other specialist centres (such as the report by Jo Weston and Mr Martin Elliott,[69] and the report by Mr (later Professor)

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[64] WIT 0096 0007 Mr Hutter

[65] WIT 0096 0002 Mr Hutter

[66] WIT 0096 0008 Mr Hutter

[67] For example, the report commissioned by the DHSS from the Society of Cardiothoracic Surgeons of Great Britain and Ireland: UBHT 0061 0205; *'Interim Report of the Working Party on Neonatal and Infant Supra Regional Cardiac Surgical Units in England and Wales'*, July 1989. Graphs of figures are at UBHT 0061 0212 – 0217. See also Chapter 6

[68] For example, DOH 0002 0112; *'Report from the Working Party Set Up by the Royal College of Surgeons of England on Neonatal and Infant Cardiac Surgery: Supra Regional Funding and Designation'*, June 1992. Tables of figures are at DOH 0002 0116 – 0124. See also Chapter 6

[69] JDW 0004 0930; *'Comparative Analysis of Paediatric Cardiac Surgery Outcome Data from Bristol'*, April 1995

Marc de Leval following his visit to the UBHT with Dr Stewart Hunter on 10 February 1995 [70]).

The United Kingdom Cardiac Surgical Register (UKCSR)

43 Mr Dhasmana stated in his written evidence to the Inquiry:

> 'The [UKCSR] provided annual figures in the form of averages compiled from the returns to the Society of Thoracic and Cardiovascular Surgeons of Great Britain and Ireland (S.T.C.V.S-UK). All cardiac centres in the U.K., including supra regional centres, would be providing data for the register. The register has mentioned a number of defaulters on a few occasions. Bristol has always contributed to the register. These figures were taken as comparators with known limitations. … The U.K.C.S.R was circulated to each member of the society. … The U.K.C.S.R annual figures were the only known comparator during this time.'[71]

44 Dr Joffe discussed the distribution of the comparative figures from the UKCSR in the following exchange:

> 'Q. There would be a comparison which you would be told of by the surgeons because they had access to the comparison figures for the UK generally?
>
> 'A. Yes.
>
> 'Q. And you say that they were made available; what do you mean by that?
>
> 'A. I believe that they were sent around or copies of the results were sent around to the cardiologists for perusal …'[72]

45 Mr Wisheart discussed the value of the UKCSR figures for making comparisons in the following exchange:

> 'In terms of comparing [my performance] with people outside Bristol, the only comparator available to us was in the most recent annual report of the register [the UKCSR] that was available to us. So, for example, say we were compiling the report for 1988 some time in the early months of 1989. The probability is that we would have available to us the report for 1987 but not for 1988. … The value of the register figures … is that, if we just assume their accuracy for the moment, they then reflected the work in the whole country. That is quite different from information that is available to us in the literature for any particular operation or group of operations, because mostly work in the literature is the work of a particular unit. Obviously, that unit may or may not be representative of the work in a country.

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[70] UBHT 0061 0471; *'Bristol Paediatric Cardiac Surgery 1990–1995'*, an independent commentary by Mr Marc de Leval with tables of comparative data, and an introduction by Mr Hugh Ross, Chief Executive of UBHT, January 1996. See also Chapter 30

[71] WIT 0084 0051 Mr Dhasmana

[72] T90 p. 10 Dr Joffe

> ‘So it had that value and it has to be distinguished, therefore, from other sources of information that we would tap into.’[73]

46 Mr Dhasmana, in his written evidence to the Inquiry, gave an example of how he used data for comparison:

> ‘Using U.K.C.S.R as a comparator, I knew that my figures (as shown in Annex-A[74]) had improved overall in almost all categories in the period 1990-5. … In A.V canal the mortality rate was down from 27.7% at the end of 1989 to 17.5% during the second period, and approaching the U.K figure of 11%, in 1995.’[75]

47 Leading Counsel to the Inquiry asked Mr Wisheart how he interpreted differences between figures in the UKCSR and his results in the following exchange:

> ‘Q. This is the paragraph I want to focus on:[76] “Simply looking at the figures suggests that my mortality of 29 per cent was nearly double the 16 per cent reported in the UKCSR. However, if the higher risk, which is appropriate on account of the additional abnormalities, is assigned to my patients, then the actual expected mortality in this small group must be much greater than 16 per cent. Thus, if there is a discrepancy between my observed 29 per cent and the actual expected mortalities, it is much smaller than the raw figures of 29 and 16 per cent would suggest.” What you are doing in these paragraphs is this, is it: taking the raw figures, as you call them, for your series and for the UKCSR and seeking an explanation as to why, despite the appearance of the raw figures, your figures are in truth little different from those which the surgical register reflects; is that the process?
>
> ‘A. I am not sure whether or not I got to the point of “little different”, but I think the process was that I had information in front of me about my patients which I sought to use in relation to the UKCSR. I mean I was not seeking to achieve an end, which is I think what your remarks suggested, I was seeking to understand the facts that were available to me and that understanding could have been one thing or it could have been another. So I was seeking to understand those facts, all of those facts.’[77]

Working Party reports

48 Dr Joffe was asked by Leading Counsel to the Inquiry whether he had seen the Interim Report of the Society of Cardiothoracic Surgeons (the appendices to which contained figures allowing comparison between Bristol and the other, named supra regional centres for neonatal and infant cardiac surgery) and the amendments made to it in handwriting:[78]

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[73] T41 p. 67–8 Mr Wisheart
[74] WIT 0084 0055 Mr Dhasmana
[75] WIT 0084 0052 Mr Dhasmana
[76] Referring to Mr Wisheart’s evidence at WIT 0010 0029
[77] T92 p. 104–5 Mr Wisheart

‘Q. In July 1989 … we have the interim report of the Working Party on neonatal and infant supra regional cardiac surgical units in England and Wales. This is a report to the Supra Regional Services Advisory Group. Did you ever see it?

‘A. … I am not sure I have.

‘Q. What you might remember, and I will take you straight to it, is … the table at the back. The original writing at the top is “Figures for 1988 by centre (alphabetical)”. The rest of the writing is added later by someone’s hand?

‘A. Yes. I have not seen this before.

‘Q. You have not?

‘A. No.

‘Q. It is, as it happens, the second column from the right in each of these particular classes. The first is “open under 1 year” and the next is “open over 1 year”. Perhaps we can just take a long view of the sheet. That is Bristol and the other bars are those other centres which were designated at the time.

‘A. Yes. I am sorry, I really do not know what is being represented, whether it is operations or —

‘Q. These are numbers of operations.

‘A. Yes. Under 1?

‘Q. The top is under 1, the second is over 1, and then closed operations at the bottom.

‘A. Yes, I beg your pardon, you said Bristol was second from the right. I was looking under Newcastle.

‘Q. Second from the left.

‘A. Yes.

‘Q. If we bear in mind the top figure, the 29, and just go to WIT 74/1092, turn it sideways, these represent point estimates of mortality in 1988 and confidence intervals around them demonstrated by the bars. It shows, limited to 1988, the relative performance in terms of mortality of the different units. For that year, we have seen the figure 37.5%?

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[78] WIT 0074 1083 Dr Baker; *‘Interim Report of the Working Party on Neonatal and Infant Supra Regional Cardiac Surgical Units in England and Wales’*, July 1989

‘A. Yes.

‘Q. And we can see the second from the left, as it happens, is again Bristol.

‘A. Yes.

‘Q. It appears to represent that the better units tend to be those doing a larger number?

‘A. Yes.

‘Q. And that was not surprising, I suspect, or would not be surprising?

‘A. Yes, that is correct.

‘Q. You did not see this at the time.

‘A. No.

‘Q. Did you have any idea at the time how other individual units were actually performing?

‘A. No, not at all.

‘Q. If you had seen information such as that in order to put the information you got each year from the annual report into some sort of context, you would have been able to compare Bristol year by year, depending on what the other years looked like with the performance of other units?

‘A. Yes.

‘Q. If that showed that Bristol as a unit was consistently either the worst or one of the worst, what reaction do you think you would have had to that?

‘A. I would have been very disappointed, naturally, but I would need to see this on a year by year basis before making a confirmed response. But of course, it would be one of disappointment, but again, it would be a case of, as you pointed out, fewer turnover of patients, and again, as I have mentioned, we would have reviewed this looking at the particulars of the cases in detail, as indeed we did.

‘Q. Let me give you a hypothesis. If this pattern, or something rather like it, were repeated over most years, to what reason do you think would you ascribe the relative low performance of Bristol? For what particular reasons?

‘A. I do not think I can add to those we have discussed. We talked about the split site, et cetera.

> ‘Q. So the split site; the absence of a dedicated paediatric cardiac surgeon?
>
> ‘A. Yes.’[79]

49 Mr Wisheart was also asked by Leading Counsel to the Inquiry about Working Party Reports (the July 1989 Interim Report of the Society of Cardiothoracic Surgeons,[80] and the June 1992 Report of the Royal College of Surgeons of England[81]) in the following exchange:

> ‘Q. Did you know about the comments that had been made to the Supra Regional Services Advisory Group in the report of the working parties?
>
> ‘A. I have more difficulty with my recollections there because I certainly saw some reports but I have since seen other documents, through this Inquiry chiefly, which I had never seen before. I think the summary of my position on this would be that I knew that they knew about the split site and they never indicated in any way to us that the split site was either a particular problem in their minds or that it was something that really meant we should not be a designated centre. I mean, they never came to us with anything on that particular front. Indeed, when we sought capital monies from them that would have helped us to deal with it, it was not forthcoming, either in 1987 or in the early 1990s. So I can only assume that they did not regard it as unacceptable.’[82]

50 Mr Dhasmana in his written evidence stated:

> ‘… Mr Wisheart was regularly sending our figures for neonates and infants to the Department of Health in connection with a report on the supra regional service. But I did not receive any regular feed back regarding other centres. I attended the B.P.C.A.[83] meeting in 1992/3 in London, where the Supra Regional Advisory/ Assessment Board’s Report was being discussed. This Report showed Bristol amongst the bottom two or three, but the numbers were small. The recommendation was to increase the volume of work, as results were good in centres with a larger volume of cases.’[84]

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[79] T90 p. 54–7 Dr Joffe

[80] The report commissioned by the DHSS from the Society of Cardiothoracic Surgeons of Great Britain and Ireland: UBHT 0061 0204; *‘Interim Report of the Working Party on Neonatal and Infant Supra Regional Cardiac Surgical Units in England and Wales’*, July 1989

[81] DOH 0002 0112; *‘Report from the Working Party Set Up by the Royal College of Surgeons of England on Neonatal and Infant Cardiac Surgery: Supra Regional Funding and Designation’*, June 1992

[82] T94 p. 85 Mr Wisheart. See also Chapter 22

[83] British Paediatric Cardiac Association

[84] WIT 0084 0051 Mr Dhasmana

Statistics relating to clinical outcomes available from professional meetings, contacts and journals as a means of comparison

51 Mr Wisheart referred in his written evidence to the Inquiry to the sharing of data with other centres:

> 'This took place through communication and publication of data within the context of peer reviewed scientific meetings and journals, including the informal meetings of paediatric cardiac surgeons in Great Britain from 1990. In addition to attendance at meetings … both Mr Dhasmana and I regularly read the journals related to Paediatric Cardiac Surgery.'[85]

Professional meetings, other professional contacts and professional journals

52 Mr Dhasmana in his written evidence to the Inquiry stated:

> '… there was some scepticism attached to information received in conversations with colleagues from other centres, as people did not normally like to talk about problems faced during operations. … Mr de Leval is probably the only surgeon to have published his problems in continuing with the Arterial Switch Programme at the G.O.S. [Great Ormond Street] in 1993/4.'[86]

53 Mr Wisheart stated:

> 'Both Mr Dhasmana and I regularly attended National and International Conferences, in the field of paediatric cardiac surgery, as well as various courses and seminars, which were held from time to time. There were informal conversations with colleagues at other centres, of which there will be no record. I visited other centres for periods of up to one week …'[87]

54 Mr Dhasmana stated:

> 'I attended the "Surgery for Congenital Heart Disease" course run by G.O.S London every other year from 1986 to 1994, and the "Paediatric Cardiac Surgical" course in Paris in 1993. I also attended paediatric cardiac surgical symposiums and meetings run at the annual meetings of S.T.C.V.S-U.K, the European Association, the British Cardiac Association, British Paediatric Cardiac Association (B.P.C.A) and the American Association for Thoracic Surgery (A.A.T.S) frequently. Therefore I had knowledge of advances being made and procedures adopted to keep pace with developments in paediatric cardiac surgery. The information available on these courses and at the various seminars, conferences and meetings were in regard to certain groups of operations performed at known centres of excellence … However, discussions with colleagues at these events were useful in helping to make further improvements. It was as a result of discussions at a B.P.C.A meeting in

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[85] WIT 0120 0292 Mr Wisheart
[86] WIT 0084 0052 Mr Dhasmana
[87] WIT 0120 0292 Mr Wisheart

> Birmingham, in November 1992, that I approached Mr Brawn for further help with the Arterial Switch Programme at Bristol.'[88]

55 Mr Dhasmana went on:

> 'I am not aware of any published mortality data on paediatric cardiac surgical operations from a particular centre. However, I have attended meetings where excellent results in one particular operation from a centre were presented, i.e. Arterial Switches and A.V. Canal from meetings held at Birmingham, Bristol and COBE[89] respectively. Arterial Switch results for complex T.G.A. and other conditions from Dublin. I have also seen published results of Arterial Switches in T.G.A with V.S.D. from the Brompton Hospital in 1988 or 89. These were isolated publications of good results in a particular group. We ourselves presented some good results at some of these meetings (List attached – Annex B),[90] and published our good results in Senning operation (British Heart Journal. 69.5, 436–441, 1993) …'[91]

Other statistics relating to clinical performance

56 Apart from the statistics produced by the surgeons, cardiologists, and anaesthetists in Bristol, sources of data were kept by administrative staff in the UBH/T and by the Department of Health.

Patient Administration System

57 The principal source of data kept by administrative staff was the Patient Administration System (PAS). PAS was a computerised system for storing, analysing and recording information that was introduced within UBH/T in 1988. Mr Andrew Hooper, formerly UBH/T PAS Manager, in his written evidence to the Inquiry stated:

> 'PAS is an administrative system only. It was implemented to replace the manual administrative systems, which had been supported by locally developed computer systems in the Health Authority, prior to 1988. PAS does not replace clinical data. It is solely administrative. For example, it provides an index of all patients who have attended the Trust, whether on an in-patient or out-patient basis. It is able to provide information concerning waiting lists and also to print documents, for example, labels and letters, so saving administrative time. … PAS feeds PAD [Patient Administration Database] with patient based information that is used for statistical information and contract purposes. … the in-patient module is an

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[88] WIT 0084 0052 Mr Dhasmana. Mr Dhasmana's visit to Birmingham is referred to in more detail in Chapter 27

[89] 'COBE' refers to COBE Cardiovascular Inc., which ran meetings for paediatric cardiac surgeons in the early 1990s

[90] WIT 0084 0061 Mr Dhasmana. See Chapter 3 for an explanation of these clinical terms

[91] WIT 0084 0051 Mr Dhasmana

> administrative tool to enable staff to record the date of admission, the fact and date of transfer to wards, the date of discharge, any change of consultant, whether the patient is being or has been treated at another hospital within the Trust, and referral to another hospital if within the Trust. Most of this information is recorded in "real time", in other words it is recorded as the event occurs.'[92]

58 PAS contained information on patients' diagnoses and procedures. Mr Hooper was asked by Leading Counsel to the Inquiry about how the diagnostic information got onto the PAS:

> 'Q. So how did the diagnostic information get on there?
>
> 'A. The way that it works is obviously a patient comes into hospital, they have their care, are discharged from the hospital, and then the notes one would normally expect to go back to the consultant's secretary to have a summary dictated. That summary should be dictated as quickly as possible after the discharge, although some clinicians are better than others at doing discharge summaries, so the discharge summary would normally be a side of A4, the top half would have the demographic information, the middle portion would probably have the diagnostic information written down, into a main and secondary diagnosis. If they had an operation, there would be a section for the operation details. At the bottom you would have the text the medical staff dictated about the patient's stay. A copy of that discharge summary would obviously go to the GP and any other interested parties. A copy would be retained in the medical records. As soon as that discharge summary has been dictated and typed, those notes would then go off to the clinical coders for that episode of care to be coded. That would be done as quickly as the discharge summary was dictated. Most of the coding clerks would code directly, all the coders would code from the diagnostic and operational information that had been put on to that discharge sheet.'[93]

59 In his written comment on the preliminary overview of data sources published by the Inquiry, Mr Hooper stated:

> '… it is not correct to describe it [the PAS] as a "case-based information system". It is an administrative system. The distinction lies in that of the 5,000 plus users of the system in UBHT 99% of those people using it are only interested in the accuracy of the demographic information and episodal administrative information (i.e. dates of admission and discharge) contained in it. PAS then feeds the statistical information through to PAD [Patient Administration Database]. It has the ability to produce standard reports and utilise an enquiry package. … it was an administrative system which fed information systems.'[94]

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[92] WIT 0211 0002 – 0003 Mr Hooper

[93] T39 p. 12–13 Mr Hooper

[94] INQ 0001 0024

60 Referring to PAS systems in general, Ms Ann Harding, then Acting Director of the NHS Information Authority, told the Inquiry:

> '… I think this is one of the problems that we have, the data is collected for the purposes which clinicians believe is managerial, and therefore not relevant to them, and I have a great deal of sympathy for that, because the level of detail at which a clinician would want the information for the purposes of audit is not readily encompassed within the levels of diagnosis and operative coding that we currently have.
>
> 'I also think that we have been quite lax in not feeding back to clinicians the information that is being submitted to the central returns about what it is they are doing. When we did give information back to clinicians, they said "I do not do that operation, I do not have that many patients with that diagnosis", and I think therefore one of the things we must do is to find ways of ensuring that the information does go back to them so they in some ways validate it before it is used for other purposes.'[95]

61 Mr Hooper was asked by Mrs Howard, a Member of the Panel, to comment on the setting up of stand-alone systems within the UBHT to support the clinical staff in the information that they wished to collect, in the following exchange:

> 'Q. You made it clear that this was very much an administrative system, and we have also heard about what I would phrase the "lack of ownership" from clinical staff with regards to that. Do you have any comment about subsequent setting up of stand-alone systems within the Trust to support the clinical staff in the information that they wished to collect? That would be the first part of the question. I would like to explore that after your answer.
>
> 'A. Certainly, as far as I am concerned, I have only ever been involved in implementing the corporate systems. I think probably the Trust … philosophy has always been, where possible, we would like to use those corporate systems, but that is not to say that if a clinician or a group of clinicians wanted to go and purchase perhaps an audit system — they should be able to do that. I think the problem with doing that is, if you are inputting the data into two separate systems, it is always going to be difficult reconciling the information on the two systems.'[96]

62 The data in the PAS was used in ad hoc audit reports, and in making returns to external organisations. Referring to his use of data in the PAS, in his written statement to the Inquiry, Dr Pryn stated:

> '… This was a system used by the ward clerks and enabled me to check whether or not the children had been discharged home and seen in outpatient clinics

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[95] T39 p. 26 Miss Harding

[96] T39 p. 51–2 Mr Hooper

> following surgery. This was an indicator as to whether or not they were indeed alive at the time of discharge.'[97]

The CHKS Report

63 In the early 1990s,[98] UBH/T began to use the services of CHKS Limited. Mr Gary Tharme, Sales and Marketing Director of CHKS Limited, wrote to the Inquiry:

> 'CHKS were formed out of a joint venture in 1990 between the King's Fund and CASPE Research and have been building a normative database of UK NHS acute clinical activity since 1992. …
>
> 'The National Comparative Database was launched in 1992 and now has over 100 Trusts subscribing from all parts of the UK.
>
> 'Our aim is to continually improve the quality and use of clinical information in the NHS.
>
> 'We compare hospitals'clinical activity with others that are locally relevant. Comparisons can be simple or extremely refined. Typical comparisons can be at Trust, Hospital, Specialty, HRG [Health Resource Group], and procedure or diagnosis level. Target levels of performance can be derived, for instance looking at high performing Trusts. …
>
> 'Trusts regularly send CHKS information about their activity, which we compare with a range of peer group hospitals that they feel, are relevant to them. Standard performance monitoring reports are sent to the client by return.'[99]

64 In a letter to the Inquiry, Mr Rashid Joomun, the UBH/T's Trust Information Manager, stated:

> 'The Trust provided CHKS with data monthly, which they processed and sent back high level reports in the form of comparative tables. They also provided us with a monthly database on which we could do analysis.'[100]

65 CHKS produced a report,[101] dated 1992, which contained figures of diagnoses, lengths of stay and deaths in relation to the Cardiology and Cardiothoracic Surgery specialties in UBH/T and in a group of similar hospitals for comparison. Statistics relating to paediatric cardiology and cardiac surgery in particular, were not separately identified in the report.[102]

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[97] WIT 0341 0040 Dr Pryn

[98] UBHT 0343 0002 Mr Joomun

[99] SEM6 0003 0131 – 0132 Mr Tharme

[100] UBHT 0343 0003 Mr Joomun

[101] HOME 0011 0001; *'National Comparative Database, United Bristol Healthcare NHS Trust, Reports for Cardiology and Cardiac Surgery'*, CHKS Limited, 1992

[102] UBHT 0343 0003 Mr Joomun

66 In a letter to the Inquiry, Mr Joomun further stated:

> 'Action was taken to improve data quality. This was mostly centred around diagnostic coding. General Managers would be informed individually of their directorates' problems and it was expected that they would take the necessary action to remedy these problems. … As far as I know, none of the Directorates had direct access to the routine reports produced by CHKS.'[103]

Hospital Episode Statistics

67 The PAS was used, further, to provide summary data on episodes of care for patients, for the national returns to the NHS known as Hospital Episode Statistics (HES). In his written statement to the Inquiry, Mr Richard Willmer, a Branch Head in the Statistics Division of the DoH, in describing HES, stated:

> 'The HES system collects records for all (both NHS and private) in-patient consultant episodes of care, including day cases but excluding regular day or night attenders, in NHS hospitals in England.'[104]

68 Mr Willmer also stated:

> 'HES was introduced on the recommendation of the NHS/DHSS Steering Group on Health Services Information, which was appointed by the Secretary of State for Social Services in February 1980. The Chairman, Mrs E Körner, published the First Report on the collection and use of information about the clinical activity in the National Health Service in 1982. The report which is commonly known as the "Körner"report, states at section 8.4;
>
> ' "The DHSS needed information about bed use for:
>
> ' "a. Policy development. Detailed statistical analysis may be required when pursuing issues arising from a preliminary analysis of simple tabulations.
>
> ' "b. Resource procurement and allocation. To prepare and argue the case for adequate funding for the NHS, the DHSS requires ready access to detailed information about the pattern of care in hospitals. Information is also needed for the operation of the resource allocation system, for the monitoring of the system's effects and for the development and improvement of the existing system.
>
> ' "c. Accountability. Health authorities are accountable to the Secretary of State and the Secretary of State to Parliament for the setting of policies and priorities for the use of NHS resources, and the use of resources to achieve those objectives.
>
> ' "d. Research and development activities. Both DHSS and OPCS [Office for Population Censuses and Surveys] carry out a range of epidemiological,

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[103] UBHT 0343 0006 Mr Joomun

[104] WIT 0189 0009 Mr Willmer

> operational research and economic studies, which contribute to policy development and service planning.
>
> 'The Hospital Episode Statistics (HES) system, and miscellaneous Körner Aggregate returns resulted from these recommendations, and is largely still based on the principles established in the First Report.
>
> '… The main additional purposes … are: *performance assessment* of the NHS by DoH and the NHS themselves; identifying *inequalities* in health and healthcare and *small area studies* eg effects of local environmental factors. Even now, there are known deficiencies in the data which impose constraints on the uses but with knowledge and care expert users are seeking to exploit the data more fully than in the past."'[105]

69 Mr Willmer further stated:

> 'HES data were originally collected centrally from the NHS through the Regional Information System (RIS) based in each of the Regional Health Authority (RHA) areas. The regions varied as to what data they held on their own databases (eg whether or not names and addresses were held), how they compiled their HES submission, and how data were shared with NHS colleagues. What did not vary was the subset of data items the RHAs supplied to OPCS for HES.'[106]

70 In his first report to the Inquiry, Professor Stephen Evans, one of the Inquiry's experts on statistics, stated:

> 'Bristol, in common with other hospitals within the National Health Service (NHS), is required to provide summary data on episodes of care for patients. It does this using the local computer-based Patient Administration System (PAS) for providing national returns to the NHS, known as Hospital Episode Statistics (HES). Most other Health Care Trusts in England and Wales have similar systems for producing these returns. More details on the national picture derived from HES are given in a separate report (Aylin et al. 1999). The Bristol PAS is a fairly comprehensive computer system developed from a long tradition of using computers for patient administration in the Bristol area that was begun in the late 1960's. Neither in Bristol nor elsewhere have patient administration systems generally been used for looking at clinical outcomes in a rigorous way. In most instances the recording of death is limited to those deaths which occur prior to discharge from hospital. The Bristol system has included patient outcome, in terms of death, for at least some patients beyond the period when a patient was actually in hospital. This is unusual and allows for a more comprehensive picture of the vital status of patients than is usually the case for administration-based systems.'[107]

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[105] WIT 0189 0004 – 0005 Mr Willmer (emphasis in original)

[106] WIT 0189 0006 Mr Willmer

[107] INQ 0012 0007 – 0008; *'A report on local data relating to children who received cardiac surgery under the terms of reference of the Bristol Royal Infirmary Inquiry'*, October 1999, Professor SJW Evans

> ‘The purpose of the system is not to store information that a doctor requires to care for the patient, nor is it intended for audit of the quality of care. Any such use must take account of the likelihood that important details may not be recorded.’[108]
>
> ‘The administrative clerks (known as “coders”) who classify diagnoses and operations for the PAS are not medically qualified, and they may misunderstand the medical information in the medical records of patients. The medical records themselves may not be clear in describing the diagnoses or operations for every patient. The ICD [International Classification of Diseases] coding system may also have inadequacies when used in a very specialised area. Individual coders vary in their experience, but there are some highly experienced coders who are very good at carrying out the classification of diagnosis and operation.’[109]

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[108] INQ 0012 0012; *‘A report on local data relating to children who received cardiac surgery under the terms of reference of the Bristol Royal Infirmary Inquiry’*, October 1999, Professor SJW Evans,

[109] INQ 0012 0013; *‘A report on local data relating to children who received cardiac surgery under the terms of reference of the Bristol Royal Infirmary Inquiry’*, October 1999, Professor SJW Evans,

Section two: the views of the Inquiry's Experts on the interpretation of statistics relating to clinical performance which were available to clinicians in Bristol during the period 1984 to 1995

Statistics relating to clinical performance produced by the clinicians in Bristol

71 Earlier in this chapter, reference was made to a series of three Annual Reports on paediatric cardiology and cardiac surgery in Bristol that were produced by the clinicians in Bristol during the period of the Inquiry's terms of reference.[110],[111],[112]

72 Four members of the Inquiry's Group of Experts[113] were asked to review these Annual Reports, with specific reference to identifying any concerns to which they would or should have given rise at the time.

73 Dr Duncan Macrae observed:

> 'The most striking feature of all three reports to me is the high mortality quoted for open heart surgery performed in children < 1 year of age. The mortality figures of 20% in 1987, 37.9% in 1988 and 37.5% in 1989 are consistently high and over the three year period showed no sign of improvement. There could be a number of explanations for this, including case-mix. I note, in particular, that as a percentage of total activity, proportionately fewer neonates were operated upon in Bristol than at the Brompton Hospital. This may go some way in explaining the high mortality in Bristol if there was a bias towards selecting the sicker patients for operation under one year of age. Also since the numbers operated were small, I presume, from a statistical point of view, the confidence limits were wide. Nevertheless I believe that the failure of the Bristol annual reports to demonstrate an improving

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[110] UBHT 0166 0001 – 0014; *'Paediatric Cardiology and Cardiac Surgery, Bristol Royal Hospital for Sick Children and Bristol Royal Infirmary, Annual Report 1987'*

[111] HAA 0138 0003 – 0012; *'Paediatric Cardiology and Cardiac Surgery, Bristol Royal Hospital for Sick Children and Bristol Royal Infirmary, Annual Report 1988'*

[112] UBHT 0133 0073 – 0086; *'Paediatric Cardiology and Cardiac Surgery, Bristol Royal Hospital for Sick Children and Bristol Royal Infirmary, Annual Report 1989/1990'*

[113] Dr Kate Bull (Medical Adviser to the Department of Nursing and Family Services and previously Honorary Consultant Paediatric Cardiologist at Great Ormond Street Hospital), Mr Leslie Hamilton (Consultant Cardiothoracic Surgeon at The Freeman Hospital, Newcastle upon Tyne), Dr Alan Houston (Consultant Paediatric Cardiologist at the Royal Hospital for Sick Children in Glasgow), and Dr Duncan Macrae (Director of the Paediatric Intensive Care Unit at the Royal Brompton & Harefield NHS Trust)

> mortality should have raised concerns and led to discussions within the unit about the reason for this, and any necessary remedial action, given that in the wider UK context (I note that the UK figures are appended to the 1989 –'90 reports) mortality for open heart surgery under one year of age was approximately half of that reported in Bristol.'[114]

74 Mr Leslie Hamilton observed:

> 'The first report contains an amalgamation of figures over a four year period and the unit would have been justified in accepting these mortality figures as a baseline. It is difficult to be specific as the small numbers involved mean the absolute mortality figure will have wide confidence intervals. The figures for "closed" surgery in both age groups would seem to be satisfactory. The mortality figure in the "open" category for the over one age group would again be within acceptable limits. The mortality rate for the "open" surgery in the under one age group are [*sic*] high but that for 1984–87 would have been comparable with national results. The mortality rates in 1988 and 1989 (37.5%) are high with a national mortality rate recorded in the Register [UK Cardiac Surgical Register] of approximately 20%. Even allowing for under reporting of deaths in the National Register and the relatively small numbers in Bristol these figures for 1988 and 1989 would have given rise for concern. It might have been argued that if Bristol had a conservative approach to surgery in this age group and undertook palliative surgery for many conditions, then it would mean that they were only carrying our [*sic*] corrective surgery (i.e. "open") on the very sickest children in the under one age group. Thus the individual cases would need close analysis.'[115]

75 Dr Alan Houston observed:

> 'The main clinical concern … is the mortality in the open procedures < 1 year of age. However, the lower ratio of operations in this group needs to be explained.
>
> 'It would be necessary to consider whether some infants were referred to another centre. And if so were they the less severely ill ones — with the worse ones who needed urgent treatment being referred to Bristol as they were too ill to travel to another more distant centre. This might explain the higher Bristol mortality rate.
>
> 'If all were referred and some not operated upon and dying, the mortality ratio becomes even higher than 1.7 and would likely be over 2.0. Double the national mortality would be a major concern, even without statistical analysis of the data.'[116]

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[114] INQ 0043 0001; *'Clinical audit data'*, 14 December 1999, Dr Macrae

[115] INQ 0043 0008; *'Key clinical audit data'*, 13 December 1999, Mr Hamilton

[116] INQ 0043 0005 – 0006; *'Clinical audit data on outcomes'*, undated, Dr Houston

76 Dr Kate Bull, referring to the high mortality reported for open-heart surgery in the under-1s in Bristol by 1989, observed:

> '… I believe many readers would be left with the raw figures and some hesitancy about whether there "really was" an issue to be raised. However, even with little in the way of quantitative skills, the impression that mortality for open-heart surgery in infancy was "twice the national average" (37.5% v 18.8%) would have been a conclusion that many readers could and should have come to.'[117]

77 Dr Bull concluded:

- 'The annual reports of Paediatric Cardiology and Cardiac Surgery were primarily documents that gave accounts of the "outcome of developments" rather than the "outcome of patients".
- 'However, by the time that the annual report of 1989 was circulated, a problem with mortality for open-heart surgery in infancy in Bristol was discernible.
- 'In that report a table was generated with some care and presented sufficient historical Bristol and contemporary national data to have given readers reason to "commission" a more detailed report.'[118]

78 As regards the information produced within the Department of Anaesthesia at the BRI, in the document *'Analysis of Paediatric Cardiac Mortality Data from UBHT 1990–92'*,[119] Professor Michael Campbell, Professor of Medical Statistics at the University of Sheffield and an Expert to the Inquiry in statistics, observed:

> 'This contains analysis of paediatric cardiac mortality data from UBHT 1990–1992 and compares it to the national average year of 1991. It omits the neonatal arterial switch operation. It shows Bristol to be statistically significantly worse than the rest of the UK on a number of operations. I have checked the chi-squared tests and they seem correct.'[120]

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[117] INQ 0043 0013; *'Expression of Concern'*, 13 December 1999, Dr Bull

[118] INQ 0043 0014; *'Expression of Concern'*, 13 December 1999, Dr Bull

[119] UBHT 0061 0080 – 0102, also referred to as the 'Bolsin/Black audit'

[120] INQ 0043 0019; *'Commentary on statistical analyses in response to letter from Dr Chadwick 04/10/1999'*, 8 October 1999, Professor Campbell

Statistics relating to clinical performance at other specialist centres (for the purpose of comparison) available from external sources

The UKCSR

79 Mr Leslie Hamilton stated:

> 'Standards for comparison are difficult — only the best results (by definition) are presented at conferences and the figures from the UK Register usually did not appear for at least a year. It must be further stressed that the UK Cardiac Surgical Register was not set up as an audit tool. Recording of data, particularly in the late 80s, was rather crude and there was certainly no validation. Thus no clinician would have used the mortality figure from the UK Register as being an accurate model, recognising that deaths were likely to be under reported.'[121]

80 Dr Eric Silove, Consultant Paediatric Cardiologist at Birmingham Children's Hospital NHS Trust and a member of the Inquiry's Expert Group, stated:

> 'Unfortunately, the UKCSR data was the only pool of information readily available to all clinicians in the UK who wanted to get what they might have considered to be a reasonable estimate of what the expectations were in the UK. It is unlikely that most centres would have aspired to produce results as good as the best in the United States or, for that matter at Great Ormond Street Hospital. It is also unlikely that clinicians at any centre would have taken into account the best results when communicating expected mortality rates to patients and families. It is more likely that they would have relied on the UKCSR data, however flawed it may have been.'[122]

81 In their Overview Report, the Inquiry's Experts in statistics, Dr Spiegelhalter, Professor Evans, Dr Aylin and Professor Murray, considered, from a statistical perspective, what could have been known at the time by Bristol clinicians about Bristol's performance as compared with the performance of other centres, on the basis of simple statistical analyses of the data available from the UKCSR:

> 'It is possible to consider what simple analyses might have been performed using the data and the statistical tools that would have been readily available to the surgeons at the time. The participating centres in the [UK]CSR were supplied with detailed annual reports giving mortality rates split by age and procedure, aggregated over all participating centres. This would have allowed a centre to compare its mortality rates with corresponding national figures.

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[121] INQ 0043 0007; *'Key clinical audit data'*, December 1999, Mr Hamilton

[122] INQ 0028 0022; Expert clinical commentary from Dr Silove on *'A systematic review of the outcomes of open heart paediatric surgery'*

> ‘Open [heart] surgery performed in children aged under one year is an appropriate subgroup to monitor, since these children are at high risk and include the majority of deaths.[123] In this group the ratio of the overall mortality rates at Bristol to the rates for other centres in England for 1985 through to 1995 were 1.18, 1.21, 1.24, 2.04, 1.93, 0.79, 2.05, 1.19, 3.18, 1.67 and 0.50 respectively. A chi-squared test performed each year would have given a crude indication of whether the local mortality rate differed from the national rate by more than could be explained by chance. Using such a test, the data for 1988, 1989, 1991 and 1993 are statistically significant at the 5% level. If years had been pooled in pairs or triplets to give larger numbers, then the results for 85/86 and 86/87 are non-significant, as are the results for 85/86/87, but the results for 87/88 and 86/87/88 are statistically significant. Thus with any of these approaches, it is not until the data for 1988 were included that the divergence from the national rates became statistically significant, and this was reinforced by the data for 1989. Given that there was a delay of the order of 18 months before the [UK]CSR data were fed back to centres, it would have been 1990 before the data from the [UK]CSR might have given any reason for concern, and the independent reinforcement for the 1989 data, which would become available during 1991, would have heightened this concern. However, the data for 1990 then came back into line with national figures … which might have been taken as reassurance that any problems which might have existed previously had been resolved.
>
> ‘This final point illustrates the difficulty of interpreting crude data based on small numbers of patients each year. Taking running totals from three year periods the data are statistically significant for 86/87/88, 87/88/89, 88/89/90, 89/90/91, (borderline non-significant for 90/91/92), 91/92/93, 92/93/94 and 93/94/95. Clearly there is a consistent and on-going pattern of poor outcomes, but it is difficult to know what weight should have been put on these data at the time, with there being questions over the data quality and with inadequate statistical tools to adjust for case mix and to analyse accumulating data from many different centres.’[124]

Professional journals

82 Ms Katerina Vardulaki and others[125] were commissioned by the Inquiry to review the contemporary literature to identify the body of knowledge that, in theory, was available to the clinicians in Bristol. Their approach was systematically to review case series[126] which had been published. They concluded:

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[123] A comparison of annual admissions, deaths and mortality rates in Bristol derived from local sources of data for open operations on under-1s can be found at INQ 0045 0054; *‘Overview of statistical evidence presented to the Bristol Royal Infirmary Inquiry concerning the nature and outcomes of paediatric cardiac surgical services at Bristol relative to other specialist centres from 1984 to 1995’*, Dr Spiegelhalter et al., September 2000

[124] INQ 0045 0037; *‘Overview of statistical evidence presented to the Bristol Royal Infirmary Inquiry concerning the nature and outcomes of paediatric cardiac surgical services at Bristol relative to other specialist centres from 1984 to 1995’*, Dr Spiegelhalter et al., September 2000

[125] INQ 0039 0001 – 0104; *‘A systematic review of the outcomes of open heart paediatric surgery’*, April 2000

[126] In their report to the Inquiry, Ms Vardulaki et al. defined a case series as: ‘A series of clinical cases, usually consisting of consecutive patients, seen in one or more centres between two time points’: INQ 0039 0007; *‘A systematic review of the outcomes of open heart paediatric surgery’*, April 2000. At INQ 0039 0004 they reported: ‘Searches only yielded case-series, i.e. no comparative studies such as randomised trials or cohort studies were found’

> ‘Case series on five open-heart operations/congenital anomalies have been reviewed systematically and the data have been synthesised. The pooled 30-day mortality estimates (at a particular point in time) are likely to represent “best achievable performance” rather than the performance to be expected in everyday practice. …
>
> ‘The review was commissioned primarily with the aim of understanding better the knowledge base that might reasonably have been expected to be available to the Bristol clinicians during 1984–1995. We have identified and synthesised the knowledge that existed but have pointed out, by analogy with other literature on systematic reviews, that it is probably unrealistic to have expected the Bristol clinicians to be aware of this knowledge. We propose that the paediatric surgical community should judge the relevance of the knowledge presented in the review to everyday practice.’[127]

83 Seven members of the Inquiry’s Expert Group[128] were asked to comment on the extent to which the evidence on mortality in the review by Ms Vardulaki’s et al. reflected ‘common knowledge’ among members of the paediatric cardiac community during the period of the Inquiry’s Terms of Reference.

84 Dr Duncan Macrae stated:

> ‘You asked me to comment on the extent to which the case series presented in the report would have been available to practising clinicians during the enquiry [*sic*] period. I think it is fair to say that the majority of the journals cited were readily available throughout that period in Medical Schools and Departmental Libraries throughout the UK.’[129]

85 Dr Robert Arnold stated:

> ‘Clearly the evidence of 30 day mortality derived from so many publications utilising very sophisticated statistical techniques has not previously been available. The individual reports of large series of cases published in the leading journals were accessible and should have been known by any surgeon or cardiologist working with congenital heart patients.’[130]

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[127] INQ 0039 0071 – 0072; *‘A systematic review of the outcomes of open heart paediatric surgery’*, April 2000

[128] Dr Robert Arnold (Consultant Paediatric Cardiologist at Alder Hey Children’s Hospital), Dr Kate Bull (Medical Adviser to the Department of Nursing and Family Services and previously Honorary Consultant Paediatric Cardiologist at Great Ormond Street Hospital), Mr Philip Deverall (formerly Director and Head of the Department of Cardiothoracic Surgery at Guy’s Hospital), Mr Leslie Hamilton (Consultant Cardiothoracic Surgeon at The Freeman Hospital, Newcastle upon Tyne), Dr Duncan Macrae (Director of the Paediatric Intensive Care Unit at the Royal Brompton & Harefield NHS Trust), Mr Babulal Sethia (Consultant Cardiac Surgeon and Clinical Director of Paediatric Services at the Royal Brompton and Harefield NHS Trust), and Dr Eric Silove (Consultant Paediatric Cardiologist at Birmingham Children’s Hospital NHS Trust)

[129] INQ 0028 0016; Expert clinical commentary from Dr Macrae on *‘A systematic review of the outcomes of open heart paediatric surgery’*, 20 July 2000

[130] INQ 0028 0002; Expert clinical commentary from Dr Arnold on *‘A systematic review of the outcomes of open heart paediatric surgery’*, 20 July 2000

86 Dr Eric Silove stated:

> ‘The case series evidence presented in the report would have been available to practising clinicians during the period covered by the Inquiry (1984 – 1995) but would not have been accessible in the analysed format of the Report. It would have been unrealistic to have expected any clinician to conduct similar analyses. …
>
> ‘The evidence about mortality rates in the best centres, presented in the report, probably was commonly known at the time to practising clinicians but it would not have been viewed as immediately achievable in most centres.’[131]

87 Mr Leslie Hamilton stated:

> ‘... surgeons would have had a feeling of the general principles outlined in the report but would not have had the specific factual evidence on which to base their assumptions.’[132]

88 Dr Kate Bull stated:

> ‘Most of the journals used for this review would be fairly readily available to most specialists in the field and most of the material would remain unread by any individual. Scanning the contents of a journal and knowing that he or she cannot absorb it all, a clinician is selective. Thus only a proportion of the material presented would be “actively known”.
>
> ‘… the extent to which the report corresponds to “common knowledge” is hard to say. My own initial reaction to the graphs was that they give an optimistic impression of results in general.’[133]

89 Mr Babulal Sethia, Consultant Cardiac Surgeon and Clinical Director of Paediatric Services at the Royal Brompton and Harefield NHS Trust, observed:

> ‘I think that the evidence presented in the report does, in the main, match what was commonly known at the time concerning surgical risks and outcomes of higher risk procedures …
>
> ‘Most of the journals quoted … would be perceived by the paediatric cardiac surgical community as sources of seminal or authoritative evidence on surgical risks and outcomes. During the time frame under consideration most of the best publications appeared in the American literature. An important source of evidence on surgical risks and outcomes would have been the Annual meetings of both the

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[131] INQ 0028 0023; Expert clinical commentary from Dr Eric Silove on *‘A systematic review of the outcomes of open heart paediatric surgery’*, 23 July 2000

[132] INQ 0028 0015; Expert clinical commentary from Mr Hamilton on *‘A systematic review of the outcomes of open heart paediatric surgery’*, 12 July 2000

[133] INQ 0028 0008; Expert clinical commentary from Dr Bull on *‘A systematic review of the outcomes of open heart paediatric surgery’*, April 2000

> British and European Cardiac Surgical Societies at which a steady number of congenital presentations were made on each occasion.'[134]

90 Dr Silove stated further that:

> 'From the perspective of the practising clinician, it is well-known that centres do not publish if their results are not the best or near the best. It also is self-evident that editors of the more reputable journals will not accept papers unless they have something new to offer their readers. Clearly then, the selection of the publications that were reviewed must have been significantly biased. The reported mortality rates cannot be representative of the expected results in the world as a whole, nor in any one country. We therefore need to view the mortality results as the very best that could be expected in the United States (5 centres), Australia (1 centre), and the United Kingdom (1 centre). This point is made by the authors in their Conclusions (para 110) but is not given enough emphasis in the report as a whole.'[135]

91 Dr Macrae stated:

> 'I agree that the literature presented in the review does represent fairly the common published literature in the field. As the report points out, it is likely that large ("good") centres are disproportionately represented in this series of published papers. Smaller centres are probably not adequately represented, either because they accumulate too few cases to publish contemporary series or because their results are poor and therefore not deemed publishable. If the Bristol results were only compared to published outcomes, then there is a risk that they be judged unduly harshly because of this inherent publication bias towards large high-volume centres.'[136]

92 Mr Philip Deverall stated that:

> 'I do … accept that publications from centres of excellence represent gold standards. One has to accept and believe the veracity of the data in this type of publication but equally these publications do not tell the whole truth about the results of treatment which are experienced throughout the world. Bad results are not published. Small numbers of results, which would often reflect the practice of a regional unit, would in general not be considered worthy of publication in a major journal. However and despite these reservations the gold standard data of best practice would represent a goal to which all would aspire.'[137]

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[134] INQ 0028 0019; Expert clinical commentary from Mr Sethia on *'A systematic review on the outcomes of open heart paediatric surgery'*, July 2000

[135] INQ 0028 0021; Expert clinical commentary from Dr Silove on *'A systematic review of the outcomes of open heart paediatric surgery'*, July 2000

[136] INQ 0028 0016; Expert clinical commentary from Dr Macrae on *'A systematic review of the outcomes of open heart paediatric surgery'*, July 2000

[137] INQ 0028 0012; Expert clinical commentary from Mr Deverall on *'A systematic review of the outcomes of open heart paediatric surgery'*, July 2000

93 Mr Deverall drew attention to the 'inherent time lapse between practice and publication', and referred to there being 'at least a three year period before knowledge would become available to the general reading surgical public'.[138]

94 As regards the relevance of the published literature to discussions between clinicians and parents concerning the risks of, and consent to, surgery, Dr Macrae stated:

> '… the published papers do accurately reflect the known surgical risks and outcomes. In the present era, all of these risks would be discussed by a surgeon seeking consent in detail. I suspect that in the era starting in the mid '80's, risks were bundled together and perhaps a little glossed over at times. I think there may have also been a greater tendency in this period to rely on anecdotal recollections of local or regional practice, when describing results or procedures to parents, rather than quoting risks from published series.'[139]

95 Dr Silove stated:

> 'It is also unlikely that clinicians at any centre would have taken into account the best results when communicating expected mortality rates to patients and families. It is more likely that they would have relied on the UKCSR data, however flawed it may have been.'[140]

96 Dr Bull stated:

> 'To be fair to the clinicians, I believe it [the review of the published research] could have gone further in conveying the breadth of estimates of early mortality that the clinician has to reconcile and point out that there is no robust method for doing this.'[141]

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[138] INQ 0028 0012; Expert clinical commentary from Mr Deverall on *'A systematic review of the outcomes of open heart paediatric surgery'*, 17 July 2000

[139] INQ 0028 0017; Expert clinical commentary from Dr Macrae on *'A systematic review of the outcomes of open heart paediatric surgery'*, 20 July 2000

[140] INQ 0028 0022; Expert clinical commentary from Dr Silove on *'A systematic review of the outcomes of open heart paediatric surgery'*, 23 July 2000

[141] INQ 0028 0008; Expert clinical commentary from Dr Bull on *'A systematic review of the outcomes of open heart paediatric surgery'*, April 2000

97 Mr Deverall advised that the surgeons in Bristol:

> '… should have been aware of the trends and whatever reservations they may have had in regard to centres of excellence they should have been aware of the gold standards being set. I have significant doubts as to whether the busy surgeons in Bristol could have found the time and support necessary to take advantage of the means of acquiring knowledge, which I have described. I have a major doubt that even had the surgeons been able to most efficiently acquire experience and knowledge that they could apply this to their patients in an optimal way. The facilities, for example a split site, the equipment, for example echocardiography machines, and the clinical profile of the patients, for example babies presenting late in the evolutionary clinical process, would all introduce conditions making the achievement of an optimal outcome more difficult.'[142]

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[142] INQ 0028 0013; Expert clinical commentary from Mr Deverall on *'A systematic review of the outcomes of open heart paediatric surgery'*, 17 July 2000

Section three: the principal conclusions of the Inquiry's Experts on statistics

98 The Inquiry commissioned its Experts on statistics to advise on the following:

- 'the quality and reliability of key statistical sources, both individually and overall; to include comment on whether or not any of the sources approach "gold standard" quality;
- 'the validity of the analytical and statistical assumptions used in analysing and synthesising key statistical sources; to include comment on classification errors, adjustment for surgical risk and case mix, and estimation of excess deaths;
- 'the overall statistical pattern emerging across sources; to include comment on the strength and consistency of statistical signals, and whether, and the extent to which, these are consistent with published research evidence;
- 'the overall reliability, scientific robustness and degree of confidence attaching to statistical evidence to the Inquiry; to include comment on whether, how, and the extent to which, reliable conclusions can be drawn from flawed statistical sources;
- 'valid conclusions relevant to the Inquiry's remit, if any, that can be drawn from the statistical evidence;
- 'any emerging broad lessons for the future.'

The Experts' summary of their principal conclusions

99 In the executive summary[143] to their Overview Report, Dr Spiegelhalter, Professor Evans, Dr Aylin and Professor Murray summarised their conclusions:

1. 'This overview provides a critical review of statistical evidence presented to the Inquiry regarding the nature and outcomes of paediatric cardiac surgery in Bristol between 1984 and 1995, focusing on the strengths and limitations of the available data sources, and the reliability of conclusions that have been drawn. Key published sources and commentaries have been taken into account. Such a

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[143] INQ 0045 0002 – 0005; *'Overview of statistical evidence presented to the Bristol Royal Infirmary Inquiry concerning the nature and outcomes of paediatric cardiac surgical services at Bristol relative to other specialist centres from 1984 to 1995',* September 2000, Dr Spiegelhalter et al. All subsequent references in this section are to this report, unless otherwise stated

comparative exercise raises a number of difficult issues concerning data quality, the need to aggregate over subgroups, risk-adjustment and so on (Section 1).[144]

2. ‘The focus of the analysis is on the performance of surgical services that existed in centres, rather than the performance of individual surgeons. It is therefore not appropriate to adjust for pre-operative risk-factors that may be influenced by preceding care (Section 1.3.5). Comparisons of performance were primarily restricted to analyses of 30-day mortality. The main findings were presented in terms of “excess number of deaths”; namely the number of deaths observed in a given stratum at Bristol minus the number which would have been expected had Bristol been similar to other centres in the country. The excess deaths were summed over strata, and the assessed statistical significance of any excess took account of centre to centre variability (Section 1.3.6).

3. ‘Case-mix adjustment was based on age at operation, operative grouping and epoch of operation. Coding of diagnoses and operative procedures in paediatric cardiac surgery is inherently complex and controversial: the operative grouping adopted was devised with substantial clinical input (Section 2).

4. ‘All data sources were flawed, and no one source could be considered as representing the “truth”. Sources used different definitions and variable degrees of quality control: data concerning follow-up of children after discharge from hospital, for example, were erratic. National data were administrative (Hospital Episode Statistics – HES) and professional (UK Cardiac Surgical Register – CSR). HES data have a poor reputation among clinicians, but a linkage exercise with national death registration showed a reasonably accurate correspondence with recorded 30-day in-hospital mortality (Section 3.1.4). There was evidence within CSR of highly variable submissions from some units over the period in question. Although using different definitions and arising from relatively independent sources, HES and CSR data showed reasonable consistency at an aggregated level, although considerably poorer for individual procedure groups (Section 3.3). The crucial issue is not whether HES or CSR precisely measure activity and outcome, but the extent to which feasible data inadequacies could explain any observed divergent performance (Section 3.4).

5. ‘None of the five local data sources could be taken as a reliable basis for clinical audit (Section 4). In spite of all these problems, there was a surprising degree of agreement between the diverse sources regarding performance in Bristol, especially when restricted to looking at mortality rates following open surgery. This degree of consistency lends credibility to the conclusions drawn from the data (Section 5).

6. ‘When compared with performance elsewhere, the main finding was a substantial and statistically significant number of excess deaths at Bristol (Section 6.2).

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[144] The sections referred to are those contained in the main body of the Experts’ Overview Report

Adjusting for operative case-mix did not influence this finding. Particular emphasis was placed on the analysis of data from 1991 to 1995, since data were available for that period from both of the national data sources. Depending on the precise approach to the analysis, the number of excess deaths for open surgery during this period was estimated to be of the order of 30 to 35. The excess mortality corresponded roughly to the mortality rate at Bristol being double that observed elsewhere in England for children aged under one year and even greater for children under 30 days. There was a trend observed outside Bristol for overall mortality rates to fall substantially over the Inquiry period, and this trend was not observed in the Bristol data. Further analysis showed that the excess was not restricted solely to switch and atrial-ventricular septal defect (AVSD) operations, and that missing data on outcomes in HES had minimal influence (Section 6.4.1). Evidence for excess mortality was robust to sensitivity analysis to a number of potential data inadequacies (Section 6.4.3).

7. ‘Data sources were not of sufficient quality to make any firm conclusion concerning morbidity outcomes (Section 6.3).

8. ‘Over the period 1991–1995, both HES and CSR data suggest performance in England (excluding Bristol) was roughly equivalent to published international sources (Section 7).

9. ‘There is evidence of an association between lower volume of surgery and increased mortality in open operations on under 1s over the period 1991–1995, even when ignoring the data from Bristol (Section 8.1). However, this association only explains a small proportion of the excess observed in Bristol. Other factors regarding comorbidity and status at admission are not substantially related to the observed mortality pattern in Bristol (Section 8.2).

10. ‘Between the years 1990 and 1994, there is a clear pattern of a concentration of operations just prior to the first birthday, particularly for AVSDs, and the operative mortality rate at this age is higher than that observed elsewhere. This pattern does not feature in any other centre, and the relevant operations in Bristol appear to be delayed rather than brought forward. This finding is associated with around 25% of the observed excess mortality in Bristol (Section 8.3).

11. ‘The Clinical Case Note Review suggested that around 30% of children received less than adequate care, and that in just over 5% different management would reasonably be expected to have made a difference in outcome. Many aspects of the process of care were criticised, with no particular highlight on surgical performance. However, similar measures for other centres are not available, and so we cannot know whether similar criticisms could be made of procedures carried out elsewhere (Section 8.4).

12. ‘In spite of the many flaws in the data, we do not believe that apparent divergent performance of this magnitude and consistency can be explained fully by statistical variability or systematic bias in data recording. Rather we conclude that there is strong evidence of poor performance at Bristol, especially for open surgery in children aged less than one year, over the period 1988 to 1995 (Section 9.2). Simple statistical analysis of available data might have suggested this pattern by around 1990 (Section 9.4), although the 1990 performance then matched the national average and so might have provided temporary reassurance. We must stress that this does not necessarily imply that there was poor performance by individual surgeons during this period. The whole system of care provided for these children, from diagnosis and referral through to post-operative care and discharge needs to be examined to look for an explanation for the observed poor performance (Section 9.5).’

The principal conclusions in greater detail

100 In the main body of their Report, Dr Spiegelhalter et al. set out their principal conclusions in greater detail. As regards the statistical evidence relating to activity[145] and mortality in Bristol derived from the data produced by Bristol, they concluded:

> ‘There are clear limitations to all sources, and none is subject to defined procedures for data collection, follow-up and validation. It would be fair to say that none is held in high regard as a source of reliable evidence for clinical audit. However, Evans (1999) concludes that where direct comparison is sensible, the pattern is similar and there are no startling discrepancies. Although there is no gold standard for comparison, the Bristol PAS system appears of reasonable quality, and hence this lends confidence to Bristol returns to the national HES database. Our overall comparison suggests that the different sources agree well on the open operations in general and for many specific procedures.
>
> ‘The main findings of interest concern mortality rate [*sic*] for open surgery in under 1s. Overall, sources agree that the mortality rate was around 25–30% during the period under scrutiny, although with considerable variability between different procedures.’[146]

101 As regards the statistical evidence on activity and mortality in Bristol compared with other specialist centres, as derived from UKCSR and HES data, the experts concluded:

> ‘Although the [UK]CSR data report statistically significant excess mortality for Bristol in over 1s during 1988–1990, the primary finding from both [UK]CSR and HES is of excess mortality from 1991–1995 in open operations in under 1s, in which the mortality rate in Bristol was around double that in other centres. This

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[145] At INQ 0045 0014, Dr Spiegelhalter et al. stated: ‘An event has to be identified that measures activity and hence forms the basis for the denominator in any calculated mortality rate. The primary analysis focused on the number of admissions/spells as the basis for comparison, although some of the data sources use operations as their measure of activity. … There is normally only one operation per admission and so there is limited difference according to which is chosen.’

[146] INQ 0045 0024

> difference is retained after stratifying for operative group, which is the available determinant for case-mix. There is no evidence for excess mortality in closed operations, or for open operations in over 1s from 1991–1995. Reported mortality for open operations in under 1s fell in other centres from 21% in 1984–1987 to 12% in 1991–1995. Bristol appears not to have followed that pattern of improvement. There is no evidence of excess mortality in Bristol during Epoch 4,[147] although activity in Bristol was too small to draw any firm conclusion.
>
> 'We emphasise that the estimated total excess deaths for HES depends on the age-stratification used: the excess risk is greater in younger children: for all open operations in epoch 3[148] the total is 30.1 when dividing only into under and over 1s (Table 6.1) and 34.3 when including a < 90 day category (Aylin et al., 1999).'[149]
>
> 'HES identifies excess mortality with 95% confidence for switches (G3), AVSD (G5), ASD (G6)[150], open operations stratified for case-mix, (G1 to G11), and all open operations taken together.'[151]
>
> 'The [UK]CSR results show that each year between 1988 and 1994 (with the exception of 1990), Bristol had either the highest or near the highest mortality rate for open surgery in under 1s. This is reinforced by the HES data between 1991 and 1994. It is clear that Bristol's activity was consistently below the median in the country …'[152]

102 Referring to the national sources of data, the Experts concluded:

> 'The two national sources, HES and the CSR, are admittedly imperfect. Both suffer considerably from lack of agreed operating procedures for ensuring completeness and accuracy of activity, coding and outcome results. Both the OPCS4 coding scheme and the use of non-clinical coders lead HES to be viewed with suspicion by clinicians. There are also strong concerns about variability between centres in the [UK]CSR's coding procedures and recording of mortality. Even if they were meticulously completed, agreement between the two sources could not be expected due to their different criteria. However, HES was found to be surprisingly accurate in its recording of in-hospital mortality and, with certain clear exceptions, the sources described the same broad picture.'[153]

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[147] April to December 1995

[148] 1991 to March 1995

[149] INQ 0045 0025

[150] Group 6 includes more complex procedures such as closure of persistent ostium primum, and sinus venous atrial septal defects, as well as simple atrial septal defects

[151] INQ 0045 0026

[152] INQ 0045 0026

[153] INQ 0045 0035

103 Referring to the local sources of data, they concluded:

> 'The local sources were found to provide good agreement on activity and overall mortality, although comparison at a finer level was sensitive to the coding conventions used. Nevertheless, the six sources on Bristol's activity and outcome agree well for open operations in general and, to a lesser but still reasonable extent, for finer consensus procedure groups of interest. Where there is disagreement, then there are clear reasons, usually resulting in transfer of operations between two groups.'[154]

104 Dr Spiegelhalter et al. set out their detailed conclusions concerning the evidence of divergent performance in Bristol:

> 'There is no evidence of excess mortality in closed operations carried out in Bristol, and limited evidence in open operations on children aged over 1 year. However, there is strong and consistent evidence of excess mortality in open operations in children less than 1 year old at operation. It is estimated from HES data that in the period 1991–1995, 24.1 (95% confidence interval 12 to 34) of 41 recorded deaths are in excess of that expected were Bristol a "typical" centre: finer age-stratification increases the estimated excess mortality. [UK]CSR data suggest the excess mortality dates back at least to 1988. Open procedures on children aged less than 1 that can be identified with reasonable consistency as having excess mortality include "switches", operations for TAPVD, AVSD and, although rare in this age group, ASD.[155] It is to be expected that excess mortality is easier to detect in higher risk groups.
>
> 'The excess mortality was not just restricted to AVSDs and switch operations, and the conclusions are robust to admissions with missing outcomes. National mortality rates were comparable to those in the international literature. One other centre had a consistent pattern of excess mortality in open operations in children over 1 year,[156] but there were no other centres with consistently divergent raised mortality in the younger age group.'[157]

105 The Experts stated, as their overall conclusions:

> 'The single most compelling aspect of the data is the magnitude of the discrepancy between the outcomes observed at Bristol and those observed elsewhere. For children aged under one year undergoing open surgery between 1988 and 1994, the observed mortality rate at Bristol was roughly double that observed elsewhere

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[154] INQ 0045 0035

[155] Group 6 includes more complex procedures such as closure of persistent ostium primum, and sinus venous atrial septal defects, as well as simple atrial septal defects

[156] Leading Counsel to the Inquiry announced in the oral hearing on 3 November 1999 that this centre was Harefield Hospital. In their Overview Report to the Inquiry, Dr Spiegelhalter et al. stated: 'This finding must be treated with caution. Harefield has been an innovative centre for transplant surgery and these operations are included in the CSR (although not in the HES open category), and it also has a reputation for taking difficult cases from abroad.' INQ 0045 0026

[157] INQ 0045 0036; see Chapter 3 for an explanation of these clinical terms

> in 5 out of 7 years. While the national trend over this period was for mortality rates to fall substantially, no such trend was seen in the Bristol results. In spite of the many flaws in the data sources, we do not believe that statistical variation or any systematic bias in data collection can explain a divergence of this magnitude. We therefore conclude that there is strong evidence of divergent performance at Bristol in the areas identified above, and we believe that the imperfections of the data do not cast serious doubt on these conclusions.'[158]

106 They added:

> 'Given the many flaws that have been identified in existing data sources, it is clear that only gross divergence could have been identified with any degree of confidence. If, for example, the mortality rate for open operations in under 1s observed at Bristol had been 50% higher than elsewhere rather than 100% higher, it would have been very difficult to exclude the possibility that the difference had arisen through a combination of differences in case mix, in the coding of operative procedures, and in the thoroughness of achieving follow-up data.'[159]

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[158] INQ 0045 0038

[159] INQ 0045 0039

Section four: the evidence of the Inquiry's Experts relating to post-operative morbidity

Terminology

107 Dr Kate Bull described, in a paper prepared for the Inquiry, the meaning of the term 'morbidity' in the context of paediatric cardiac surgery:

> 'Doctors use the term "morbidity" to contrast with a complication-free recovery to a normal state. Cardiac surgery has cardiac outcomes with effects on longevity and quality of life that vary from trivial to severe; very few heart operations are "corrective". The long-term non-cardiac complications of open heart surgery in children include a variety of problems under the heading of "brain damage" or "learning difficulties", problems with the mechanics of breathing (diaphragm palsy, tracheal and chest wall problems) and the psychological consequences of the disease and its treatment on child, siblings and parents. There are also many short-term complications, which may increase length of stay in intensive care or in hospital including infection and respiratory problems; often these are not associated with long-term sequelae. As in natural language, the medical use of a term does not necessarily mean that it has been unambiguously defined.'[160]

108 The definition of 'post-operative morbidity' adopted by the Inquiry was set out by Leading Counsel to the Inquiry:

> 'We take the term "post-operative morbidity" to mean problems with a child's health which were not apparently present before the surgery and which manifest themselves as functional impairments or disabilities, and which would not have been present, or present to such an extent, in the absence of surgery.'[161]

Identifying morbidity in the form of brain damage following heart surgery in children

109 Dr Bull explained:

> 'To assess how commonly brain damage occurs and understand the range of severity involved, ideally we need to identify a large cohort of children, unselected as having a particular problem and follow them up for a long time. In the nature of a fast-changing medical environment, by the time long-term studies are complete they may be rendered less relevant by changes in patient population and in surgical procedure. This may go some way to explaining why such studies do not currently exist. From a scientific point of view, assessing a cohort of operated children fairly

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[160] INQ 0049 0002; *'Key issues in retrospective evaluation of morbidity outcomes following paediatric cardiac surgery'*, November 2000, Dr Bull

[161] T88 p. 3, Leading Counsel to the Inquiry

> early after surgery has the advantage of relevance (e.g. to assessing alternative techniques for cerebral protection during surgery) but the disadvantage that the findings may have limited predictive validity for understanding how the deficits will impact on a child's prospects for future education and independence. There is also an issue of specialism; the preoperative and early postoperative assessment is the domain of paediatric neurologists and neuro-physiologists. Later assessment is also the domain of educational psychologists, physiotherapists and other allied professions. Paediatric cardiologists and surgeons have few of the relevant skills themselves.'[162]

110 Dr Bull went on:

> 'The incidence and severity of brain damage around the time of surgery is not completely haphazard and not all children with heart disease even approach surgery with good prospects for normal brain function later. Some are very sick during labour and after delivery. For some children, their heart disease is only one manifestation of a bigger problem that may have been genetically programmed (e.g. the situation in Down's syndrome with atrio-ventricular septal defect). When a syndrome is recognised, it is also more difficult confidently to attribute late abnormality to peri-operative events, partly because so many started off with some neurological abnormalities and partly because knowledge of the developmental milestones of children with syndromes is more sketchy.
>
> 'There are also cardiac diagnoses (for instance, coarctation, interrupted aortic arch and hypoplastic left heart, Fallon 1995) which are not related to syndromes but which seem particularly prone to postoperative neurological complications. Some of these complications may not be avoidable with current techniques and understanding. In "left heart syndromes", the fetal brain arteries do not develop in a normal pressure and flow environment and later may not accommodate stress well. Also managing surgery when blood flow to the brain and lower body cannot both be optimal at the same time is very challenging. …
>
> 'There are no studies associating particular profiles of learning difficulties with previous heart operations. There are no studies explicitly discriminating "avoidable" from "unavoidable" brain damage but the implication of much of the literature is that, even with best practice, there is inevitably some trade-off between repairing a complex heart problem and inflicting some damage on the brain. The children with profound motor and cognitive disabilities are only the tip of an iceberg of children with more minor difficulties.'[163]

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[162] INQ 0049 0003; *'Key issues in retrospective evaluation of morbidity outcomes following paediatric cardiac surgery'*, November 2000, Dr Bull

[163] INQ 0049 0003 – 0006; *'Key issues in retrospective evaluation of morbidity outcomes following paediatric cardiac surgery'*, November 2000, Dr Bull

111 Dr Bull concluded:

> 'In the face of all this complexity involving pre, intra and postoperative factors, it is clear that seeking out a single cause of a complication is often not realistic. Even when an event like a post-operative cardiac arrest apparently accounts for a complication like brain damage, the arrest itself is only part of a chain of causation which may lead back to a whole set of conditions preceding it.'[164]

The nature and extent of post-operative morbidity in Bristol

112 Evidence relating to the nature and extent of post-operative morbidity in Bristol was drawn from three local sources of data: the Surgeons' Logs [SL], the Coded Clinical Records [CCR], and the Patient Administration System [PAS].[165]

113 Of the SL, Professor Stephen Evans in his review stated:

> 'The surgeons' logs, as might be expected, are not good sources of information on long term complications of paediatric cardiac surgery. The overall level of 3.2% of children with a recorded code, 2.2% with a recorded complication (codes 996–999), and only 0.5% with a neurological complication is very low, and is likely to reflect under-reporting in the original logs.'[166]

114 Mr Wisheart stated:

> 'I would wish to point out that the record of postoperative complications and follow up information was not well maintained, nor relied on.'[167]

115 Of the CCR, Professor Evans stated:

> 'The Clinically Coded Records were coded with a view to include the post-operative complications, but it is possible that the key problems were not obvious from the medical records. However it is clear that the numbers of children with recorded complications who were still alive is very much less than the numbers of children who died.'[168]

116 He went on:

> 'Thus of 1520 children recorded as alive in the CCR there are at most 26 (1.7%) recorded with neurological complications. Some of these children had closed

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[164] INQ 0049 0007; *'Key issues in retrospective evaluation of morbidity outcomes following paediatric cardiac surgery'*, November 2000, Dr Bull

[165] Further sources of evidence on post-operative morbidity at Bristol were available as written and oral evidence of Bristol parents and clinicians, and experts. Other sources of local data, such as the South West Congenital Heart Register and the Perfusionists' Logs, were examined by the Inquiry's Experts and found to be unsuitable as sources of statistical evidence relating to post-operative morbidity. See INQ 0014 0026

[166] INQ 0029 0009; *'Further reports based on local sources of data for the Bristol Royal Infirmary Inquiry'*, 17 May 2000, Professor Evans

[167] WIT 0120 0256 Mr Wisheart

[168] INQ 0029 0012; *'Further reports based on local sources of data for the Bristol Royal Infirmary Inquiry'*, 17 May 2000, Professor Evans

> operations coded so that the rate in children with open operations who were still alive is 26/1388 (1.9%).'[169]

117 Of the PAS, Professor Evans stated:

> 'Post-operative complications that are immediately obvious may be recorded on the PAS, and with linkage of subsequent admissions there is a possibility that complications only recognised as such at a later stage will be recorded. From the PAS data it is clear that the level of complications recorded in those children who survived was at a low level.'[170]

118 Professor Evans concluded:

> 'It is clear that there is a level of disagreement in the three sources.'[171]

119 Of the sample of cases examined for the Clinical Case Note Review, 4 out of the 40 children who were still alive 30 days after surgery in Bristol were found to have a moderate level of recorded disability. Professor Evans observed:

> 'Although 4/40 is 10%, because the CCNR was weighted towards younger, high-risk operations the reweighted estimate is 89/1473 (estimated number with disability in whole sample/estimated number who were alive at 30 days), an overall rate of 6%. However, all the children with recorded disability were aged under one year at the time of operation and had open heart surgery. In this group the rate is estimated to be 89/348 a rate of 20%. This includes all the children, with disability, not just those whose disability may be related to their medical care. Of the four noted in the CCNR to have disability, two had a post-operative complication recorded in the CCR and one had one in the PAS (one of the four was not in the PAS since their operation was before 1988 when the PAS came into use).'[172]

120 Professor Evans concluded:

> 'In the first report on [HES][173] higher proportions of central nervous system (1.6%) and renal complications (2.6%) were found in Bristol than elsewhere. These results were for all children, including those who died. The overall levels found in the [PAS] were of this order of magnitude, and somewhat higher in the [CCR]. The Clinical Case Note Review (CCNR) report found a level of recorded disability of about 6% (using the estimate for all children) in those who were alive, but half were believed to be unrelated to the medical care received. The absolute numbers in the CCNR were very small.

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[169] INQ 0029 0012; *'Further reports based on local sources of data for the Bristol Royal Infirmary Inquiry'*, 17 May 2000, Professor Evans

[170] INQ 0029 0013 – 0014; *'Further reports based on local sources of data for the Bristol Royal Infirmary Inquiry'*, 17 May 2000, Professor Evans

[171] INQ 0029 0015; *'Further reports based on local sources of data for the Bristol Royal Infirmary Inquiry'*, 17 May 2000, Professor Evans

[172] INQ 0029 0016; *'Further reports based on local sources of data for the Bristol Royal Infirmary Inquiry'*, 17 May 2000, Professor Evans

[173] INQ 0013 0001 – 0073; *'Analysis of Hospital Episode Statistics for the Bristol Royal Infirmary Inquiry'*, 27 October 1999, Dr Aylin et al.

> ‘Published work where special study of complications has been done suggests much higher rates, in the range 10–30% for neurological injury. The routinely collected data do not detect anything like these rates. They cannot be used to estimate disability rates accurately, partly because of problems of definition. There is therefore uncertainty in whether Bristol had a higher or a lower rate of post-operative complications compared with other UK centres.’[174]

Post-operative morbidity in Bristol compared with other specialist centres

121 Evidence relating to the nature and extent of post-operative morbidity at Bristol compared with other specialist centres was drawn from HES.[175] In their first report to the Inquiry on HES, Dr Paul Aylin et al. stated:

> ‘Complications were recorded in a higher proportion of all admissions in UBHT than elsewhere in England. … Central nervous system complications are mentioned in 1.6% of admissions with an open procedure in UBHT, 4 times more than elsewhere.’[176]

> ‘This may be due to better recording of diagnoses at UBHT.’[177]

> ‘Although there are a higher proportion of complications in UBHT admissions than elsewhere in England, UBHT also records more diagnoses per admission generally than elsewhere in England (4.2 diagnoses per admission compared to 4.0 per admission). We also know that UBHT is less likely to use vague diagnoses such as “Other ill-defined and unknown causes of morbidity and mortality” (ICD9 799). This suggests that diagnostic information in HES records from UBHT is more complete than elsewhere and may explain the higher reporting of complications. It is also not known whether complications were present before or after the procedure in question.’[178]

122 Dr Aylin et al. concluded:

> ‘There is … a suggestion of a higher complication rate in procedures carried out in the UBHT, but this could be explained by their apparent higher quality recording of diagnosis.’[179]

123 In their second report to the Inquiry, Dr Aylin et al. stated:

> ‘Further analysis of our HES data using diagnoses in the ICD-9 range 996-999 (complications of surgical and medical care) shows that within open procedures,

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[174] INQ 0029 0002; *‘Further reports based on local sources of data for the Bristol Royal Infirmary Inquiry’*, 17 May 2000, Professor Evans

[175] The UKCSR was examined by the Inquiry’s Experts and found to be unsuitable as a source of evidence relating to post-operative morbidity

[176] INQ 0013 0028; *‘Analysis of Hospital Episode Statistics for the Bristol Royal Infirmary Inquiry’*, 27 October 1999, Dr Aylin et al.

[177] INQ 0013 0004; *‘Analysis of Hospital Episode Statistics for the Bristol Royal Infirmary Inquiry’*, 27 October 1999, Dr Aylin et al.

[178] INQ 0013 0031; *‘Analysis of Hospital Episode Statistics for the Bristol Royal Infirmary Inquiry’*, 27 October 1999, Dr Aylin et al.

[179] INQ 0013 0033; *‘Analysis of Hospital Episode Statistics for the Bristol Royal Infirmary Inquiry’*, 27 October 1999, Dr Aylin et al.

> 26.3% (95%CI 22.5-30.4%) of spells in UBHT have complications recorded compared with 11.6% (95%CI 10.9-12.3%) elsewhere. … More information on the consistency with which secondary diagnoses are coded in the UK is required before using them here. … As there was no specific new hypothesis as to what conditions to investigate, we felt that any further analysis of secondary diagnoses would result in comparisons of data quality between trusts rather than actual differences in co-morbidity.'[180]

124 Professor Stephen Evans concluded:

> 'In the first HES report where complications are discussed [INQ 0013, pp. 0028, 0031 and 0058], the proportions with neurological (central nervous system) complications with open procedures was 1.6% and 2.6% for renal (urinary) complications. These have not distinguished those who were alive and those who died. The overall level of complications found in the PAS and CCR are of this order of magnitude. The CCR has recorded more of the complications than the PAS, but it is possible that diagnoses that are a result of surgery may not be recorded in the PAS if they are not noticed immediately.
>
> 'It seems likely from published work that there is severe under-recording of complications in HES in centres other than Bristol. Recording there is at a high level when compared with other centres, but probably under estimates the rate of neurological complication.'[181]
>
> 'The evidence from local sources suggests that Bristol routine data collection gives a more reasonable estimate of complications following surgery, rather than that it is genuinely at a higher rate there.'[182]

125 In their review of published evidence on outcomes of open-heart paediatric surgery Ms Katerina Vardulaki et al. stated:

> 'Longer-term outcomes, such as deterioration in functional and neurological status, the need for re-intervention, late deaths attributable to operation-related factors and non-cardiac disorders, were described in some papers. However, the quality and detail of reporting of such outcomes was inconsistent across papers, making it impossible to attribute them to relevant clinical sub-groups or to generate meaningful quantitative estimates of their frequency.'[183]

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[180] INQ 0030 0007; *'Supplementary Analysis of Hospital Episode Statistics for the Bristol Royal Infirmary Inquiry',* 29 June 2000, Dr Aylin et al.

[181] INQ 0029 0016; *'Further reports based on local sources of data for the Bristol Royal Infirmary Inquiry'*, 17 May 2000, Professor Evans

[182] INQ 0029 0017; *'Further reports based on local sources of data for the Bristol Royal Infirmary Inquiry'*, 17 May 2000, Professor Evans

[183] INQ 0039 0005; *'A Systematic Review of the outcomes of Open Heart paediatric surgery'*, April 2000, Ms Vardulaki et al.

The Experts' overall conclusions

126 In their Overview Report to the Inquiry, Dr David Spiegelhalter, Professor Stephen Evans, Dr Paul Aylin and Professor Gordon Murray reviewed the evidence on post-operative morbidity and concluded:

> 'In response to the findings of Aylin (1999, INQ 0013 0028) of an apparently higher rate of neurological complications in Bristol, Evans (2000, INQ 0029) examined evidence on complication rates in local data sources. The Surgeons' Logs (SL) did not, predictably, contain good information on longer-term outcomes, while both in the coded clinical records (CCR) and PAS the recorded neurological complication rates among survivors of open surgery was very low (1.9% and less than 1% respectively). There was poor agreement between sources and Evans (2000, INQ 0029 0016) concluded that there was under-reporting in all centres, with Bristol possibly being slightly more accurate in its reporting. The Clinical Case Note Review (CCNR) did look in detail at the possibility of disability in those who had not died at 30 days, but with only 40 cases, even though they were preferentially sampled from high risk groups, the number with any disability was very small (4, all "moderate"disability). It is therefore not possible to draw confident conclusions on the true morbidity rate or make comparisons with other centres. …
>
> 'The routine data sources available form an inappropriate basis for any firm conclusions concerning morbidity rates in Bristol.'[184]

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[184] INQ 0045 0024; *'Overview of statistical evidence presented to the Bristol Royal Infirmary Inquiry concerning the nature and outcomes of paediatric cardiac surgical services at Bristol relative to other specialist centres from 1984 to 1995'*, September 2000, Dr Spiegelhalter et al.

Section five: views on the interpretation, reliability and validity of the evidence on statistics received by the Inquiry

Comments of the clinicians at Bristol (and others)[185] on the evidence of the Experts on statistics received by the Inquiry, and the Experts' responses

This section sets out the views of the Bristol surgeons (and others) on the interpretation, reliability, and validity of the evidence received by the Inquiry from its experts on statistics. It also sets out the experts' responses to these views.

The interpretation of the statistical evidence relating to clinical performance in Bristol

127 Mr Wisheart stated that:

> 'Children at one centre could differ from the national profile in terms of case mix or risk stratification. Case mix refers to the proportion of patients whose operation is basically high risk, (e.g. [Persistent Truncus Arteriosus] PTA) or low risk (e.g. ASD). I have already referred to the importance of case mix in determining the outcome in our under ones for 1984–87. Risk stratification refers to the presence of additional incremental risk factors in a patient, whether their operation is basically in a low risk or a high-risk category.
>
> 'There is no scientific basis for a risk stratification exercise in paediatric cardiac surgery at the present time, nor is there data available about patients across the country, to enable the comparison to be made.'[186]

128 Mr Dhasmana stated:

> 'I have read Mr Wisheart's response to the Spiegelhalter analysis and would broadly agree and endorse those views. In particular I agree with his comments on

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[185] These submissions, and the formal responses of the Experts, are reproduced in Annex B

[186] WIT 0120 0300 – 0301 Mr Wisheart

> aggregation and risk stratification. Unlike in adult cardiac surgery the absence of any agreed risk stratification for children is a major obstacle to comparative analysis.'[187]

129 As regards the practice of grouping procedures together which was adopted by the Inquiry's Experts on Statistics, Mr Jaroslav Stark, formerly consultant cardiac surgeon at Great Ormond Street Hospital for Sick Children, and a member of the Inquiry's Expert Group, stated:

> 'The selection of operations into these groups was difficult as some operations of different complexity and different mortality had to be placed together. The case mix in these groups may vary between centres and makes comparison of mortality rates more difficult. Examples of such groups are G3 [switch], G6 [ASD] and G9 [Fontan].'[188]

130 Referring to risk stratification, Mr Wisheart stated:

> 'Risk stratification is likely to be of much greater significance for certain patient groups than for others. For patients with relatively straightforward abnormalities, who have elective surgery at an older age, issues of risk stratification are likely to be relatively modest. On the other hand where patients are very young, have major congenital abnormalities, are often operated either as an emergency or urgently and in whom a whole range of additional risk factors may be present, the importance of risk stratification is likely to be much greater. The apparent divergences identified by the Inquiry's experts are predominantly in the youngest patients; it is amongst these patients that the importance of risk stratification is likely to be greatest.'[189]

131 Dr Geoffrey Burton, consultant anaesthetist at the BRI until 1990, stated:

> 'The Statistical Evidence presented to the Inquiry, although useful, can only have a very limited significance because it fails to take into consideration the preoperative state of the patients.'[190]

132 Lorna Wiltshire, Bed Manager and trauma and orthopaedic nurse at the BRI in 1990, stated in her written evidence to the Inquiry:

> 'It was my impression that Mr James Wisheart operated on the technically more difficult cases. My perception was that Mr James Wisheart was prepared to operate to give the child or baby a chance, where perhaps other surgeons might not have been prepared to operate at all. The other comment I can make is that the age

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[187] WIT 0084 0150 Mr Dhasmana

[188] WIT 0567 0004 Mr Stark

[189] WIT 0120 0301 Mr Wisheart

[190] WIT 0555 0002 Dr Burton

group of the children was very wide and that a number of children were very ill by the time they arrived for surgery.'[191]

133 Mr Wisheart stated:

> 'I would not suggest that across the whole range of the work, or even the whole range of infant or neonatal work, there was any systematic difference in the children presenting to us compared to children presenting elsewhere. However I do believe, that there may be evidence of a significant difference in at least 3 identifiable sub-groups of patients. These are:
>
> '(1) Patients referred to me for complete repair of AVSD in the years 1990–1994 inclusive. There were 15 such patients and only 4 were free of additional significant abnormalities or risk factors. This is … very unusual, as normally significant additional factors are present in only 20–25%. For example Left Ventricular Outflow Tract Obstruction ["LVOTO"] is normally present in 2% AVSDs; in my series of 15, there were 3 patients with LVOTO.
>
> '(2) In the under one year age group of operations carried out by me, in 1991, there were a significant number of high risk children. The fact that I agreed to operate on them undoubtedly increased my mortality in that year.
>
> '(3) For the years 1984–87 inclusive, our overall mortality in Bristol for the under one year age group was one third higher than nationally. This was however attributable to the *case mix* of the children operated. When we used the UK mortality to calculate the expected mortality for the patients on whom we actually operated, we found that the expected and observed mortalities were virtually identical.'[192]

134 In his closing submission to the Inquiry, Mr Wisheart stated:

> 'The main findings seem to be of excess deaths in some sub-groups in the under ones, which when aggregated indicate an important number of excess deaths for the under ones as a group in the epoch 1991–1995 and to a lesser extent 1988–1990.
>
> 'That there are excess deaths in the neonatal switch operations and C-AVSD operations in 1991–1995 is not in dispute. These seem to be the most important contributors to the total number of excess deaths. In January 1996, Marc de Leval stated that apart from these two sub-groups the results in Bristol, including those under one year of age, matched the rest of the UK for the period 1992–1995. Is this correct? In other words, are the other sub-groups in the under one year of age, within an acceptable range either individually or when aggregated? If they are, then it is still necessary to find an explanation of the high mortality in the neonatal switch operations and in the correction of C-AVSDs by me. Disappointing findings

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[191] WIT 0330 0016 – 0017 Ms Wiltshire

[192] WIT 0120 0301 – 0302 Mr Wisheart

> for C-AVSDs are to be found in my series of patients, whereas Mr Dhasmana's results for this condition are in line with the national performance. It is clearly and objectively documented that there were significant additional risk factors in eleven of the fifteen patients in whom I operated in this series. It is my belief that consideration of these factors would bring my results of C-AVSDs within an acceptable range.'[193]

135 Mr Wisheart went on:

> 'However, the reason why robust methods of risk stratification must be included in any assessment of surgical performance is that this is the only way to protect the access of high risk patients to the surgical treatment which they need. Without such robust methods of risk stratification, surgeons will feel themselves under irresistible pressure to find reasons not to operate on high risk patients.'[194]

136 Mr Dhasmana commented on the interpretation of his results for his series of Arterial Switch cases:

> '1. There were no comparative figures from any other centres in the U.K. to make any reliable conclusions from. However, independent experts at the G.M.C. [General Medical Council] Inquiry did state that there was a higher incidence of abnormal coronary arterial pattern in my series of Arterial Switches.
>
> '2. It was not proven, but possibly, some of these children's condition may have deteriorated whilst waiting for surgery, especially in conditions like A.V. Canal, T.G.A. with V.S.D.s and T.A.P.V.D. In some of these patients one of the main causes for failure of surgery has been a pulmonary vascular crises [*sic*]. These patients were on varying degrees of the urgent list; some of these could not be operated upon soon after referral because of lack of resources. I believe that in the present set up, in particular consequent on unification at the Children's Hospital, there is no waiting list for such patients.'[195]

137 Referring to the period of time which patients waited for surgery, Dr Stephen Pryn, consultant anaesthetist at the Bristol Royal Infirmary from 1993, stated:

> 'I was concerned that patients with AV canals were too old when presented for surgery with the consequence that they had developed raised pulmonary vascular resistance which had become only partially reversible. One patient in particular who underwent repair of an AV canal in August 1994 when she was about 9 months old did not survive; she had been seen and diagnosed at three months when her raised pulmonary vascular resistance was still fully reversible.'[196]

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[193] SUB 0009 0022 – 0023 Mr Wisheart; see Chapter 3 for an explanation of clinical terms

[194] SUB 0009 0023 Mr Wisheart

[195] WIT 0084 0053 Mr Dhasmana; see Chapter 3 for an explanation of clinical terms

[196] WIT 0341 0014 Dr Pryn; see Chapter 3 for an explanation of clinical terms

138 In response to Mr Wisheart's concerns at the absence of risk stratification in the evidence presented to the Inquiry, Dr Spiegelhalter et al. replied:

> 'Risk stratification for surgical risk factors may not be appropriate when evaluating an organisation since it may tend to obscure limitations in pre-operative care.'[197]

139 In their Overview Report, Dr Spiegelhalter et al. stated further:

> 'When comparing whole surgical systems in centres, one should ideally concentrate on case-mix stratification: i.e. factors beyond all influence of the organisation. In contrast, if surgical performance alone were being compared, then a full "operative-risk stratification" exercise may be appropriate, taking into account the precise clinical state and previous history of the patient just prior to their operation. However, this is *not* appropriate methodology when comparing the whole surgical system, since many features at operation may be influenced by early care, timing of operation etc. – it is even arguable that one should not adjust for age at operation since the process of care could influence this factor … Since the objective is a comparison of the systems in centres, results in the analysis have been broken into strata defined by broad procedure groups, epoch of operation and broad age-groups.'[198]

140 In response to Mr Wisheart's submission that 'excess deaths' were restricted to the switch and C-AVSD procedures, Dr Spiegelhalter et al. examined the results when these specific procedures were excluded from the analysis:

> 'The [UK]CSR [data] show a significant 83% increase in mortality over other centres. The HES data show a 44% increase in mortality over centres elsewhere, although this is not statistically significant at conventional levels. However [the tables] show that there can be at least 95% confidence in excess mortality in some subgroups: for example, TAPVD in < 90 days, and Closure of ASD[199] in 90 days to 1 year. The data reported to the [UK]CSR show significant excess mortality, even excluding switches and AVSDs. (It could be argued, because of the known lack of distinction in the [UK]CSR between switch (group 3) and inter-atrial repair (group 2), that group 2 should also be excluded from [the table]. We have repeated the analysis excluding group 2, and it increases the contrast between Bristol and elsewhere.)'[200]

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[197] INQ 0034 0002 Dr Spiegelhalter et al.

[198] INQ 0045 0012 – 0013; *'Overview of statistical evidence presented to the Bristol Royal Infirmary Inquiry concerning the nature and outcomes of paediatric cardiac surgical services at Bristol relative to other specialist centres from 1984 to 1995'*, September 2000, Dr Spiegelhalter et al. (emphasis in original)

[199] Group 6 includes more complex procedures such as closure of persistent ostium primum, and sinus venous atrial septal defects, as well as simple atrial septal defects

[200] INQ 0034 0004 – 0005; *'A Response to Submissions on behalf of Mr JD Wisheart, Appendix 2, The Inquiry's Statistical Analysis'*, May 2000, Dr Spiegelhalter et al.; see Chapter 3 for an explanation of clinical terms

141 They concluded:

> ‘Our estimates of excess mortality are not based solely on Switch and AVSD operations – other procedures make significant contributions.’[201]

And noted:

> ‘Excess mortality cannot be explained by identifying additional risk factors for patients with adverse outcomes: the risk profile of the entire series must be considered.’[202]

142 Mr Wisheart also submitted:

> ‘The CCNR has underlined emphatically that paediatric cardiac surgery is a team activity, and that its results are determined by the work all of [*sic*] members of the team.’[203]

143 In reply, Dr Spiegelhalter et al. observed:

> ‘The acknowledgement of the importance of the team activity serves to downgrade the need for an analysis stratifying for factors present at surgery. Care prior to surgery may affect the presence or knowledge of such factors, and hence “adjusting” for these could tend to obscure important differences between centres in pre-operative care.’[204]

The national sources of statistics used to compare clinical performance

144 Mr Wisheart expressed a variety of concerns about the reliability and validity of the UKCSR as a source for comparing performance between centres:

> ‘I now believe that there are substantial limitations upon the reliability and the validity of the UKCSR. Therefore its value to this Inquiry as a comparator must be in doubt.
>
> ‘… Reservations about the reliability and validity of the Register stem from the possible under-reporting of mortality, the lack of information from some individual centres, other missing data, intra-centre variability and the use of differing definitions. In addition, the absence of information about the range of results obtained by individual centres or surgeons, and the absence of any allowance for risk stratification limit further the value of the available data.’[205]

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[201] INQ 0034 0002; *‘A Response to Submissions on behalf of Mr JD Wisheart, Appendix 2, The Inquiry’s Statistical Analysis’*, May 2000, Dr Spiegelhalter et al.; see Chapter 3 for an explanation of clinical terms

[202] INQ 0034 0002; *‘A Response to Submissions on behalf of Mr JD Wisheart, Appendix 2, The Inquiry’s Statistical Analysis’*, May 2000, Dr Spiegelhalter et al.

[203] SUB 0009 0026 Mr Wisheart

[204] INQ 0034 0009; *‘A Response to Submissions on behalf of Mr JD Wisheart, Appendix 2, The Inquiry’s Statistical Analysis’*, May 2000, Dr Spiegelhalter et al.

[205] WIT 0120 0294 Mr Wisheart

145 Mr Dhasmana stated:

> 'The reliability of data published in the U.K.C.S.R. has always been questioned, as the figures were never validated. Errors could have been made at the source of entry, as junior members of staff could have been entrusted with form filling, with no arrangements for double checking the figures. The 30-day mortality figures may not represent the true picture, as at some institutions patients are transferred back to referring hospitals after a few days and therefore the follow-up information for this group for the first 30 days may not have been complete. We were also aware that a centre of excellence with a large volume of cases might mask the true mortality figures of smaller centres. The probable deficiencies in data collection and lack of comparison of like with like, meant the resulting average figures given in the Register were not perceived as being statistically accurate, and this limited its value as a tool in providing adequate comparators.'[206]

146 Referring to the UKCSR, Mr Bruce Keogh, Secretary of the Society of Cardiothoracic Surgeons of Great Britain and Ireland, told the Inquiry:

> 'I think it is incumbent upon me to doubt the reliability, otherwise I would not be doing my job properly. I have less reason to doubt the activity data, but I do sometimes feel that operative mortalities that are reported may be a bit low.'[207]

147 Mr Wisheart expressed concern as to the reliability of the categories used in the UKCSR as a means of recording surgical activity. Referring to the reliability of data derived from the UKCSR's diagnostic category 'Transposition of the Great Arteries', he observed:

> 'The handling of Transposition by the Inquiry's experts with regard to the type of operation carried out has not been successful. I do not believe that there is any evidence that paediatric cardiac surgeons have ever consistently classified the Mustard or Senning operation as palliative, in making returns to the UKCSR.'[208]

148 As for the 'over-1' age category in the UKCSR, he stated:

> 'There is a problem in using the UKCSR as a comparator for the Inquiry's children aged 1–15. The UKCSR's category of "over 1" includes older teenagers and adults having open heart surgery for congenital abnormalities; there is no cut-off point in the UKCSR figures at age 15, until the mid-nineties.'[209]

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[206] WIT 0084 0052 Mr Dhasmana

[207] T38 p. 134 Mr Keogh

[208] INQ 0012 0066; *'A review by Mr Wisheart of the evidence offered by Professor Evans, Dr Aylin, Professor Murray, and Dr Spiegelhalter'*

[209] INQ 0045 0081; *'Review of data sources and statistical methods, available to the Public Inquiry for discussion'*, 23 September 1999, Mr Wisheart

149 As regards the reliability of the national data as a basis for comparing mortality at Bristol and elsewhere, Mr Wisheart submitted:

> 'Although Dr Spiegelhalter feels it is unlikely that Bristol has produced good quality data whilst other centres have produced unreliable data, serious doubt about the reliability of the data from the other centres has been expressed by a number of experts. The other data is of two types; first, Hospital Episode Statistics (HES) which was collected for administrative purposes and not for the clinical purposes for which it is now being used, and secondly, the United Kingdom Cardiac Surgical Register (UKCSR), the shortcomings of which have been repeatedly rehearsed. The reliability of the UKCSR is most dramatically questioned by the observation that of twelve centres reporting their results for 1988–1991 both to the UKCSR and to a Working Party of the Supra Regional Services Advisory Group of the Department of Health, only one returned the same figures to both – and that one was Bristol. Other questions about the comparator data are:
>
> - 'There is thought to be under-reporting of death.
> - 'There are believed to be variations in the definition of death which have been used by different centres and surgeons.
> - 'Survival status is not known in some HES and some UKCSR data.
>
> 'Unless there is a high degree of confidence in the data both from Bristol and from elsewhere, there cannot be confidence in the comparison.'[210]

150 Mr Wisheart stated further:

> '… the figures [in the Experts' Overview Report] are based upon HES and [UK]CSR which are not high quality, and importantly, do not agree with each other. Indeed the disagreement between HES and [UK]CSR is striking in terms of numbers of deaths, death rates and excess deaths. For example, the number of excess deaths in open operations in children under one, between 1991 and 1995, by case mix stratification, is estimated by [UK]CSR to be 12.9 and by HES to be more than double that figure at 27.2. There is no agreement about the total number of deaths in these databases, therefore I believe that these discrepancies should be examined and resolved. I had hoped that they would have been resolved much earlier but as the end of the Inquiry approaches, there remains uncertainty.'[211]

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[210] SUB 0009 0023 – 0024 Mr Wisheart

[211] INQ 0045 0100; *'The response of Mr Wisheart to the Overview of statistical evidence concerning the nature and outcomes of paediatric cardiac surgical services at Bristol relative to other specialist centres from 1984 to 1995'*

151 Mr Jaroslav Stark wrote to the Inquiry:

> 'The quality of the data available from HES and the UKCSR for a period 1984–1995 is of great concern. This raises serious doubts about the validity of any conclusions based on the analysis of this data. The use of such unreliable data for the assessment of the performance of the paediatric cardiac unit at Bristol may have wider implications. It may set a precedent for the future.'[212],[213]

152 In their report to the Inquiry, Ms Audrey Lawrence [214] and Professor Gordon Murray advised:

> '… surgeons have unanimously more confidence in the data they have provided to the [UKCSR] than in that provided by the hospital administration system (HES), in terms of both procedures and deaths.'[215]

153 Referring to the data returned by Bristol to HES and UKCSR, Mr Wisheart stated:

> 'I believe that the data available from Bristol is usable, in that both Mr Dhasmana's and my surgeon's logs are reliable sources of information. … The information returned to the UKCSR was based on the data in our two logs.'[216]

154 He stated further:

> 'The data will be very accurate for Bristol, but there is no knowledge of the accuracy from other centres.'[217]

155 Referring to the CCR, Mr Wisheart stated:

> 'The CCR provides a reliable standard against which the local Bristol data can be judged.'[218]

> 'For all the Bristol patients a Coded Clinical Record was created from the case notes and this must be regarded as being of extremely high quality, almost certainly the highest quality database which exists within the Inquiry. Data of comparable quality has not been created for any other centre.'[219]

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[212] WIT 0567 0010; *'Comments on statistical analysis and review of outcomes of paediatric cardiac surgical services at Bristol and other specialist centres'*, 7 April 2000, Mr J Stark

[213] Professor John Yates, Director of Inter-Authority Comparisons and Consultancy, Health Services Management Centre, University of Birmingham, expressed the view in a submission to the Inquiry that HES data was of value for comparative analysis (see WIT 0568 0027 – 0043), although aspects of his statistical methodology were criticised in peer review reports commissioned by the Inquiry (see for example INQ 0036 0001 – 0013, Professor Stephen Gallivan)

[214] Research management consultant, Lawrence Research

[215] INQ 0033 0003 Ms Lawrence and Professor Murray

[216] WIT 0120 0299 Mr Wisheart

[217] INQ 0045 0081; *'Review of data sources and statistical methods available to the Inquiry for discussion'*, 23 September 1999, Mr Wisheart

[218] WIT 0120 0471 Mr Wisheart

[219] INQ 0045 0092 Mr Wisheart

> 'If the analysis [advanced by the Experts] was based on the CCR, which is clearly a very high quality database, then it might well be that this argument [the conclusions reached by the statistical Experts] would carry great weight.'[220]

156 In response to these expressions of concern over the reliability of HES and UKCSR as sources of data from which to draw comparisons, Dr Spiegelhalter, Professor Evans, Dr Aylin and Professor Murray stated:

> 'The Submission [of Mr Wisheart] expresses concern about under-reporting and varying definitions of deaths in other centres. There is always the possibility, although it does not seem especially plausible, that Bristol has produced good-quality data, while the bulk of the rest of the country were systematically under-reporting mortality.'[221]

> 'Further investigation of the accuracy of the mortality rates derived from the HES data has shown that over 95% of 30-day deaths following open surgery are recorded in HES, and that Bristol's accuracy is typical.'[222]

> 'When no data source is a gold-standard, corroboration between reasonably independent sources reinforces the conclusions from both.'[223]

157 In their Overview Report to the Inquiry, Dr Spiegelhalter et al. observed:

> 'The reasonably consistent patterns … lend added weight to the HES evidence, as do the KP70 [224] and linkage exercises carried out to assess the quality of the recorded activity and outcomes in HES. There is no evidence that Bristol was at variance with the national pattern in HES reporting. The [UK]CSR data must be treated with great caution *at the level of individual procedure groups*. The crucial issue is whether the undoubted inaccuracies are sufficient to cast doubt on any observed divergent performance.'[225]

> 'A possible marker of data quality is the ratio of episodes recorded by HES to those on KP70 (paper returns to the DoH). Aylin et al. (2000, INQ 0030 0017) found that there was excellent agreement both in Bristol and elsewhere for cardiothoracic surgery as a whole, but were unable to compare for paediatric cardiac surgery.'[226]

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[220] INQ 0045 0100 Mr Wisheart

[221] INQ 0034 0006; *'A Response to Submissions on behalf of Mr JD Wisheart, Appendix 2, The Inquiry's Statistical Analysis'*, May 2000, Dr Spiegelhalter et al. See also WIT 0567 0004 Mr Stark

[222] INQ 0034 0002; *'A Response to Submissions on behalf of Mr JD Wisheart, Appendix 2, The Inquiry's Statistical Analysis'*, May 2000, Dr Spiegelhalter et al.

[223] INQ 0034 0002; *'A Response to Submissions on behalf of Mr JD Wisheart, Appendix 2, The Inquiry's Statistical Analysis'*, May 2000, Dr Spiegelhalter et al.

[224] Mr Richard Willmer, a chief statistician at the Department of Health, describes the nature and purpose of KP70 returns (Körner Patient aggregated return no 70) in his supplementary written statement, WIT 0189 0133 – 0134

[225] INQ 0045 0021; *'Overview of statistical evidence presented to the Bristol Royal Infirmary Inquiry concerning the nature and outcomes of paediatric cardiac surgical services at Bristol relative to other specialist centres from 1984 to 1995'*, September 2000, Dr Spiegelhalter et al. (emphasis added)

[226] INQ 0045 0018; *'Overview of statistical evidence presented to the Bristol Royal Infirmary Inquiry concerning the nature and outcomes of paediatric cardiac surgical services at Bristol relative to other specialist centres from 1984 to 1995'*, September 2000, Dr Spiegelhalter et al.

> 'Although using different definitions and arising from relatively independent sources, HES and [UK]CSR data showed reasonable consistency at an aggregated level, although considerably poorer for individual procedure groups … The crucial issue is not whether HES or [UK]CSR precisely measure activity and outcome, but the extent to which feasible data inadequacies could explain any observed divergent performance …'[227]

The statistical methods used by the Experts to analyse the data

158 Mr Wisheart in his submission to the Inquiry challenged the validity of aspects of the statistical methods used by the Experts to analyse the data, in particular referring to the effect of the coding and grouping of data:

> 'This seems to distort some figures. It is clearly the case for Transposition of the Great Arteries (TGA) but also has had unexpected consequences when the patients in my own Surgeons Log are processed this way.'[228]

159 Mr Stark observed:

> 'Most surgeons are not familiar with OPCS4 coding, as it is not used in their clinical work. Some of the codes are rather strange and for some procedures specific codes are missing. None of the paediatric cardiac surgery databases with which I am familiar use this coding system.'[229]

160 In response to Mr Wisheart's expression of concern about the effect of coding, Dr Spiegelhalter, Professor Evans, Dr Aylin and Professor Murray stated:

> 'Coding in paediatric cardiac surgery and cardiology is notoriously difficult. Our coding scheme was developed after extensive consultation and was applied in an unbiased and systematic way to all centres … it is important to note that "errors" in coding will tend to make patient groups more homogeneous and hence lead to high-risk groups having lower observed mortality, and low-risk groups having higher mortality. Since there is no dispute about the total number of deaths, it does not seem reasonable only to focus on discrepancies where mortality appears to have been over-stated – if such groups exist, they will be balanced by other groups in which mortality has been under-stated.'[230]

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[227] INQ 0045 0003; *'Overview of statistical evidence presented to the Bristol Royal Infirmary Inquiry concerning the nature and outcomes of paediatric cardiac surgical services at Bristol relative to other specialist centres from 1984 to 1995'*, September 2000, Dr Spiegelhalter et al.

[228] SUB 0009 0024 Mr Wisheart; see Chapter 3 for an explanation of clinical terms

[229] WIT 0567 0003 Mr Stark

[230] INQ 0034 0006; *'A Response to Submissions on behalf on Mr JD Wisheart, Appendix 2, The Inquiry's Statistical Analysis'*, May 2000, Dr Spiegelhalter et al.

161 Referring to his concerns about the effect of 'missing outcomes'[231] [shortfalls in the data on deaths, due to failure to link episodes within an admission, or because no outcome was recorded] in HES and UKCSR, Mr Wisheart submitted:

> 'I believe that the arbitrary method of handling this problem may well have contributed to the apparent excess mortality, particularly in the neonates and the children under one in 1991–1995 where the excess mortality seems to be the greatest.'[232]

162 In response, Dr Spiegelhalter et al. stated that they carried out:

> '… a simple analysis to examine what the impact of these missing outcomes might be, taking the most optimistic view that they all were survivors'.[233]

163 They concluded:

> '… even if we assume that all missing outcomes were survivors, there is little effect on the findings. We therefore reject the conclusion that missing outcomes makes the HES analysis unreliable.'[234]
>
> 'Missing outcomes in HES data has negligible effect on the conclusions.'[235]

164 Referring to his concerns about the Experts' use of pooled (unstratified) data for purposes of comparison, Mr Wisheart submitted:

> 'It is clear that in the analyses, some techniques have been reported which involve pooling of data and others have been reported which aggregate differences between relatively homogeneous sub-groups. The validity of using pooled data for comparison raises many questions. To enable a clear understanding to be reached we would ask for analyses which involve pooling of data to be identified.'[236]

165 Dr Spiegelhalter et al. stated:

> 'The distinction between "case-mix" (operative procedures) and "risk-stratification" (clinical risk factors) is very useful. By aggregating over consensus groups we achieve adjustment for case-mix, since excess mortality is only attributed in comparison with mortality elsewhere within the specific stratum defined by

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[231] SUB 0009 0024 Mr Wisheart

[232] SUB 0009 0024 – 0025 Mr Wisheart

[233] INQ 0034 0006; *'A Response to Submissions on behalf of Mr JD Wisheart, Appendix 2, The Inquiry's Statistical Analysis'*, May 2000, Dr Spiegelhalter et al.

[234] INQ 0034 0006 – 0007; *'A Response to Submissions on behalf of Mr JD Wisheart, Appendix 2, The Inquiry's Statistical Analysis'*, May 2000, Dr Spiegelhalter et al.

[235] INQ 0034 0002; *'A Response to Submissions on behalf of Mr Wisheart, Appendix 2, The Inquiry's Statistical Analysis'*, May 2000, Dr Spiegelhalter et al.

[236] SUB 0009 0025 Mr Wisheart

> operative group, age group and epoch. That is why we present data both for *pooled* open operations, and *aggregated* over operative group. The summary table on INQ 15/0004 shows this makes little difference in the conclusions.'[237]

166 They concluded:

> 'There is very little disagreement as to whether individual children died or not. This supports the value of overall comparisons of pooled open operations, since these are not so susceptible to coding problems.'[238]

167 In a letter to the Inquiry, Dr Jan Poloniecki, lecturer in statistics at St George's Hospital Medical School, submitted:

> 'The statistical conclusions that have been drawn first by the GMC and now at the BRI Inquiry are fatally flawed by reason of inadequate allowance for repeated significance testing, and not taking into account the method by which Bristol was selected for scrutiny …
>
> 'It [the Inquiry] should consider whether the question of what is an acceptable difference in death rates is capable of a single answer, and that some differences might be acceptable to some surgeons and some patients but not necessarily to all patients or all purchasers.'[239]

168 Dr Aylin, Dr Best, Professor Evans, Professor Murray and Dr Spiegelhalter responded:

> '… we believe that examination of the statistical evidence to the BRI Inquiry will show that these valid concerns were, where appropriate, fully taken into account.'[240]

169 Professor Campbell, Professor Curnow, Professor Gallivan, Ms Macfarlane, and Professor McPherson published the following joint statement:

> 'As members of the Expert Group advising the Bristol Royal Infirmary Inquiry, we have advised on the initial data processing and analysis and heard presentations of the thorough and impressive work of the statisticians contracted by the Inquiry. We have seen their reports submitted to the Inquiry. We are in full agreement with their response on Allstat[241] dated November 26 to the earlier criticisms by Dr Poloniecki.'[242]

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[237] INQ 0034 0007 – 0008; *'A Response to Submissions on behalf of Mr JD Wisheart, Appendix 2, The Inquiry's Statistical Analysis'*, May 2000, Dr Spiegelhalter et al. (emphasis in original)

[238] INQ 0034 0002; *'A Response to Submissions on behalf of Mr JD Wisheart, Appendix 2, The Inquiry's Statistical Analysis'*, May 2000, Dr Spiegelhalter et al.

[239] PHA2 0001 0112; letter from Dr J Poloniecki, 10 November 1999

[240] INQ 0015 0133; *'Statistical analysis at BRI Inquiry – Re open letter to Inquiry'*, 26 November 1999, Dr Aylin, Dr Best, Professor Evans, Professor Murray and Dr Spiegelhalter

[241] Allstat is a UK-based worldwide e-mail broadcast system for the statistical community

[242] INQ 0015 0132; *'Statistical analysis at BRI Inquiry'*, 27 November 1999, Professor Curnow

170 Mr Wisheart concluded his submission:

> ‘There seem to be important questions outstanding in relation to the reliability of comparator data, the use of analyses involving pooled data, and some figures given for Bristol which seem to be at odds with the surgeons’ own data.
>
> ‘… If the stages of confirmation and explanation are not achieved, should the Inquiry not acknowledge that the uncertainties inherent in the preliminary data render them unreliable as the basis for any judgement?’[243]

171 Dr Spiegelhalter et al. responded:

> ‘We agree that no source of data can be considered as a gold-standard. However, if two reasonably independent sources of evidence corroborate each other and are largely consistent, then this supports both their conclusions. Furthermore, there is no statistical justification for the claim that using pooled data on open operations is in any way “unreliable” – in fact, given the difficulties in obtaining agreed coding categories of diagnoses and operations, such a pooling may be more reliable than a more sophisticated technique.
>
> ‘… The statistical evidence does not support the claim that “the uncertainties in the preliminary data render them unreliable as the basis for any judgement” – the strength and consistency of the “signal” dominates the indisputable “noise” that exists.’[244]

Differences in the data presented in the evidence of the Inquiry’s Experts and the data submitted by the Bristol surgeons

172 Mr Dhasmana stated:

> ‘Mr Wisheart has drawn attention to the problems with the raw data and I would endorse those views. The mortality figures for the neonatal arterial switch programme are clearly wrong and I believe that those quoted for ASD and VSD are also incorrect.
>
> ‘My own surgical log, which I believe to be the most accurate monitor of my surgical performance, demonstrates that between 1990 and 1995 I operated upon 61 children with ASD’s and there were no deaths. Indeed for my entire consultant experience in this group I have only 1 recorded death out of 95 operations.
>
> ‘Likewise my figures for VSD’s are 2 deaths out of a total of 72 operations between 1990 and 1995 (6 deaths out of 117 for my whole experience).’[245]

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[243] SUB 0009 0026 Mr Wisheart

[244] INQ 0034 0008 – 0009; *‘A Response to Submissions on behalf of Mr JD Wisheart, Appendix 2, The Inquiry’s Statistical Analysis’*, May 2000, Dr Spiegelhalter et al.

[245] WIT 0084 0149 – 0150 Mr Dhasmana

> 'The conclusions[246] drawn by the statistical team on behalf of the Inquiry are not accepted. It is believed that there are serious flaws with some underlying data. In particular, the results quoted for ASD's and arterial switches are wrong.'[247]

173 Mr Wisheart questioned the accuracy of figures [248] presented in a report to the Inquiry by one of the Inquiry's Experts in statistics. In particular, he raised concerns (by reference to his own and Mr Dhasmana's data) about the number of operations and the number of deaths which the Inquiry's Expert had identified in relation to particular categories of procedure.

174 The report showed 5 deaths in 90 operations for Atrial Septal Defects in 1991–1995. Mr Wisheart stated:

> 'Mr Dhasmana and I believe there were no deaths out of 102 operations.'[249]

175 The report showed 5 deaths in 50 operations for aortic or pulmonary valve surgery. Mr Wisheart stated:

> 'Mr Dhasmana and I believe that there was one death out of 35 operations.'[250]

176 The report showed 3 deaths in 23 operations for mitral valve surgery. Mr Wisheart stated:

> 'Mr Dhasmana and I believe that there was one death out of eleven operations.'[251]

177 In relation to the estimated numbers of excess deaths based on HES data, as shown in the report,[252] Mr Wisheart submitted:

> '… [the estimate] is substantially wrong and is likely to be a significant over-estimate of the number of excess deaths … .'[253]

178 Dr Spiegelhalter, Professor Evans, Dr Aylin and Professor Murray responded:

> 'The point at issue is the classification of operations. There is no evidence that deaths have been recorded when they have not occurred in more than a very few instances overall. The problem is that the classification of operations is difficult. With random misclassification of type of operation, but accurate determination of

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[246] As set out in the initial statistical reports to the Inquiry, published in November 1999

[247] SUB 0010 0019 Mr Dhasmana; see Chapter 3 for an explanation of clinical terms

[248] Mr Wisheart refers in his submission to the table presented at INQ 0015 0004; *'An initial synthesis of statistical sources concerning the nature and outcomes of paediatric cardiac surgical services at Bristol relative to other specialist centres from 1984 to 1995'*, October 1999, Dr Spiegelhalter. The number of operations and the number of deaths quoted by Mr Wisheart appear to be extracted from the table presented at INQ 0015 0048

[249] SUB 0009 0025 Mr Wisheart

[250] SUB 0009 0025 Mr Wisheart

[251] SUB 0009 0025 Mr Wisheart

[252] The estimated numbers of excess deaths are reported in the table at INQ 0015 0004

[253] SUB 0009 0025 Mr Wisheart

> death, then [there] will be a tendency for mortality rates in the different groups to be more similar to one another than would be the case if no misclassification occurred. In particular groups there may be a higher rate, but in other groups there will be a lower rate than there should be. *Focusing only on the groups with a higher rate is biased. It is for this reason that examination of all open operations was also done in the statistical analysis.* The other issue is that coders in different centres, who are each familiar with the OPCS4 system, will tend to code operations in a way that reflects that coding system, rather than clinicians' views. The key comparisons are made between centres, and no doubt, individual clinicians in those other centres are also likely to have different ways of classifying their operations. Random misclassification is likely to make the different groups more similar across centres also.
>
> '… There is very little disagreement between the sources of data in regard to individual children as to whether they died or not. There is disagreement between Mr Wisheart's grouping by diagnosis, and the other sources that are grouped by operative procedure. While it is possible that some groups seem to show a higher rate in the statistical reports provided to the Inquiry than in Mr Wisheart's grouping of the data, there will be other groups where Mr Wisheart's data would seem to have a higher mortality rate than the statistical reports. He has not drawn attention to these, since his own comments apply only to selected groups.'[254]

179 Dr Spiegelhalter et al. further observed:

> 'It is important to emphasise that the entire analysis of paediatric cardiac surgery at UBHT has been based on operative procedures rather than on diagnosis. This was made very clear in our reports. Two of the major reasons for choosing to use operation were – a) the UKCSR recorded data by numbers of procedures rather than numbers of diagnoses, and b) when comparing different centres, it is likely that agreement about procedures may be greater than agreement on diagnosis. The Submission [by Mr Wisheart] presents its analyses based on diagnosis rather than on operation, and hence considerable discrepancies must be expected between the analysis of the Inquiry's Data (including that of the Surgeons' Logs) and the analysis in the Submission of the Surgeons' Logs.
>
> '… Further analysis based on linkage of HES records with national death certification records has been carried out by Professor Murray … This shows that in open operations HES identifies around 95% of 30-day deaths (in spite of HES only aiming to capture in-hospital deaths). In conclusion, we do not find statistical evidence to support the statement "that the estimate of excess deaths based on HES data is substantially wrong".'[255]

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[254] INQ 0034 0015; *'A Response to Submissions on behalf of Mr JD Wisheart, Appendix 2, The Inquiry's Statistical Analysis'*, May 2000, Dr Spiegelhalter et al. (emphasis added)

[255] INQ 0034 0008; *'A Response to Submissions on behalf of Mr JD Wisheart, Appendix 2, The Inquiry's Statistical Analysis'*, May 2000, Dr Spiegelhalter et al.

180 Referring to the apparent discrepancies between HES data and hospitals' departmental records, Dr Spiegelhalter et al. in their Overview Report observed:

> 'Stark (2000a, WIT 0567 0004) reports substantially lower counts of activity (sum of operations identified as "open" or "closed") measured by HES and reported in Aylin et al (1999) and Spiegelhalter (1999), compared to the numbers of operations recorded in contemporary departmental records. Some undercount must be expected due to the Inquiry's use of admissions [to hospital] as a measure of activity, rather than operations as used in the departmental records. There will be additional contributions due to miscoding of records in HES, and in particular from admissions excluded from the open/closed groups (see Section 2.4).[256] It is difficult to interpret such discrepancies, as there is unknown variability between departmental record systems in, say, what constitutes an "operation". What is important for the Inquiry's analysis is that the same coding and exclusions (on the basis of OPCS4 codes) have been applied to all centres in a consistent manner. As noted at Section 2.5 above,[257] random errors in coding will tend to reduce differences between groups and hence between centres.'[258]

181 Dr Spiegelhalter et al. reached the conclusion that:

> 'Although we have had some months to reflect on the issues and carry out further examination of the available data, we see no statistical justification to revise to any substantial extent the analyses and opinions stated in written and oral evidence to the Inquiry.'[259]

The Bristol surgeons' formal written comments on the Experts' Overview Report and the Experts' responses

182 The Inquiry's Experts on Statistics presented their Overview Report to the Inquiry in September 2000. In that Report, as has been seen, efforts were made to take account of concerns expressed. In October and November 2000, Mr Wisheart and Mr Dhasmana submitted formal written comments on the Experts' Overview Report, to which the Experts replied.

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[256] See INQ 0045 0015; *'Overview of statistical evidence'*, September 2000

[257] See INQ 0045 0015; *'Overview of statistical evidence'*, September 2000

[258] INQ 0045 0018; *'Overview of statistical evidence'*, September 2000

[259] INQ 0034 0002 – 0003; *'A Response to Submissions on behalf of Mr JD Wisheart, Appendix 2, The Inquiry's Statistical Analysis'*, May 2000, Dr Spiegelhalter et al.

183 Mr Dhasmana stated:

> 'I would … like to respond to their conclusion that the high mortality was not restricted to AVSD and switches.
>
> 'I believe that these two groups were the main factors in contributing to the high mortality in this age group [under 1 year of age]. I have stated in my evidence to the GMC and the Public Inquiry that Bristol traditionally lagged behind the rest of the country by about 5 years in keeping up with the pace of development in paediatric cardiac surgery. The arterial switch programme, particularly in neonates, started in earnest in other centres around the late 80's and they were able to overcome their initial high mortality by the early 90's, as shown by the falling trend of mortality in the neonatal age group in this report. On the other hand, in Bristol the neonatal switch programme started in January 1992 and stopped in October 1993. I believe that this contributed to the high mortality figures seen in epoch 3 of this study period. … I always recognised the high mortality of switches in the neonatal period and discussed the mechanisms adopted towards improving the result, which could not be sustained.'[260]

184 In response, Professor Evans and Dr Spiegelhalter observed:

> 'The discussion in the Overview at section 6.4 [INQ 0045 0027], and tables 6.2 [INQ 0045 0056] and 6.4 [INQ 0045 0059] make it clear that, both according to the UKCSR and the HES analysis, the results at Bristol were not as good as those at other centres for other operations. It is clear that the major contribution, as Mr Dhasmana states, is from AVSD and switches. He also notes that there were worse results for other operations, but suggests that the numbers were too small for meaningful comparison. The statistical methods used by the experts in the Overview Report have been able to combine these groups and the overall effect suggests that the worse mortality was not restricted to the highest risk groups.'[261]

185 Mr Dhasmana commented on the Experts' conclusion that Bristol lagged behind the falling trend in mortality elsewhere:

> 'The "Overview Report" … has recognised that there was no excess mortality in this age group[262] during epoch 4 … for the period April 95–December 95. The overview report appears to pay little attention to this improvement by stating that the activity was too small to draw any firm conclusion …
>
> '… I operated on a full range of paediatric cardiac procedures except for the arterial switches during that period. This was in accordance with the recommendation of

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[260] INQ 0045 0118; formal written comment from Mr Dhasmana on the *'Overview of statistical evidence'*; see Chapter 3 for an explanation of clinical terms

[261] INQ 0045 0136 – 0137; *'Response to Further Submission by Mr Dhasmana in response to Overview of Statistical Evidence'*, December 2000, Professor Evans et al.,

[262] The under-1 age group

> the de Leval and Hunter committee report (UBHT 0340 0305). I shared the paediatric cardiac work with Mr Pawade, the new appointee from May 1995 till September 95, when the open-heart surgical programme moved to the Children's hospital. The low mortality in this age group [under-1s], recognised by the "Overview Report", demonstrates that I kept pace with the falling trend in mortality in this age group. The absence of neonatal switches during this period supports my statement that the neonatal switches affected the mortality rate under my care during the third epoch and masked the improvement in my clinical work. I have already submitted a complete list of paediatric cardiac operations from 1986 till September 1995 … which demonstrates the improvement in clinical results in all most [*sic*] all groups except for the arterial switches. The de Leval and Hunter committee in their report attributed the cause of high mortality in this group to be multi-factorial (UBHT 0340 0304). I believe that high mortality in this group, coupled with mortality in the TAPVD series under my care, reflects the problem we had of split-site management of neonates and infants undergoing cardiac surgery.'[263]

186 Professor Evans and Dr Spiegelhalter responded:

> 'There are two problems with the interpretation of data in the period of Epoch 4, April 1995 to December 1995. As Mr Dhasmana notes, the number of arterial switch operations in this period was dramatically reduced. The expected mortality in the remaining groups would then result in a lower overall total mortality. The second is that this is a much shorter time span than the other epochs so that the total numbers of operations and deaths is very much less. In the statistical reports we have not wished to stress the fall in mortality rate in Epoch 4 because, from a statistical point of view, the data are too sparse to over-emphasise the apparent fall in mortality rate. The Overview makes it clear that in this time period there was no evidence at all for any excess mortality in any age group.'[264]
>
> 'The overall conclusions of our statistical analysis stand. We agree that the detailed interpretation of group 6 [ASDs] operations based on the original grouping in the local sources was, in some circumstances, subject to error. This has been corrected for the final Overview and did not affect any earlier between centre comparisons. We did not intend that anyone should rely on detailed comparisons based on the local sources, nor that between surgeon comparisons should be a focus of our analyses. The correction of the errors has made the local sources more consistent with one another, strengthening rather than weakening the conclusions.'[265]

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[263] INQ 0045 0118 – 0120; formal written comment from Mr Dhasmana on the *'Overview of statistical evidence'*; see Chapter 3 for an explanation of clinical terms

[264] INQ 0045 0137; *'Response to Further Submission by Mr Dhasmana in response to Overview of Statistical Evidence'*, December 2000, Professor Evans et al.

[265] INQ 0045 0136; *'Response to Further Submission by Mr Dhasmana in response to Overview of Statistical Evidence'*, December 2000, Professor Evans et al.

187 They concluded:

> ‘The Overview of the statistical reports does not need to be altered in any way. The data and conclusions are not undermined by what Mr Dhasmana submits. There has been no attempt to distinguish between individual surgeons, since the nationally available data do not permit individual surgeon comparisons.’[266]

188 Mr Wisheart stated:

> ‘… I have presented a case that the Overview has given insufficient weight to some of the evidence, namely:
>
> - ‘that caution should be exercised when dealing with these figures.
> - ‘that there are important differences, rather than reasonable agreement, between HES and [UK]CSR data and their analysis.
> - ‘That the [UK]CSR data is inappropriate for comparative purposes at the level of diagnostic categories.
> - ‘That clinicians (eg Stark and Keogh) have grave lack of regard for HES as a credible basis for evaluation of clinical events.
> - ‘that the various sources of inaccuracy in the mortality data, together with the unresolved discrepancies over figures in various consensus groups, lead to uncertainty about the magnitude of the apparent divergence of outcomes in Bristol compared to elsewhere.
> - ‘the need for clarification of the difference between pooled and aggregated data, and its significance.
> - ‘that some possible reasons for divergence in the Bristol outcomes, compared to elsewhere, have been identified; namely, volume of surgery, timing of surgery and the disproportionately high frequency of additional risk factors in two sub-groups of patients.’[267]

189 Professor Evans, Dr Spiegelhalter, Professor Murray and Dr Aylin responded:

> ‘We agree that the quality of the data is a major issue. We disagree that the quality of the data is insufficient to allow conclusions to be drawn about comparative mortality between Bristol and other centres. It is a question of judgement as to when the quality of data is insufficient and the authors of the overview have taken

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[266] INQ 0045 0137; *‘Response to Further Submission by Mr Dhasmana in response to Overview of statistical evidence’*, December 2000, Professor Evans et al.

[267] INQ 0045 0112 Mr Wisheart; response to the *‘Overview of statistical evidence’*

> care to acknowledge the deficiencies but at the same time we feel that the overall conclusions are robust.'[268]

190 Mr Wisheart stated:

> 'Without apparent regard for the views of Lawrence and Murray, the Overview proceeds to report its findings for excess deaths based on analysis of the [UK]CSR using procedure groups, individually and aggregated, without any obvious caution.'[269]

191 Professor Evans et al. responded:

> 'It is suggested … that we have not regarded the views of Lawrence and Murray on the analysis of the [UK]CSR. This is incorrect, firstly because Murray is an author of the Overview. Secondly the effect that errors may have on the conclusions are not such as to result in bias against Bristol. The classification into procedure groups of operations for cardiac surgery will always be subject to errors. The key question of importance in epidemiological terms is that such classification error is not different in the different centres. There is no evidence from Lawrence and Murray's study that such differential misclassification has occurred. Our judgement is that in spite of the weaknesses of the different sources of data they all point towards the overall conclusion that there were excess deaths in the younger children in Bristol. There is considerable consistency between the analyses based on pooled data and those based on dividing the data into separate procedure groups. This indicates that there were no major differences between centres in the mix of cases treated in those centres. The absence of major case-mix differences between centres means that argument about details of procedure groups is of limited relevance.'[270]

192 Mr Wisheart stated further:

> 'The main finding of this Overview, is the number of excess deaths in children under one, operated between 1991 and 1995. The HES estimate of 27.2 is more than twice as high as the [UK]CSR estimate of 12.9 (for aggregated, stratified open cases; Tables 6.1.and 6.2). This seems to be a large difference both in relative terms and in absolute numbers, and to fall well short of "reasonable consistency".'[271]

193 Professor Evans et al. responded:

> '… Mr Wisheart emphasises the differences between the HES and [UK]CSR estimates of the number of excess deaths in children aged less than one. Even with extremely good agreement between the sources in the basic data, the different

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[268] INQ 0045 0139; *'Response to Further Submission by Mr JD Wisheart in response to Overview of Statistical Evidence'*, December 2000, Professor Evans et al.

[269] INQ 0045 0095 Mr Wisheart; response to the *'Overview of statistical evidence'*

[270] INQ 0045 0139 – 0140; *'Response to Further Submission by Mr JD Wisheart in response to Overview of Statistical Evidence'*, December 2000, Professor Evans et al.

[271] INQ 0045 0096 Mr Wisheart; response to the *'Overview of statistical evidence'*

> definitions of activity would lead to different numbers of excess deaths. The key point is that each of these excesses has good evidence that they are more than zero and that although the precise estimates do not agree this is nevertheless reasonably consistent evidence of an increase in Bristol.'[272]

194 Referring to discrepancies between HES and UKCSR data, Mr Wisheart stated:

> 'If one quarter of the centres and one half of the procedure groupings lie outside an acceptable range of consistency [20%], how can one regard the level of agreement between the two sources of data as "reasonable"?'[273]

195 Professor Evans et al. responded:

> '… Mr Wisheart suggests that discrepancies beyond 20 percent are unacceptable. This is not true and it is certainly to be expected that there will be some variation in the ratio of death rates between HES and [UK]CSR.'[274]

196 Mr Wisheart stated:

> 'The under-reporting of deaths in HES, both quantified and unquantified, could contribute an increment to the estimate of excess deaths in Bristol, in children under one year of age from 1991–1995, but it is unlikely to exceed 5% of the total.'[275]

197 Professor Evans et al. responded:

> 'There is a misunderstanding regarding the underestimation of death rates in HES. It is important to realise that this underestimation will not only apply to other centres but it applies also to Bristol. The fact that Bristol has about the average underestimation makes it clear that there is no evidence that Bristol has a markedly different rate of underestimation of deaths compared with other centres. Any contribution to the error in the estimate of excess deaths in Bristol will be very small and it is not clear that this would automatically lead to an overestimate of excess deaths in Bristol.'[276]

198 Mr Wisheart stated:

> 'Table 6.2 continues to include figures for Group 6 (Atrial-Septal Defects) which I believe to be wrong. Please see my Response to a Group of Statistical Papers (2).

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[272] INQ 0045 0140; *'Response to Further Submission by Mr JD Wisheart in response to Overview of Statistical Evidence'*, December 2000, Professor Evans et al.

[273] INQ 0045 0097 Mr Wisheart; response to the *'Overview of statistical evidence'*

[274] INQ 0045 0140; *'Response to Further Submission by Mr JD Wisheart in response to Overview of Statistical Evidence'*, December 2000, Professor Evans et al.

[275] INQ 0045 0098 Mr Wisheart; response to the *'Overview of statistical evidence'*

[276] INQ 0045 0140; *'Response to Further Submission by Mr JD Wisheart in response to Overview of Statistical Evidence'*, December 2000, Professor Evans et al.

> At Para 3.5 I make a detailed presentation based on the belief that the worst possible figures in this group are that there were 3 deaths amongst 5 patients, rather than 5 deaths among 10 patients as is indicated in Table 6.2. If my figures were accepted this would reduce the number of excess deaths by 1.65 to 2.65.'[277]

199 Professor Evans et al. responded:

> 'Although it is acknowledged that group 6, which includes atrial-septal defects, may have some misclassification, if consequently there is over-recording of deaths in that group then those deaths would be balanced by under-recording of deaths in some of the other groups. Therefore they would not substantially affect the number of excess deaths overall. Similar arguments apply to the other groupings so that picking on those groups where the numbers recorded by the surgeons are lower than those in the Overview is biased. Examination of all groups, where there will be some with higher numbers recorded by the surgeons than in the Overview, should be done. The failure to realise that there should be higher numbers of deaths in the other groups leads to a misunderstanding regarding the estimation of the number of excess deaths. The values presented by Mr Wisheart need to be balanced by those in the opposite direction.'[278]

200 Mr Wisheart stated:

> 'The Inquiry's statistical experts have not accepted my point about discrepancies over figures, data and coding ... on the grounds that there was said to be agreement by all parties about the number of deaths which occurred in Bristol. This means that if a death is not allocated to one group, it is allocated to another and when the analysis of these groups are aggregated, errors of allocation will not matter. This lack of rigor [*sic*] inevitably undermines the confidence required in such serious work.'[279]

201 In response, Professor Evans et al. stated:

> 'We would wish to strongly refute the argument … that there has been "lack of rigour" in the overall analysis. Mr Wisheart does not seem to accept that if a given child had died, but the classification of the group was incorrect, then an underestimate of deaths will occur in the group to which they should have been allocated. This is balanced by the overestimation of deaths in the group to which they had actually been allocated. It is also important to realise that this effect will occur in centres other than Bristol, and will apply approximately equally to all centres.'[280]

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[277] INQ 0045 0099 Mr Wisheart; response to the *'Overview of statistical evidence'*

[278] INQ 0045 0140 – 0141; *'Response to Further Submission by Mr JD Wisheart in response to Overview of Statistical Evidence'*, December 2000, Professor Evans et al.

[279] INQ 0045 0100 Mr Wisheart; response to the *'Overview of statistical evidence'*

[280] INQ 0045 0141; *'Response to Further Submission by Mr JD Wisheart in response to Overview of Statistical Evidence'*, December 2000, Professor Evans et al.

202 Stating that 'The data are too flawed to allow a conclusion to be reached',[281] Mr Wisheart added:

> 'I wish to repeat the case, which I have made on a number of occasions in my earlier submissions, that taken together the various potential flaws may make a considerable contribution to the estimate of excess deaths.'[282]

203 Professor Evans et al. responded:

> 'We do not agree that the data are "too flawed" to allow conclusions to be reached.'[283]

204 Mr Wisheart stated:

> '… there are four estimates [of excess deaths] in all for open surgery carried out on all age groups between 1991 and 1995. These estimates range from 15.7 to 31.2, with HES estimates consistently greater than [UK]CSR estimates. Bearing in mind the acknowledged flaws in the data and the caution which has been advised in their use elsewhere in this Overview, it seems very strange that the estimate given in the Executive Summary is at and beyond the upper limit of the range of reported estimates.'[284]

205 Professor Evans et al. responded:

> '… it is suggested that the estimate of excess deaths given in the executive summary of the Overview [285] … is greater than that given elsewhere. At paragraph 6.2.1 of the Overview it is made clear that the estimate of the excess depends on the age stratification used. When the age stratification includes a "less than 90 days" group then the excess is 34.3. There is uncertainty in this value and the executive summary reflects this.'[286]

206 Mr Wisheart observed:

> '*Public perception.* If it is stated that there are a certain number of excess deaths in any category, this is seen as meaning that that number of deaths should not have occurred. This is so whether or not the number is statistically significant (statistical significance indicates the probability that the number of excess deaths is truly greater than zero). This concept also fails to take account of the fact that around the

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[281] INQ 0045 0102 Mr Wisheart; response to the *'Overview of statistical evidence'*

[282] INQ 0045 0102 Mr Wisheart; response to the *'Overview of statistical evidence'*

[283] INQ 0045 0141; *'Response to Further Submission by Mr JD Wisheart in response to Overview of Statistical Evidence'*, December 2000, Professor Evans et al.

[284] INQ 0045 0104 Mr Wisheart; response to the *'Overview of statistical evidence'*

[285] The estimated range of excess deaths was identified in the Executive Summary of the *'Overview Report'* in the following terms: 'Depending on the precise approach to the analysis, the number of excess deaths for open surgery during this period was estimated to be of the order 30 to 35.' INQ 0045 0003

[286] INQ 0045 0141; *'Response to Further Submission by Mr JD Wisheart in response to Overview of Statistical Evidence'*, December 2000, Professor Evans et al.

> mean performance of the centres, there will be a normal variation with a range which must be considered acceptable. Yet any deviation from the mean is described as excess deaths, even if it lies within that acceptable range.'[287]

207 Professor Evans et al. responded:

> '… Mr Wisheart questions the public perception of the phrase "excess deaths", and we acknowledge that these words are not the ideal, but there does not seem to be a good alternative way of expressing "observed – expected". We have made it clear exactly how the numbers were obtained.'[288]

208 Mr Wisheart stated:

> '… in principle, if a patient comes to surgery with advanced pulmonary vascular disease, one must regard that as something which has been permitted to occur as a result of the total system of care. Ideally, surgery would take place before such a development. On the other hand, the presence of associated additional anatomical abnormalities within the heart, or indeed outside the heart, are patient factors which cannot be influenced by the system of care, other than in the selection or non selection of such a patient for surgery. Therefore they remain as patient related factors which will influence the outcome of care and are legitimate considerations when assessing the system of care.
>
> '… The presence of additional anatomical abnormalities in Mr Dhasmana's series of neo-natal Switch operations is also well documented. These are coarctation of the aorta in 1 patient, and coronary arterial abnormalities in 4 other patients which add to the risk of the operation to a varying extent.
>
> 'Within the framework of considering factors outside the control of the system of care which may contribute to adverse outcomes, it seems that one should still consider both the volume of surgery and the presence of significant associated anatomical abnormalities in the patients. Each of these two factors would make a significant contribution to understanding the occurrence of excess deaths in this group of patients.'[289]

209 Professor Evans et al. responded:

> 'The issues of risk adjustment … are described entirely reasonably, but the presence of, for example, anatomical abnormalities in other centres has not been allowed for.'[290]

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[287] INQ 0045 0105 Mr Wisheart; response to the *'Overview of statistical evidence'* (emphasis in original)

[288] INQ 0045 0141 – 0142; *'Response to Further Submission by Mr JD Wisheart in response to Overview of Statistical Evidence'*, December 2000, Professor Evans et al.

[289] INQ 0045 0108 – 0109 Mr Wisheart; response to the *'Overview of statistical evidence'*

[290] INQ 0045 0142; *'Response to Further Submission by Mr JD Wisheart in response to Overview of Statistical Evidence'*, December 2000, Professor Evans et al.

210 Mr Wisheart stated:

> 'The authors of the Overview say that the crucial issue is whether the flaws in the data are *likely* to be great enough to overcome the observed patterns in the data. I suggest that a more prudent view is to ask whether it is *possible* that they might offer an explanation. If account is taken of the flaws in the data, and the potential explanations for divergence which have been put forward, I believe that it is definitely possible that the observed patterns may be overcome.'[291]

211 Professor Evans et al. responded:

> '… it is implied that the standards of proof are those for criminal prosecution. This is not a court so it is not a matter of standards of proof. However, it is always "possible" that an explanation exists for every adverse case. The issue is not one of "possibility", but "plausibility". It remains the case that the Overview takes into account the relevant uncertainty and draws conclusions based on the expert opinion of its authors as statisticians and epidemiologists. We have carefully considered Mr Wisheart's comments, and recognising that our phraseology could be improved in places, we feel no reason to change the substance or conclusions of our overview.'[292]

Assessments of the Experts' Overview Report

212 The Inquiry commissioned two experts in statistics to assess the Overview Report: Professor Stephen Gallivan Director of the Clinical Operational Research Unit at University College London; and Professor Robert Curnow, Emeritus Professor at the University of Reading and former President of the Royal Statistical Society. Professor Gallivan commented:

> 'In order to investigate the robustness of their findings, the authors have carried out an extensive programme of "sensitivity analysis".
>
> '… In all cases, even with the final artificially optimistic scenario, analysis still indicated strong evidence for substantial excess mortality at Bristol.
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> 'In view of the evidence from this sensitivity analysis, one can only conclude that the analytical approach adopted was indeed statistically robust.'[293]
>
> 'No major errors or ambiguities were detected in the report.'[294]

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[291] INQ 0045 0113 Mr Wisheart; response to the *'Overview of statistical evidence'* (emphasis in original)

[292] INQ 0045 0142; *'Response to Further Submission by Mr JD Wisheart in response to Overview of Statistical Evidence',* December 2000, Professor Evans et al.

[293] INQ 0045 0070 – 0071; *'Peer Review Report – Overview of statistical evidence'*, October 2000, Professor Gallivan

[294] INQ 0045 0071; *'Peer Review Report – Overview of statistical evidence'*, October 2000, Professor Gallivan

> '… to deny the divergence of outcome, one would need to believe that HES and [UK]CSR both gave grossly inaccurate estimates for many of the 11 mortality rates, or alternatively, that case load and mortality at Bristol has been hugely misrepresented. In the opinion of this reviewer, this is highly improbable.'[295]
>
> 'Given such strong evidence that outcomes at Bristol were indeed divergent, analysis has been carried out to examine whether there were intrinsic factors, other than case mix, that could mitigate such findings.
>
> '… It can be seen that none of these factors provides mitigation for the level of excess mortality estimated and provides further reassurance that the findings are not a statistical artefact. Again, this suggests that the analysis provides reliable and valid evidence of divergence of the outcomes at Bristol.'[296]

213 Professor Curnow stated:

> 'In my view, the scrutiny of the various data sources, their comparison and synthesis; the data analyses, and the reporting of the conclusions from the analyses are of the highest professional standard. The analyses have been exhaustive and have been based on appropriate and up-to-date methodology. In their interpretative role, the authors have steered a careful route, balancing the possible misinterpretations of the available data because of biases in the collection and collation stages with the need to derive robust conclusions where this is possible. The authors have studied the sensitivity of their conclusions and recommendations to the inadequacies of the data. This has been done in terms of both possible biases in the data and the representation of the inevitable random variation in the outcome measures. In no place could I identify areas where the authors had been other than cautious in their findings.
>
> 'I can therefore confirm that I believe the authors have fulfilled their remit. The analytical approach is statistically robust and fit for purpose. I have found no errors or ambiguities of a statistical nature. I believe the overall conclusions to be reliable and valid.'[297]

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[295] INQ 0045 0073; *'Peer Review Report – Overview of statistical evidence'*, October 2000, Professor Gallivan (emphasis in original)

[296] INQ 0045 0074; *'Peer Review Report – Overview of statistical evidence'*, October 2000, Professor Gallivan

[297] INQ 0045 0067 Professor Robert Curnow

Chapter 20 – Concerns: Foreword, 1984 and 1985

Concerns

Foreword

1 The next 11 chapters set out, in chronological order, the development of concerns about the paediatric cardiac surgical services at the United Bristol Hospitals and the UBHT (UBH/T). There is a distinction between a view that the service at the Bristol Royal Infirmary/Bristol Royal Hospital for Sick Children (BRI/BRHSC) was capable of improvement but was nevertheless acceptable, and a view that the service (or aspects of it) at the BRI/BRHSC was unacceptably poor. The expression of the latter view is that which the Inquiry regards as a 'concern'.[1]

2 The following chapters, arranged annually, thus concentrate upon comments from various sources that the service was unacceptably poor. However, there is also evidence which led some individuals to identify what they saw as shortcomings in the Bristol service, and evidence from which it might be argued that others should have done so. This evidence, to an extent, is also reviewed in the chapters that follow. In particular, the Inquiry is conscious that the identification of a number of minor shortcomings might, when taken together, equate to an expression of concern. It is not the function, however, of this account of the evidence put before the Inquiry to pass any judgment upon these matters. It merely lays out the relevant evidence. Furthermore, at the end of each chapter will be found the available data (if any) for the year which the paediatric cardiac surgery Unit produced for its return to the UK Cardiac Surgical Register (UKCSR). Mr Wisheart said that he had maintained records of each and every operation he did (as did Mr Dhasmana), and that one of the purposes of doing so was to allow for a continuing review of performance.

3 It should also be noted that concerns expressed were not only in relation to Neonatal and Infant Cardiac Surgery (NICS). This was only part of the paediatric cardiac surgery work carried out at the BRI.

4 Finally, it should not be assumed that because events set out in the following chapters were simultaneous, or occurred in sequence, that any one individual was aware of that which was occurring, or being said, outside his or her direct personal involvement.

5 In order to provide an overview of the events which happened in any one year, there is a chronology in Chapter 31. Like all chronologies, it aims to assist by simplifying, and should not be taken as a substitute for the evidence, but merely a précis of some of the main features of it.

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[1] In addressing this issue, the Inquiry bears in mind the distinction between expressing the opinion that the service at the BRI/BRHSC was capable of improvement but nevertheless acceptable; and the view that the service at the BRI/BRHSC (or aspects of it) was unacceptably poor. It is the latter which is meant by 'an expression of concern'. See Issue N Inquiry on the Inquiry's Issues List in AnnexB

1984

6 In the context of the designation of Bristol as a Supra Regional Centre (SRC) in 1984, Sir Terence English, past President of the Royal College of Surgeons of England (RCSE), was asked by Counsel to the Inquiry: 'Could it be said of Bristol that in 1983 there had been developed there a special expertise in neo-natal and infant cardiac surgery?' He answered: 'No'.[2]

7 The view of Dr Norman Halliday, Medical Secretary of the Supra Regional Services Advisory Group (SRSAG),[3] was:

> '… Bristol did not actually shine as a star, whereas many of the other units such as Birmingham, Harefield, Brompton, Guy's, GOS [Great Ormond Street], would stand out, so it did not seem to be one of the leading lights in this area.
>
> 'Q. "Shine as a star" in what sense?
>
> 'A. In terms of clinical work that was going on there, in terms of research, in terms of the results that they were getting.'[4]

8 Dr Halliday's view as to the numbers of operations performed was similar:

> 'Q. … Is what you are saying that the track record in terms of numbers of operations done was not really a justification for Bristol becoming a supra-regional centre?
>
> 'A. Well, it certainly did not perform anything like on a par with the other units, no.'[5]

9 A table appended to the Report of the Joint Working Party of the Royal College of Physicians of London and the Royal College of Surgeons of England[6] showed the number of open- and closed-heart operations carried out on children under 1 year old in 1984 in the nine designated SRCs:[7]

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[2] T17 p. 68 Sir Terence English
[3] See Chapter 7
[4] T13 p. 28 Dr Halliday
[5] T13 p. 27 Dr Halliday
[6] Report of the Joint Working Party of the Royal College of Physicians of London and the Royal College of Surgeons of England *'Supraregional Services: Neonatal and Infant Cardiac Surgery'*, dated 1 September 1986
[7] RCSE 0002 0017; figures taken from table 3 to the Report

Supra Regional Centre	open-heart operations	closed-heart operations	total
BRI and BRHSC	11	39	50
The Freeman Hospital, Newcastle	32	40	72
Birmingham Children's Hospital	35	84	119
Brompton Hospital, London	55	94	149
The Royal Liverpool Children's Hospital	63	97	160
Southampton General Hospital	41	53	94
Guy's Hospital, London	19	74	93
Great Ormond Street Hospital for Sick Children	82	152	234
Killingbeck Hospital, Leeds	28	94	122
	366	**727**	**1,093**

The table also provided figures for two other centres which had applied for designation as SRCs:

Centre	open-heart operations	closed-heart operations	total
Harefield Hospital, Middlesex	32	19	51
Groby Road Hospital, Leicester	13	32	45

10 The designation of Bristol as an SRC is considered in Chapter 7. The evidence was that the inclusion of Bristol in the list of centres designated occurred late, and that, in effect, the only claim that Bristol had for such designation was on the basis of geography. There is also evidence, set out in Chapter 7, from Dr Halliday and Sir Terence, to the effect that the Unit at Bristol needed to be developed if it was successfully to fulfil its intended role as a designated centre.

1985

11 This was the first full year after designation of Bristol as an SRC. Evidence as to the need to establish and develop what was thought to be an appropriate caseload is contained in Chapter 7[8] and is not repeated here.

12 Records were maintained of the throughput of paediatric cardiac cases including whether or not the child operated on had survived. In particular the surgeons Mr James Wisheart and Mr Janardan Dhasmana kept logs, and each year Mr Wisheart ensured that his secretary informed the Society of Cardiothoracic Surgeons of Great Britain and Ireland (SCS) of the numbers of operations, and numbers of deaths, recorded in the Bristol Unit.

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[8] Evidence as to the views of referring clinicians is contained in Chapter 11

13 In 1985, the return to the Register showed that the Bristol Unit performed 14 open-heart operations on children under 1 year of age, and 85 on children over 1 year of age.[9] There were three deaths in the under-1 group, and two in the over-1s.[10]

14 The table appended to the Joint Working Party Report referred to in para 9 above[11] also gave figures for the number of open- and closed-heart operations carried out on children under 1 year old in 1985:[12]

Supra Regional Centre	open-heart operations	closed-heart operations	total
BRI and BRHSC	14	41	55
The Freeman Hospital, Newcastle	28	47	75
Birmingham Children's Hospital	42	68	110
Brompton Hospital, London	71	85	156
The Royal Liverpool Children's Hospital	82	113	195
Southampton General Hospital	47	53	100
Guy's Hospital, London	12	60	72
Great Ormond Street Hospital for Sick Children	74	142	216
Killingbeck Hospital, Leeds	32	80	112
	402	**689**	**1,091**

Centre	open-heart operations	closed-heart operations	total
Harefield Hospital, Middlesex	38	17	55
Groby Road Hospital, Leicester	16	42	58

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[9] UBHT 0055 0005; return to the SCS produced by the UBHT

[10] UBHT 0055 0154; return to the SCS produced by the UBHT

[11] Report of the Joint Working Party of the Royal College of Physicians of London and the Royal College of Surgeons of England *'Supraregional Services: Neonatal and Infant Cardiac Surgery'*, dated 1 September 1986

[12] RCSE 0002 0017; figures taken from table 3 to the Report

Chapter 21 – Concerns 1986

Concerns

1 Professor Gareth Crompton, Chief Medical Officer for Wales from 1978 to 1989, stated in his written evidence to the Inquiry that there was:

> '… an evident undercurrent of dissatisfaction with the Bristol Centre. This, at a time when paediatricians from Wales not working in the Cardiff Centre, e.g. Gwent and Carmarthen, were strong in their support of the care their patients were getting in Bristol.'[1]

2 Professor Andrew Henderson, at that time Professor of Cardiology, University of Wales College of Medicine, and some of his colleagues were openly critical of the quality of work at Bristol. At a meeting between the Welsh Office and South Glamorgan Health Authority (SGHA) on 20 October 1986, Professor Henderson distributed a letter that he had co-written with Mr Butchart[2] and Professor I A Hughes.[3] As regards Bristol, the letter stated:

> 'It has been suggested elsewhere that Bristol provide a supra-regional neonatal cardiac surgical service for Wales. The overriding objections to this have been stated. Moreover it is no secret that their surgical service is regarded as being at the bottom of the UK league for quality, and it is difficult to see how this problem could be resolved in the foreseeable future.'[4]

3 Professor George Sutherland, a cardiologist at Southampton General Hospital from 1983 to 1987, indicated that he was personally contacted by Professor Henderson:

> 'During 1986 I was personally contacted by Prof. A Henderson … with regard to paediatric cardiology services in Wales … Prof. Henderson expressed his concerns to me about referring children from Wales to Bristol in view of the poor surgical results in that department. He suggested that it would be appropriate that I offer a service to Cardiff similar to that Dr Keaton [*sic*] and I were offering to Plymouth.'[5]

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[1] WIT 0070 0004 Professor Crompton
[2] Consultant cardiothoracic surgeon, University Hospital of Wales, College of Medicine
[3] Cardiologist and Chairman of the Division of Child Health, University of Wales College of Medicine
[4] WO 0001 0006; letter dated 20 October 1986 from Professor Henderson and others to South Glamorgan Health Authority
[5] REF 0001 0149; letter dated 21 January 2000 from Professor Sutherland to the Inquiry

4 Professor Crompton told the Inquiry that he did take steps to try to find out if there was substance to Professor Henderson's allegations that Bristol was at the bottom of the league for quality. He raised the matter with Professor Sir Donald Acheson, then the Chief Medical Officer (CMO) for England. Professor Crompton told the Inquiry:

> '… I decided to mention to my colleague Professor Sir Donald Acheson, the Chief Medical Officer at the Department of Health, the opinion of Professor Henderson that Bristol were fortunate to have been designated a Supra Regional Centre in 1984 and that the team there had not progressed year on year as maybe the Supra Regional Advisory Group and/or others had expected. We met regularly as CMOs do in various fora to do with the National Health Service and it was in the margins of one of these that I spoke with him about the Bristol Unit. I had no evidence to present as at no time had Professor Henderson supplied me with any, even though I and my Welsh Office medical colleagues asked for any material he had to substantiate his viewpoint. Sir Donald properly asked me to see his Senior Principal Medical Officer with responsibility for the Supra Regional Services Programme, Dr Norman Halliday. That I proceeded to do the very same day. I saw Dr Halliday in his office, the only time I recall visiting with him, although I saw him often at meetings elsewhere in London where we represented our two departments. I raised with him the misgivings that Professor Henderson had raised with me about the Bristol Unit. We had a brief and un-minuted discussion. I received no confirmation that there were problems, other than about waiting lists, which the Department of Health were considering.'[6]

5 Professor Crompton said that he had told Dr Norman Halliday, Medical Secretary to the Supra Regional Services Advisory Group, of:

> '… repeated comments from Professor Henderson about his view that the quality of the service in the Bristol centre was not improving year on year, as might have been expected. That was the essence of what I said. I had no evidence other than that, and that was, I think, a fair summary of what I had heard from Professor Henderson from time to time.'[7]

6 Professor Crompton added:

> 'I would have hoped that he [Dr Halliday] would have been in a position to have assured me that there was no basis to what Professor Henderson was saying to me, or that if there was a problem, that he had been able to share a confidence as to the extent of it, if he knew. But I do not recall any acknowledgement either way in that conversation about that.'[8]

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[6] WIT 0070 0003 Professor Crompton

[7] T21 p. 29 Professor Crompton

[8] T21 p. 33 Professor Crompton

7 When Professor Crompton was asked what action he would have expected Dr Halliday to have taken upon receipt of the information that he had given him, he replied:

> 'Well, from Dr Halliday's reaction, it did not seem to have been news, because he focused on the waiting list issues, not the quality and outcomes issues, and as far as I knew maybe similar things were being said in other parts of England about other centres, he might be privy to. I was not. I did not know what was known or not known to Dr Halliday, and he kept any confidences that he had.'[9]

8 When questioned further he stated:

> 'I would have expected from the beginning, when they established the supra-regional centres, that there would have been a system of data capture and analysis and publication from each of the centres, distributed freely to the Department of Health and to Regional Health Authorities who were sending patients there from Wales or wherever and that the Supra Regional Services Advisory Group would have been in full knowledge of all the facts relating to this important initiative. If that was not the case, then I am surprised.'[10]

9 Dr Halliday gave oral evidence on two occasions. On the first of these he was asked whether he was aware of the concerns that Professor Henderson had in 1986. Dr Halliday replied:

> 'It does not ring a bell, no. I mean, throughout all the discussions with the Welsh Office and everyone in that area, there were constant concerns about Bristol, but they were vague concerns and they appeared to be about the problems of referral. We also had a situation of, quite properly, clinicians in Cardiff wishing to establish their own unit and if they were building that empire there, that would threaten Bristol. So one reason for not referring to Bristol may well have been to strengthen their own case. They would constantly send them to London whilst they argued for a service within Cardiff. So one had to balance these arguments very carefully. But no-one raised any concerns about the clinical outcome in Bristol.'[11]

10 Asked about discussions with Professor Crompton about concerns over outcomes at Bristol, Dr Halliday replied:

> 'I had many discussions with Dr Crompton. As I said earlier, I met with the Welsh Office regularly and we regularly discussed Bristol, but I do not remember any discussion with any clinician or official where the performance of Bristol was questioned. "Performance" I am interpreting as meaning clinical outcome.'[12]

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[9] T21 p. 72 Professor Crompton

[10] T21 p. 72 Professor Crompton

[11] T13 p. 50–1 Dr Halliday

[12] T13 p. 112 Dr Halliday

11 When Dr Halliday gave evidence for a second time he had had the opportunity to read the oral evidence of Professor Crompton.

12 Dr Halliday explained that he now did recollect the meeting at which Professor Crompton had expressed to him the concerns of Professor Henderson. He explained:

> '… we did not have a formal meeting. Professor Crompton was not coming to me to say "I have a major concern here that I need you to address", because had he done so we would have arranged a formal meeting, we would have had agendas, we would have taken minutes, we would have considered future action. There was nothing like that at all.'[13]

13 Dr Halliday went on to explain that, as there was no evidence to support Professor Henderson's concerns, as relayed by Professor Crompton, he could not take the issue any further. He said:

> 'I am sorry, but you receive information, you do not necessarily take action, but you do not dismiss it; you retain the information and if something else comes along to complement what you have just been told you might well take action. In terms of what Professor Crompton had told me, I had no justification for taking action. What was I expected to do? I could not go to the Royal College and say "A Professor Henderson in Wales is alleging there is something wrong in Bristol". It would be irresponsible of me to ask the College to investigate on that basis. If, however, I was presented with some evidence, some data to suggest there was something wrong then, yes, I could do something.'[14]

14 In the autumn of 1986, the Bristol Unit was visited by health officials from the Welsh Office. Professor Crompton explained that the motivation behind this visit was to:

> '… explore for ourselves whether there was any substantiation of Professor Henderson's critical comments about the Unit'.[15]

In her report of the meeting, Dr Jennifer Lloyd, Senior Medical Officer, Welsh Office, subsequently wrote:

> '… We did however raise the question of outcome with Bristol staff. They put to us the accepted point that outcome is influenced greatly by case mix. They were quite open in quoting outcomes for some of the commoner procedures they undertake. They see a gradual improvement in these as expertise grows and specialist equipment becomes available. For most of the more commonly occurring conditions their figures compare well with other centres. They acknowledge however that surgeons in different centres develop special expertise in rarer

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[13] T89 p. 123 Dr Halliday

[14] T89 p. 125–6 Dr Halliday

[15] WIT 0070 0004 Professor Crompton

> conditions and that outcomes may therefore vary greatly for these between centres.'[16]

15 As regards Dr Lloyd's reference to case mix, Dr Hyam Joffe, consultant cardiologist, said in evidence that he could see no reason for Bristol's case mix to be any different from that of any other unit in the country,[17] with the exception of Down's syndrome cases, since he claimed that Bristol was more ready to operate on children with Down's syndrome than other centres, particularly in the mid-1980s to early 1990s.[18]

16 As to the phrase in Dr Lloyd's report, 'gradual improvement ... as expertise grows', Mr Wisheart was asked whether it could be seen as an explanation for under-performance. Mr Wisheart replied:

> 'I think it could equally be a positive statement, that as experience, expertise in the volume of work undertaken grows, then it is likely that results will improve. I do not think it has to be seen as an explanation for something that may or may not be inadequate.'[19]

17 Mr Wisheart was then shown figures[20] that indicated that in 1986 the number of open-heart operations carried out on children under 1 at the BRI was very small (24) and in previous years had been even smaller: 14 in 1985, 11 in 1984 and four in 1983. Mr Wisheart went on to explain that when he had made the suggestion to Dr Lloyd that 'They [the Bristol Unit] see a gradual improvement in these as expertise grows', it was more a reflection of an aspiration rather than a statement of fact. He said:

> 'I think the historic setting of what we were talking about is very important, because surgery in the under 1s was something that had been at a very low level through the 1970s and was beginning to grow, so, okay, some folks were a year or two ahead of other folks, and quite a number of folks were not doing very much, and in the early to mid-1980s, we were in that latter group, and hoping to develop the work as others were doing.'[21]

18 Mr Wisheart added:

> '... those who are behind are seeking to achieve the standards of those who are presently in front of them … That, I think, was everyone's goal at that time.'[22]

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[16] WO 0001 0260; Report on NICS for Wales, December 1986

[17] T90 p. 4 Dr Joffe

[18] T90 p. 4 Dr Joffe

[19] T92 p. 73–4 Mr Wisheart

[20] DOH 0004 0028; Table of surgery 1975–1991 produced by the UBH/T

[21] T92 p. 75 Mr Wisheart

[22] T92 p. 76 Mr Wisheart

19 Mr Wisheart was asked about the phrase 'They put to us the accepted point that outcome is influenced greatly by case mix'.[23] In his evidence to the Inquiry Mr Wisheart made several points about case mix. First, he pointed out that a unit doing a small number of operations would probably be doing a proportionally smaller number of elective operations and probably a proportionally higher number of emergency cases and that outcome in emergency cases was nearly always worse, simply because of their unplanned emergency nature. The non-urgent and, therefore, often less serious nature of elective operations regularly led, he said, to a better outcome. Mr Wisheart then referred to some figures that he had prepared in 1988.[24] He explained that he had prepared the comparative table as a normal exercise and not as a response to any concern over rates of mortality at Bristol that had been raised with him. The table showed that in some operations – Pulmonary Stenosis, VSD + PS, and TGA in particular – Bristol had results that were better than the national average, which Mr Wisheart had calculated. In other operations the results were broadly comparable to this national average: Aortic Stenosis and TAPVD in particular. In other operations including PTA, TGA + VSD and AVSD, Bristol was below these national norms.[25] Mr Wisheart's evidence was that out of 74 open-heart operations on children under 1 in the period 1984 to 1987, 20 patients died, and that if the national mortality figures for the year 1984 to 1985 were extrapolated to the Bristol case mix in the period 1984 to 1987, then one would have expected to see 19.24 deaths.[26] Exchanges between Counsel to the Inquiry and Mr Wisheart on this point were as follows:

> 'Q. The overall conclusion then that you drew from this was that the difference in overall figures in Bristol compared to the UK was because Bristol was doing a higher number within the period 1984 to 1987 of those cases which carried the higher risk of mortality.
>
> 'A. Yes.
>
> 'Q. And if one allowed for that in the way that you have done here, the results were so close as to be almost indistinguishable?
>
> 'A. Yes. I am not sure that "allow" is the right word because it suggests a concession, and I do not think it is a concession; I think it is a statement of reality, if I may.'[27]

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[23] T92 p. 69–73 Mr Wisheart

[24] UBHT 0167 0032. (These figures are 1988 figures. Thus, they may have retrospective value. They were not available, nor were other such figures, at the time of the visit by the Welsh Office.)

[25] See Chapter 3 for an explanation of these clinical terms

[26] T92 p. 82 Mr Wisheart

[27] T92 p. 83–4 Mr Wisheart

Report of the performance of the PCS Service in 1986

20 The Unit forwarded to the UK Cardiac Surgical Register (UKCSR) the data that was available from the Unit itself. The Unit's return to the UKCSR for 1986 showed the following data for open-heart surgery:[28]

Operations – Over-1s	Operations – Under-1s
89 (10)	24 (6)

21 Of the under-1s, there was only one child operated on for 'complete a-v canal (corrective procedure)': that child died. Only two were operated on for 'truncus arteriosus (corrective procedure)', both of whom died. There was one operation for 'TGA with VSD (corrective procedure)'; the child died.

22 The outcomes for the UK as a whole, as recorded in the 1986 Annual Report on the UKCSR, showed the following mortality rate for 1985:[29]

Over-1s	Under-1s
7.2%	21.7%

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[28] Figures taken from UBHT 0055 0162 – 0164; Unit return to the UK Cardiac Surgical Register; figures in parentheses are for deaths

[29] Figures taken from UBHT 0055 0269; UK Cardiac Surgical Register, 1986

Chapter 22 – Concerns 1987

Concerns

Concerns expressed in Wales

1 In the late 1980s the Children's Heart Circle in Wales (CHCW) had taken a lead in advocating to the Welsh Office the development of a comprehensive paediatric cardiac service in Wales.

2 Mr Peter Gregory, of the Welsh Office, wrote a minute for Ministers in which he described the Heart Circle as:

> '… the Welsh arm of a national organisation representing the interests of parents of children with heart complaints and the patients themselves. It is well known for its charitable works and, through the Trust for Sick Children in Wales, is much involved in fund raising for the parents' accommodation to be built in association with the paediatric cardiac unit in Cardiff. The CHCW is not very cohesive, lacking a strong central focus, and its members are highly motivated people (most of them have children with heart problems). Accordingly, the CHCW is a volatile and outspoken Group and one heavily influenced to their way of thinking by clinicians in the cardiac unit in Cardiff.'[1]

3 Mr Gregory added that the CHCW had been:

> '… alleging that Welsh Office Ministers are dragging their feet about the provision of the paediatric cardiac unit and that, in an attempt to cut its cost, the highly specialised cardiac surgery for the newly born and children under 1 year has been dropped'.[2]

4 In May 1987 Mr Neil Hall wrote a report for the CHCW entitled *'Meanwhile our Children are Dying'*.[3] The report supported the creation of a paediatric cardiac surgery unit in Cardiff. The report also included remarks about the paediatric cardiac service in Bristol:

> '… a degree of concern has been expressed by independent, well-informed sources about the standard of operations carried out at the receiving centre at Bristol. It has been suggested that this concern is widely held. If we consider the referral practices of doctors in Wales now and in the past, it is apparent, at least, that doctors without a vested interest in any particular receiving centre (they used to work there, for example) are less inclined to refer to Bristol than might be expected, given that it is much nearer than any of the other centres. Some parents have actually asked that their children not be referred to Bristol for surgery, preferring to travel to London.

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[1] WO 0001 0315; minute dated 18 August 1987 from Mr Gregory to Ministers

[2] WO 0001 0315; minute dated 18 August 1987 from Mr Gregory to Ministers

[3] WO 0001 0361; *'Meanwhile our Children are Dying'*

> It has also been suggested that, in other areas, cases that might have been appropriately referred to Bristol have been referred elsewhere. In the absence of other explanations, these observations seem to confirm the suggestions that concern is widely held. It cannot be stressed too strongly, however, that such information in no way represents "hard evidence" and the author does not suggest that it does. Nevertheless, in view of the critical nature of its subject matter, and the increasing likelihood that cases from Wales will be referred to Bristol … sufficient concern has been expressed for questions to be asked.'[4]

5 Mr Gregory described the report in his minute for Ministers as: 'a highly partial, very emotive, frequently inaccurate and barely concealed piece of journalistic propaganda'.[5]

6 Dr Hyam Joffe told the Inquiry that Mr Hall's report contained 'extraordinary and outrageous statements' about Bristol.[6]

7 Dr Joffe went on:

> '… the Heart Circle itself decided to reject the document as coming from them as a Group, and that it was Neil Hall's own specific view.'[7]

8 On 16 June 1987 BBC Wales broadcast a television programme entitled *'Heart Surgery – the Second Class Service'*. In the course of the programme's support for a paediatric cardiac surgery unit in Wales, criticisms were made about Bristol. In particular, Mr Hall said in interview:

> 'We have heard – always off the record – from a number of informed sources that questions ought to be asked about the standard of care that Bristol could provide … observation of the referral practices of doctors in South Wales and in Bristol's own area would seem to confirm that there are reservations within the specialist field of paediatric cardiology about using Bristol in the future as a regional centre for South Wales.'[8]

9 In the course of interviewing Mr John Gray, then Administrator, Legal Services, Bristol & Weston District Health Authority (B&WDHA), the interviewer suggested that the Bristol Royal Infirmary (BRI) was not receiving patients from Wales because of doubts regarding the service.

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[4] WO 0001 0361; *'Meanwhile our Children are Dying'*

[5] WO 0001 0315; minute dated 18 August 1987 from Mr Gregory to Ministers

[6] T90 p. 99–100 Dr Joffe

[7] T90 p. 100 Dr Joffe

[8] *'Heart Surgery – the Second Class Service',* BBC Wales 1987

10 Mr Gray replied:

> ‘Different consultants decide to refer patients to different parts of the country for various reasons and because a consultant in this region decides to send a patient elsewhere does not mean that he is criticising our Unit, it may be that the patient has had previous investigations or that that consultant or general practitioner has personal links with another centre and wants to send the patient there.’[9]

11 To the observation that ‘Consultants have told us they wouldn’t send their own children there’, Mr Gray replied:

> ‘Well that’s not the view of independent assessors. Independent assessors have looked at the results of this Unit and found that each year is average and above average in many respects. Its mortality is very low and it has been considered by the supra regional committee to be a very good unit to develop for a supra regional purpose.’[10]

12 The Inquiry asked Mr Gray to comment on this interview and received the following response from the solicitors to the United Bristol Healthcare NHS Trust (UBHT):

> ‘I refer to your letter of 6 May 1999 concerning Mr Gray’s interview for BBC Wales in 1987. Mr Gray’s comments are as follows. First, as you know, he no longer works in the capacity of the Trust’s Public Relations Officer and ceased exercising those functions approximately five years ago.
>
> ‘At the time, in 1987, Mr Gray states that he would have been supplied with a brief by the then Chief Executive Dr John Roylance. He then acted in the capacity of spokesman for the Health Authority, working from the brief he had been given. In essence, he said what he had been told to say. Therefore, his quoted comments do not reflect either independent knowledge or his personal views. Mr Gray has no absolute knowledge of this interview after all these years.’[11]

13 In response to the programme, Mr Wisheart, Mr Dhasmana, Dr Jordan and Dr Joffe wrote a joint (undated) letter to ‘the Editor’, which took issue with the programme’s comments about Bristol:

> ‘Sir – In a BBC Wales television programme screened on 16th June 1987 on the subject of cardiac facilities in Wales, certain allegations were made about the standard of paediatric cardiac surgery in Bristol.

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[9] *‘Heart Surgery – the Second Class Service’,* BBC Wales 1987

[10] *‘Heart Surgery – the Second Class Service’*, BBC Wales 1987

[11] UBHT 0349 0010 UBHT

> ‘These allegations are totally unfounded. In fact, the outcome for operations in children performed in this unit during the period 1984–1986 is equivalent to the UK national results for 1984 (latest available data), and better for certain conditions. This is true for both open- and closed-heart surgery, and for critically ill new-borns and infants as well as for older children. We wish to set the record straight and, particularly, to allay the anxieties of families whose children are currently being treated in Bristol, or may receive attention there in the future.’[12]

14 On 3 August 1987 the four clinicians also wrote a letter to Dr D Chamberlain, Chairman of the Cardiology Committee of the Royal College of Physicians. The Cardiology Group of the Royal College of Physicians had been asked by the Welsh Office to report on the development of cardiological services in Wales. The Bristol clinicians were of the opinion ‘it is inevitable that the work of our unit will be considered in the Inquiry’.[13] The clinicians wrote:

> ‘… Firstly, it should be recognised that children with heart defects have been referred to Bristol from various parts of South Wales, especially from neighbouring Gwent, from as long ago as the late 1960s and early 1970s. There has been a steady increase in referrals since then, with a rapid rise in the number of neonates and infants needing acute attention since the designation of Bristol as a supraregional centre in 1984. Since the unfortunate death of Dr LG Davies last year, the Bristol paediatric cardiologists have been invited to run joint clinics locally and these are now held in Abergavenny, Newport, Haverfordwest and about to be in Swansea and Carmarthen. It is emphasised that these invitations were totally unsolicited; the initiatives have all come from the paediatricians in Wales and must reflect satisfaction with the service offered to the acutely ill patients, mainly infants, in the past.
>
> ‘Secondly, it was the Welsh Office which made an approach to ourselves and the Bristol and Weston Health Authority to explore the financial and other implications of the provision of a supraregional service for neonates and infants. The medical and managerial staff of the Bristol and Weston Health Authority have expressed their readiness to respond positively to the Welsh Office recommendation, in the hope that a joint Bristol/Cardiff service could be developed appropriate to the population of the South Western Region and South Wales. Of course, final decisions about the provision of services for children in Wales must rest with the Welsh authorities and medical advisors, and we would agree that individual doctors should retain the right to make referrals to a unit of their choice, but we would expect any policy decisions to be made on the basis of fact and not misinformation …

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[12] UBHT 0194 0022

[13] UBHT 0133 0029; letter dated 3 August 1987 to the Royal College of Physicians from the Bristol cardiologists

‘Thirdly, and apparently related to the above recommendation, the Bristol Paediatric Unit has been subjected to a campaign of vilification, and the word is chosen advisedly, which we find quite extraordinary and very sad. To illustrate this, and without wishing to elaborate at this stage, the following is quoted from a document written under the auspices of the Welsh Heart Circle in Cardiff, who have no direct contact with Bristol, and circulated to the other local committees in Wales, which do include many families whose children have been treated in Bristol. Many of these comments were repeated verbatim in a television programme entitled *“Heart Surgery – the second class service”*, screened on 16th June 1987 in the BBC Wales series *“Week in, week out”*:

> ‘“However, a degree of concern has been expressed by independent, well-informed sources about the standard of operations carried out at the receiving centre at Bristol. It has been suggested that this concern is widely held. If we consider the referral practices of doctors in Wales now and in the past, it is apparent, at least, that doctors without a vested interest in any particular receiving centre (they used to work there, for example) are less inclined to refer to Bristol than might be expected, given that it is much nearer than any of the other centres. Some parents have actually asked that their children not be referred to Bristol for surgery, preferring to travel to London. It has also been suggested that, in other areas, cases that might have been appropriately referred to Bristol have been referred elsewhere. In the absence of other explanations, these observations seem to confirm the suggestions that concern is widely held. It cannot be stressed too strongly, however, that such information in no way represents ‘hard evidence’ and the author does not suggest that it does. Nevertheless, in view of the critical nature of its subject matter, and the increasing likelihood that cases from Wales will be referred to Bristol, sufficient concern has been expressed for questions to be asked.”

‘And later in the document, “Given the questions raised about surgery in Bristol, this” (the recommendation to use Bristol as a receiving centre) “is a very distressing development. The notion that any deficiency that might exist in Bristol would be attended to by practising on Welsh cases is not only ethically chilling but untenable.” (The full document is available for perusal if required.)

‘It is stressed that these sections form part of a long and highly emotive plea for improved paediatric cardiac services in Wales, which aim we would fully support, but it is nonetheless damning of Bristol for all that. The undermining effect on the trust and confidence which should exist between doctors and the parents of children who are or have been patients in Bristol can be imagined. In an attempt to counter the effect of the television programme, several aggrieved parents spontaneously wrote letters to the Welsh Press in support of Bristol. We, too, felt obliged to seek publication of a letter in the Welsh press, indicating that the allegations made against Bristol regarding surgical results are totally false.

> ‘A summary of the results in Bristol in the period 1984–1986 compared with national figures for 1984 (the latest available) is enclosed for your information.
>
> ‘However, the most distressing aspect of this affair is the fact that much of the information in this document, including the allegations about the service in Bristol, emanates from “three consultant cardiologists of such qualification, experience and present position to be well placed to make such judgements”. This was suggested in the document, but stated categorically by its author in a subsequent letter in reply to a parent. It seems, therefore, that this view is widespread and, we believe, based on ignorance of the facts, since there has been no recent inquiry into the actual status of the facilities (better than most, in our view) or the surgical results (which are at least equal to those achieved by other paediatric units). We can think of no motive, other than one of medical political gain, to account for this deliberate and calculated campaign to denigrate a supraregional unit which is showing sustained growth in the number of patients treated, a steady improvement in the results achieved, and which is highly respected in paediatric and other circles throughout the South West Region, and indeed, in most parts of South Wales …
>
> ‘Despite our sense of outrage, it was our wish that this issue should have been contained, but it must now be brought to your attention since you and your committee are bound to be given various opinions regarding the Bristol service during your forthcoming investigations in Wales. There is also the risk that the adverse publicity already given to the Bristol service will be spread further and it is, naturally, our wish that this should be avoided and that any potential conflict between medical colleagues should be settled within the profession, if at all possible. We believe that the issue should be resolved on the basis of facts, and hope that you and your committee will use your good offices to this effect. From our part we are keen to provide you with all the detail you require, and would be happy for you to send a copy of this letter to Professor A Henderson if you wish.
>
> ‘We should like to invite you or your representatives to visit Bristol to see what the facilities are like and to establish the facts. We look forward to hearing from you and hope that your intervention will facilitate a satisfactory resolution of this problem.’ [14]

15 Dr Joffe was asked about the joint letter of 3 August 1987 and told the Inquiry:

> ‘Yes, I wrote this letter …’.[15]

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[14] UBHT 0133 0029 – 0031; letter dated 3 August 1987 to the Royal College of Physicians from the Bristol cardiologists

[15] T90 p. 102 Dr Joffe

16 He went on, in the following exchange:

> ‘Q. Did you think that somebody in the Bristol Unit was possibly passing information to others?
>
> ‘A. No, I do not believe this was based on Bristol information.
>
> ‘Q. This was somebody within the medical world?
>
> ‘A. Yes. … I cannot point a finger, I have some ideas, but I am unable to point to an individual or several individuals.’[16]

17 Dr Joffe was asked by Counsel to the Inquiry about some of the claims made for Bristol in the letter of 3 August 1987. In particular, he was asked about the claim that Bristol’s surgical results were ‘at least equal to those achieved by other paediatric units’.

18 Dr Joffe said:

> ‘I believe, to be honest, that that was a partial overstatement on my own part because of my passion at the time. But I believed that they were in fact roughly equal to those of other units using the relatively imprecise data that we had at our disposal at that time, and that was the belief in the Unit, I believe, that we were doing pretty well the average of what others were doing but there were a couple of conditions, two or three maybe, where we were not doing as well as we felt we ought to.’[17]

19 Dr Joffe also told the Inquiry that:

> ‘It was at that time, 1987, that Mr Wisheart talked to me on one occasion, as I think I put it in my statement, on the way back from a joint clinic in one of the centres, probably Exeter, that we had got to the point where we needed to move up a gear in order to improve the service and that the means of doing so was to appoint a full-time paediatric cardiac surgeon and that the opportunity might become available through funding from the British Heart Foundation of a Chair in Bristol which he at no time thought otherwise than that it would be allocated to a children’s paediatric cardiac surgeon.’[18]

20 Mr Dhasmana told the Inquiry that in his view the criticisms of Bristol from those in Wales were made as part of a determined campaign to establish a paediatric cardiac centre in Cardiff. He told the Inquiry:

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[16] T90 p. 102 Dr Joffe

[17] T90 p. 103 Dr Joffe

[18] T90 p. 104 Dr Joffe

> '… the problem in a way was that there were too many cardiologists coming from different parts of the country running their clinic in Wales, and I felt they came out a bit more aggressive in 1986 in order to establish their unit. That is my personal feeling: to attack the nearest and closest to get their own service, really. And I feel that that was probably the emotive part behind all these things. We in Bristol always supported a move to Cardiff – to facilitate their development of paediatric cardiac surgery, but at the same time, were anxious that we are so close by, there are not so many cases, we would have to support each other.'[19]

21 Dr John Roylance, District General Manager of the B&WDHA at the time, told the Inquiry that he had no memory of the letter of 3 August 1987 nor the events to which it related:[20]

> '… I think if this had been brought to my attention at that time I would remember it now and I have no memory of it at all.'[21]

22 Mr Wisheart wrote to Mr Gray on 22nd December 1987, sending copies to Dr Jordan, Dr Joffe and Mr Dhasmana. He referred to a letter from a solicitor, Mr Robert Johnson, to Mrs Bennett of the CHCW of 16th June 1987.[22] Mr Wisheart's letter stated:

> 'The tenor of that [Mr Johnson's] letter is that while proceedings against the Heart Circle are possible it is not our wish, and in order to enable us *not* to take proceedings against them we require the following:-
>
> '(i) that the paper is amended;
>
> '(ii) that we are told to whom the paper was circulated, and perhaps most importantly an expression of our concern that the parents of children in Wales due to be operated in Bristol will have their confidence in the service undermined. One must add to that that Mr Hall, either in his personal capacity or on behalf of the Children's Heart Circle in Wales, used some of that defamatory material in the BBC programme screened on 16th June 1987. Bearing in mind these basic considerations, the letter [in reply] dated 13th November seems to be severely deficient, in effect it is saying that the references to Bristol have been omitted and that it was not publicly distributed. I believe therefore that they need to be reminded that what we are still trying to do is to avoid taking legal proceedings against them and that in order to do so they need to be much more frank about the distribution of the paper. It is certainly our understanding that unless the committee includes a very large number of members of the Heart Circle its circulation was not restricted to the committee and we need them to provide us with names and addresses. I believe they should also be challenged with the fact that this material was used on the BBC programme, and that whether Mr Hall was acting personally

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[19] T84 p. 40–1 Mr Dhasmana

[20] T88 p. 51 Dr Roylance

[21] T88 p. 52 Dr Roylance

[22] A copy of that letter was not available to the Inquiry: Mr Johnson of Osborne Clarke, solicitors, was writing on behalf of the cardiologists

> or on behalf of the committee, he was using material which the committee had asked him to compile. Finally, they have made no suggestions as to how to counteract any undermining of confidence which might have taken place in the minds of parents in Wales. In all I think that further pressure should be brought on them to take this a good deal more seriously than they have done to date.'[23]

23 Dr Roylance told the Inquiry that he was not aware at the time that legal advice was being sought in relation to a possible action for defamation. He said:

> 'I am quite calm in not knowing about it. Saying whether I expected to know about it, no, I think the legal department worked closely with doctors on professional matters and I would only be invited to involve myself if it became a managerial issue.'[24]

24 Dr Roylance went on to say that if it came to the point at which there was a need to commit resources (for example, money to fund a legal action) then:

> '… I think I would have been told …'.[25]

25 He added:

> '… I do not think this in fact is a letter about the hospital taking umbrage but about clinicians taking umbrage about what is said about them. I certainly was not advised to address the view that the hospital was being improperly maligned.'[26]

Concerns expressed in Plymouth

26 Professor George Sutherland was a cardiologist at Southampton General Hospital from 1983 until 1987. He told the Inquiry that at some time in 1986–1987 his colleague Dr Barry Keeton was contacted by Dr Perham, a consultant paediatrician at Derriford Hospital, Plymouth.

27 Professor Sutherland stated in his written evidence to the Inquiry:

> '[Dr Perham] expressed concern to Dr Keeton that the surgical results for complex congenital heart disease in the Bristol centre were worrying him and asked if it would be appropriate for the Southwest region to send complex cases to the surgeons in Southampton where the surgical results were documented and appeared substantially better. Dr Keeton discussed the problem with me and we decided to set up a clinical service for the Southwest region … This involved one of us performing a monthly clinic in Plymouth General Hospital and the surgical cases who were complex being subsequently referred to Southampton General Hospital. Dr [Perham] and his other paediatric colleagues wished to continue to try

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[23] UBHT 0209 0012

[24] T88 p. 53 Dr Roylance

[25] T88 p. 54 Dr Roylance

[26] T88 p. 56 Dr Roylance

to support the Bristol centre and continued to send their non-complex cases for surgery there.'[27]

Concerns expressed by South Western Regional Health Authority (SWRHA)

28 Miss Catherine Hawkins, Regional General Manager for the SWRHA 1984–1992, told the Inquiry that she had concerns about the Bristol cardiac surgical service in the late 1980s. They were focused upon the adult cardiac service and largely, but not exclusively, on waiting times and throughput.[28] They were explored in the following exchange:

> 'Q. You tell us in your statement, words to the effect that for some time before 1989 you had heard or had some concern that cardiac surgery in Bristol was not up to scratch.
>
> 'A. It was a fact that at district reviews in the north and the south of the county, DGMs advised us not always formally in a meeting but sometimes at lunch afterwards that they had cardiologists who were not happy with the Bristol Unit. Part of that, they thought, might be historical because people had been used to sending patients to the Brompton and to Oxford, but partly they thought that there was a general dissatisfaction with outcomes, whether operations were done in time, whether the patients waited too long, but they could not be specific and their cardiologists would not come forward to make statements.
>
> 'Q. Can I put flesh on this? These were conversations that you had not just in the formal review but around it?
>
> 'A. Yes.
>
> 'Q. Because if one looked to the formal review, was the formal review minuted?
>
> 'A. If it was raised as an issue, if we were having a dialogue about cardiac surgery and a concern was expressed, then it may well have been minuted, but again, in those days, it was very difficult, unless you had evidence, to name or shame a doctor.
>
> 'Q. At least the general position, appreciating that cardiac surgery may be slightly unusual because of the cardiothoracic register, but the general position was that you would know that you had not got chapter and verse to go on because that was the defect in the information systems at the time?
>
> 'A. Yes. We had a hint that — we had hints, but we also had a situation where cardiologists who were dissatisfied were still referring.

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[27] REF 0001 0149; letter from Professor Sutherland

[28] It will be recalled that the service at the BRI was for adult and paediatric patients. The impact of one on the other is a recurring issue

‘Q. So, when were the district reviews at which or around which these concerns were expressed?

‘A. That varied in time. It is very hard for me to remember. I know that they were raised in — I know for sure they were raised in 1990 from one particular district.

‘Q. Exeter?

‘A. Yes. Before that, I believe it was about 1987.

‘Q. Do you remember from where?

‘A. I have a feeling that that is Cheltenham, but the DGM has died since, I am afraid, but I think it was Cheltenham.

‘Q. Who else would have been present at the meeting that might remember?

‘A. My Finance Officer was always there. The other officers varied, depending on what was being discussed. Exeter, definitely the finance man was there. He was present at all reviews.

‘Q. And he was —

‘A. Mr Arthur Wilson.

‘Q. So going back to what you can recollect about Cheltenham, probably 1987, thereabouts, you are not quite sure, do you recall the way it was put to you?

‘A. That was not in a formal context; that was over lunch where Mr Hammond[29] said, “You know, we are not really happy with referring to the BRI; we would rather go to Oxford”. Asked why, again we had this, “Well, we are not absolutely sure but they are not too happy with the performance of the Unit”. We did ask them to be more specific.

‘Q. Specific as to the performance?

‘A. As to what the real anxieties were about because unless you had that sort of evidence, you could not go back and challenge the DGM and his consultants, who were not part of the regional staff unless you had something very specific to hang on to. You could convey the concerns, but you could not say what those concerns actually were.

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[29] Mr James Hammond, District General Manager, Cheltenham & District Health Authority

‘Q. The cardiologist who would have inspired the DGM’s expression of concerns to you would probably be an adult cardiologist, would he?

‘A. Yes.

‘Q. So are we to take from that that probably these concerns related to adult rather than children’s services?

‘A. I have never had an official or informal hint about paediatric service.

‘Q. Neither formal nor informal?

‘A. No. Not to me personally.’[30]

29 Miss Hawkins was asked in the following exchange about the television programme *‘Newsnight’* broadcast in 1998:

‘Q. Can I read it out to you as what was said: “*‘Newsnight’* can reveal that it was some ten years earlier when serious misgivings about Bristol’s record for adult heart surgery were voiced by the woman in charge of the health service in the west to the Department of Health. Catherine Hawkins was Chief Executive of the Regional Health Authority from 1984 to 1992. She declined to be interviewed on camera, but has told *‘Newsnight’* of her considerable concerns about the role played by the Department of Health. A letter to *‘Newsnight’* says that in the late 1980s there was pressure from both District Health Authority and Whitehall to expand the cardiac service, despite warnings that all was not well:

> ‘“At many of our District Health Authority reviews, we find a reluctance to encourage referral by the cardiologists to the BRI because of, and I quote, unsatisfactory outcomes, close quotes. These views caused me sufficient disquiet to actively resist the rapid expansion of the service.”

‘She also told *“Newsnight”* that in 1988 her own Medical Officer warned her of a high death rate for adult heart surgery. Miss Hawkins says she raised this matter with officials from the Department of Health ”on several occasions”, and again there is a quotation:

> ‘“Civil servants were hell bent on the numbers game. They were not bothered about the outcome of the operations; they just wanted to be able to quote a big increase in the number of operations being undertaken.”

‘First of all, are those quotations accurate in the sense that they come from a letter or from what you said to *“Newsnight”*?

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[30] T56 p. 57–60 Miss Hawkins

‘A. The majority.

‘Q. The first of those quotations: “At many of our District Health Authority reviews, we find a reluctance to encourage referral by their cardiologists to the BRI because of, and I quote, unsatisfactory outcomes, close quotes.”

‘Did you say that to *“Newsnight”*, either in writing or orally?

‘A. Yes, because that, in the 1980s, was the feedback we were getting.

‘Q. You say: “At many of the District Health Authority reviews”.

‘A. Yes. Well, two or three I consider many.

‘Q. Because so far you have told us of Exeter in 1990 and Cheltenham in 1987. Was there any other you can recall?

‘A. When we first started raising the issue of the fact that we would have to develop the BRI, we did have feedback then that they did not want to refer; they wanted to continue with Oxford and Brompton. That was not Avon, because Avon had always referred to the BRI, but the other districts did not want to go along that line.

‘Q. You asked for the reason for that?

‘A. Yes, and as I say, part of that could have been the fact that they were used to the pattern of referral and they told us patients were happy with that but we still had them saying, off the record, the cardiologists, that their doctors, in quotes, were not happy with referring to the BRI.

‘Q. The words ascribed to you by *“Newsnight”* were, and I quote, “unsatisfactory outcomes ...”. In other words, those words, “unsatisfactory outcomes”, were being used to you in the course of one or more of these discussions, were they?

‘A. Yes.

‘Q. So DGMs were telling you that their cardiologists were unhappy about unsatisfactory outcomes?

‘A. They may not have said “cardiologists” specifically, but they referred to their “doctors”.

‘Q. So you had expressed to you reluctance to allow the expansion of the BRI, cardiac surgery generally, adult cardiac surgery. Did you ask your RMO [Regional Medical Officer] to investigate?

‘A. In that scenario, again, without very specific evidence or what he would be investigating, that was extremely difficult to do. In a situation where we would have to ask the individual doctors concerned for their specific cases, could we look at all their records, also, we did not have the manpower for that at that specific time, so I referred the matter back to the DGM, who should have done that.

‘Q. So you could, could you, have asked your RMO, or indeed, even yourself asked the Unit at Bristol to provide comparative statistics such as they had of their performance as contrasted with national performance?

‘A. To my knowledge, you could not have done that because units were reluctant to give up their figures. I spoke to the RMO before about that, and he said, well, you would never get a comparison because they do not want to give their statistics.

‘Q. So although you as Region were responsible for the performance of the Unit, and although your Chairmen could talk and achieve results with the Chairmen of the Unit, you would not have been able to find statistics of outcomes even if they had them?

‘A. We were not responsible for the performance of the Unit; we were responsible for monitoring it, but the BRI was responsible for the performance of the Unit.

‘Q. Let us stick with monitoring. Monitoring involves getting figures and seeing how they compare against some standard?

‘A. I think in hindsight that is easy to say. If you were there at the time, in the 1980s, that was not easy to do.

‘Q. Did you or your RMO try to get the figures from the BRI?

‘A. I would have to say no, because I would not have had the evidence to go in and demand such figures. A reluctance on the part of districts who were very content to refer out of region and not to the BRI, without being able to identify what they meant – what did they mean by unsatisfactory outcomes – was not a reason to put in two or three people to try and identify and collate statistics by hand, which is what it would be. There was no computerised record at that time.’[31]

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[31] T56 p. 60 Miss Hawkins

30 Miss Hawkins told the Inquiry in the following exchanges about relating her concerns to Dr Roylance and others:

> ‘Q. Do you recall yourself, or do you understand that your RMO ever spoke to Dr Roylance about these concerns?
>
> ‘A. If I recall, there is somewhere on 1980s, in quotes, reviews, an item on that subject with the Bristol authority. I have spoken to him informally about problems there.
>
> ‘Q. Do you recollect when it was that you spoke to him informally, roughly?
>
> ‘A. Roughly? It must have been, I think, round about 1987.
>
> ‘Q. Once or more than once?
>
> ‘A. It would have been more than once because I would have had some feedback on it. If I had said to him, “Have you got a problem”, I would have expected him to come back and tell me what the problem might be.
>
> ‘Q. Do you recall as best you can how you raised it with him, what sort of thing you said?
>
> ‘A. I would have told him that we had had bad feedback from other districts and that it looked as though there might be a problem, did he think there was and if he did, could he go and investigate.
>
> ‘Q. Do you recollect the feedback that you got?
>
> ‘A. Yes. He told me that they had identified an individual that they thought might be the problem, and that they were going to change that situation in the Unit and another consultant was being appointed and things should get better.
>
> ‘Q. You can answer the next question “Yes” or “No”. Did he identify the individual, the particular doctor who was thought to be the problem by name?
>
> ‘A. Yes.
>
> ‘Q. Was he a surgeon in cardiac surgery?
>
> ‘A. Yes.
>
> ‘Q. So far as you are aware, did he retire shortly afterwards?
>
> ‘A. Yes.

‘Q. After that, do you recall any further expression of concern by DGMs of districts other than Bristol & Weston?

‘A. I really cannot recall that –

‘Q. Until the time you came to Exeter?

‘A. It seemed to go quiescent until round about late 1990. I believe in 1990 we held reviews in December.

‘Q. I know you have been answering from memory, but if we go back to page 2 of your statement and go to the foot of it, the third paragraph in paragraph 11, you have identified the additional consultant who was to make a difference and that was, as it turned out, to be Mr Dhasmana.

‘A. Yes.

‘Q. We know he was appointed in 1986, so the time that you were looking at must have been a little bit earlier than 1987?

‘A. Yes, roundabout then.

‘Q. Can you help with whether you ever raised with the DGMs elsewhere whether things now seemed to be better or all right or words to that effect?

‘A. It sounds — I mean, that would have been done on an informal network, because I did have AGMs who were responsible for individual districts, and that would have been done when they actually sat with them to see what should be coming up as agenda items at our reviews. I mean, cardiac surgery was a very small part, as I have tried to explain, of the total acute and other services in the Region, so it was not high on my agenda every single time I sat down with a DGM.

‘Q. If one scrolled up to paragraph 7 on the same page, maybe you have just given the reason why you put it this way, you desire: “The main catchment area for the BRI … Local cardiologists did not state dissatisfaction ...”. It is a double negative. Did you put it that way because they were saying they were dissatisfied?

‘A. No, there was never any issue from the cardiologists from the BRI or around Somerset that there was a problem with the Unit.[32]

‘Q. Can we go back from that discrete topic to the question of the concerns that you heard being expressed and the way in which you approached them? *“Newsnight”* record you as saying …

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[32] T56 p. 66–9 Miss Hawkins

'"At many of our District Health Authority reviews we find reluctance to encourage referral by their cardiologists to the BRI because of, and I quote, unsatisfactory outcomes. These views caused me sufficient disquiet to actively resist the rapid expansion of the service."

'That last sentence: "These views caused me sufficient disquiet to actively resist the rapid expansion of the service." Is that a faithful reproduction of what you told *"Newsnight"*?

'A. Yes. It is what I told the Department. I resisted them on one or two years.

'Q. So it is true that is what you did, is it?

'A. Yes.

'Q. How did you actively resist the rapid expansion of the service?

'A. We would not put the capital investment in.

'Q. So Region had funds which it could have allocated to the development of cardiac services but chose not to do so?

'A. No. The point was that we could make it a top priority and let something else go for that year, but while we were actually investigating whether it was the best place to expand, then we spent capital monies on developing other DGHs [District General Hospitals].[33]

'Q. [continuing the quote from *"Newsnight"*] "Some DGMs gave vague indications that cardiologists felt BRI outcomes could be better but could not be specific in their concerns." There are about five vague words in that sentence. Can you help us to put more detail on that?

'A. If I recall, some of the issues were that because throughput was not very good, then if they referred, patients may wait too long and therefore they would be happier to send them somewhere elsewhere they knew they would be seen in a shorter space of time. Some felt that they could actually do all the tests that were required but if they sent them to the BRI, very often tests were redone and they did not seem to have a working protocol between them, which meant that maybe the selection of cases was not being adequately addressed. Those sorts of issues.'[34]

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[33] T56 p. 72–3 Miss Hawkins

[34] T56 p. 76 Miss Hawkins

31 Counsel to the Inquiry asked Dr Roylance about Miss Hawkins' evidence in the following exchange:

> 'Q. What Catherine Hawkins has told us is that at some stage, and she thinks around 1987 … she spoke to you and asked you to investigate some concerns including concerns in respect of outcomes. … She says that she had regular reviews and she says she would have been asking for the District General Manager to investigate why there were problems in cardiac surgery, she was firm in attributing anything that she had to say about concerns to cardiac surgery as opposed to —
>
> 'A. Adult cardiac surgery?
>
> 'Q. She said cardiac surgery and she did tie it to adults.
>
> 'A. Can I tie it to adults to simplify the conversation?
>
> 'Q. Certainly.
>
> 'A. Because what she was talking about at that time, and I remember the issue, was adult cardiac surgery.
>
> 'Q. In 1987 there was a conversation that you recollect between yourself – thereabouts – and Miss Hawkins?
>
> 'A. Yes, sir.
>
> 'Q. Her recollection was that you told her that the authority had identified an individual they thought might be the problem and they were going to change the situation in the Unit, another consultant was being appointed and things might get better; that is her recollection.
>
> 'A. Well, her recollection is at fault. I must say that must be a figment of her imagination because I cannot relate any event to that comment. No cardiac surgeon retired early; there was no identification of any individual and I have to say that a circumstance of that nature is not something that would have slipped my mind subsequently. I cannot explain in any way, except she was a very busy Regional General Manager with the responsibility across the whole region, I cannot explain where that concept came from but it did not come from Bristol.
>
> 'Q. She linked it to the appointment of Mr Dhasmana.
>
> 'A. Yes, that was a new appointment that replaced nobody; that was an expansion of the service.

> ‘Q. The other thing she told us about this period is that the Region were active in resisting moves to expand the service, the cardiac service in Bristol in general because of their concerns about the nature of the service provided; can you help on that?
>
> ‘A. I did not know at the time and it does make a number of previously inexplicable things perhaps understandable. It was known, recognised nationally as well as locally, that the South West was grossly underfunded for cardiological and cardiac services for adults and we were constantly pressing Region to fund more realistically the service pressure on the department. I was aware that there were considerations of creating a second centre at Plymouth, there is no secret about that. But at that time the traditional referral pattern for the south of the region was east to London and not north to Bristol. I do not know about the actual distances but the journeys were of a similar problem, similar time. So there was south of the region referred to London and the north of the region referred to Bristol but the cardiac department, particularly James Wisheart who led it, were constantly in negotiation with Region to expand the service to be more comparable with the demand. I could never understand why that funding did not materialise because the need was quite clear and opening a unit at the south of the region was not going to address that issue because it would absorb, presumably referrals which were currently going to London and actually not being funded by the South West Region, and I did not find that understandable at the time and I think it is more understandable now.’[35]

Reports of the performance of the PCS Service in 1987

32 In 1987 a table was prepared by the Unit comparing the number of operations and the mortality rate in Bristol between 1984 and 1986 with that in the UK Cardiac Surgical Register (UKCSR) for 1984:[36]

Operations Bristol 1984–1986	Mortality rate % Bristol 1984–1986	Mortality rate % UK 1984
Over-1s: 240 (19)	7.9	6.9
Under-1s: 49 (13)	26.5	21.8

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[35] T88 p. 56 Dr Roylance

[36] Figures taken from UBHT 0055 0008; figures in parentheses are for deaths

33 The note to the table stated:

> 'The Table shows 30 day mortality for Bristol operations for the three years 1984–86: this was done to provide a reasonable number of patients for comparison. The UK figures are taken from the UK Cardiac Surgical Register for 1984, which is the last year for which figures have been published.'

34 The Bristol Unit's return to the UKCSR for the year ending 31 December 1987 showed the following figures for open-heart surgery:[37]

Operations – Over-1s	Operations – Under-1s
110 (9)	25 (7)

35 In the under-1 age group, there had been three 'Complete A-V Canal (corrective procedure)'[38] operations, in two of which the patient had died; and one child operated on for 'Truncus Arteriosus (corrective procedure)', who had died.

36 In 1987 a *'Paediatric Cardiology and Cardiac Surgery Annual Report'*, the first such Annual Report, was produced by the Bristol Unit. It described an increase in the numbers of patients admitted to the BRHSC for assessment and investigations, and to the BRHSC and BRI for surgery, following designation of Bristol as a supra regional centre, and stated that:

> '… Children are now referred from the SW region, and parts of Wessex and South Wales, and beyond'.[39]

37 The Report included figures for the results of open-heart surgery for the four-year period 1984–1987:[40]

Operations – Over-1s	Mortality rate %
Simple: 107	1.9
Moderate: 184	6.5
Complex: 59	23.7
Total: 350	8.0

Operations – Under-1s	Mortality rate %
74	27.0

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[37] Figures taken from UBHT 0055 0173 – 0174; Unit return to the UK Cardiac Surgical Register 1987; figures in parentheses are for deaths

[38] See Chapter 3 for an explanation of clinical terms

[39] UBHT 0055 0011; *'Paediatric Cardiology and Cardiac Surgery Annual Report'* 1987

[40] Figures taken from UBHT 0055 0018; *'Paediatric Cardiology and Cardiac Surgery Annual Report'* 1987

Chapter 23 – Concerns 1988

Concerns

1 In his written evidence to the Inquiry regarding the articles which he had written in *'Private Eye'*, Dr Phillip Hammond, general practitioner and journalist, stated that, in 1988, whilst working as a house officer in Bath, he was told there was an adult cardiac surgeon in Bristol whose nickname was 'Killer'.[1] He stated that he was also told that: '... as far back as 1988, the Unit was nicknamed by some as the Killing Fields and the Departure Lounge because of its high mortality.'[2]

2 There was some evidence of concern amongst referring clinicians. Thus, Dr R Verrier Jones[3] stated he had been aware of such concerns at: ' ... the end of the 80s'. He said that by then: ' … there were some adverse comments being expressed about [Bristol] … but it was only hearsay'.[4]

3 On 1 September 1988 Dr Stephen Bolsin took up his post as consultant anaesthetist at the Bristol Royal Infirmary (BRI). He said that he began to have concerns about the paediatric and adult cardiac surgical services at an early stage. In oral evidence, Dr Bolsin summarised why he began to have concerns:

> 'I think the initial concerns were more generic, about the length of time taken and the duration of the operations and the bypass time … from day one, having worked at the Brompton where you would do five or six cases in a couple of theatres a day, to go to Bristol where we were doing just one case in a day.'[5]

4 In his written statement, Dr Bolsin told the Inquiry that his early impressions of the paediatric and adult cardiac surgery services at the BRI were:

> '... that the patients were operated on for much longer periods than I was used to at the Brompton Hospital and other cardiac surgery centres that I had worked at. A particular aspect of cardiac surgery that requires a short duration is the length of time that the blood supply to the heart is cut-off during the operation. This length of time is known, by specialists in the field, as the aortic cross-clamp time. During the time of the aortic cross-clamp the blood supply to the heart is cut-off and the heart effectively starts to die. The death of the heart can be slowed but not prevented and this is done by the perfusing medicines, chemicals and using low temperatures to reduce the speed at which the heart dies. If a significant portion of the heart has suffered damage during the time of the aortic cross-clamp then the patient will require a considerable amount of pharmacological support in the post by-pass period. Also the patients will suffer multiple organ failure as a consequence of the

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[1] WIT 0283 0005 Dr Hammond

[2] WIT 0283 0005 Dr Hammond

[3] Consultant paediatrician (retired) formerly at Llandough Hospital, Penarth, South Glamorgan

[4] REF 0001 0105; letter to the Inquiry

[5] T82 p. 40 Dr Bolsin

> poor action of the heart after the operation. Evidence suggesting that this occurs will be in the requirement for pharmacological support (inotropic drugs) and the length of time the patients spend on the intensive care unit with postoperative complications.
>
> 'I noticed after several months at the Bristol Royal Infirmary that the patients were suffering the complications that would be anticipated from excessive aortic cross-clamp times and long cardiopulmonary by-pass times during the cardiac operations. In fact one of the cardiac anaesthetists, Dr Geoffrey Burton, was so well aware of this problem that he often placed tunnelled central lines in the central veins of the patients in the anaesthetic room, before surgery. The reason for doing this was that the children would be so sick on the Intensive Care Unit after the operation that they would require these special lines for intravenous feeding, pharmacological support and other infusions.'[6]

5 Dr Bolsin, in an interview which formed part of a television documentary, *'Dispatches'*, made by HTV, stated:

> 'At the time I started in Bristol I was keeping a record, as I had done as a trainee, of all the cases that I was anaesthetising and I became concerned about the number of children that were dying from conditions that, I felt, should have relatively low mortalities. The length of time that the operations were taking to be completed was certainly very important. It was normal at the Brompton to operate on three or four children in a day's operation session. In Bristol we would take all day and sometimes much of the evening in order to complete one operation on a child. Now these may have been complex procedures but they would be completed in a much faster time in the other hospitals that I'd worked in.'[7]

6 Counsel to the Inquiry explored the issue with Dr Bolsin in the following exchange:

> 'A. I think the first and most striking thing about moving from the Brompton Hospital to the Bristol Royal Infirmary was the length of time the operations took, and I think that was by far and away the most striking component of the change between the Brompton and the Bristol Royal Infirmary.
>
> 'Q. You noticed that in your first year?
>
> 'A. I noticed that on my first day.
>
> 'Q. And yet you made no adverse comment on it in your first annual report?
>
> 'A. No.'[8]

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[6] WIT 0080 0106 – 0107 Dr Bolsin

[7] PAR1 0005 0210 – 0211; *'Dispatches'*, broadcast 27 March 1996

[8] T80 p. 97 Dr Bolsin

Reports of the performance of the PCS Service in 1988

7 The Unit's 1988 *'Paediatric Cardiology and Cardiac Surgery Annual Report'* reported figures for the results of surgery for that year:[9]

Operations – Over-1s	**Mortality rate %**
Simple: 18 (0)	0
Moderate: 58 (1)	1.7
Complex: 23 (7)	30.4
Total: 99 (8)	8.1

Operations – Under-1s	**Mortality rate %**
Total: 29 (11)	37.9

8 The table also compared these results with the results for the four-year period 1984–1987, set out in para 37 of Chapter 22.[10]

9 It was also apparent to those in the Unit that the number of operations was fewer than in the previous year. This was ascribed in part to the effect of building work that was being carried out during 1988.[11]

10 In a table prepared in the UBH and supplied to the Inquiry a comparison was made of the 30-day mortality for children under 1 in the Bristol Unit in the four-year period 1984–1987 and in 1988, with the mortality rate shown in the UK Cardiac Surgical Register (UKCSR) for 1984–1987:[12]

	Operations	**Mortality rate %**
Bristol 1984–1987	74 (20)	27.0
Bristol 1988	29 (11)	37.9
UK 1984–1987	2,069 (457)	22.1

11 A note to the table reported that the mortality rate in the UK was static, at between 21.2% and 23.5%, between the years 1984 and 1987.

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[9] Figures taken from UBHT 0055 0031

[10] See tables at para 32 of Chapter 22

[11] UBHT 0055 0025

[12] Figures taken from UBHT 0055 0035; figures in parentheses are for deaths

12 A comparison was also made of the 30-day mortality for children over 1 in the Bristol Unit in the four-year period 1984–1987 and in 1988, with the mortality rate shown in the UKCSR for 1987:[13]

	Operations	Mortality rate %
Bristol 1984–1987	344	8.1
Bristol 1988	99	8.1
UK 1987	1,657	7.7

13 A further table was produced in the Annual Report showing a comparison between mortality figures for children under 1 at Bristol between 1984 and 1988 and in the 1987 UKCSR:[14]

	Operations	Mortality rate %
Bristol 1984–1988	103	30.1
UK 1987	588	23.5

Of those children treated in Bristol, there had been no deaths in 17 operations for the Atrial Switch procedure: the Sennings operation. Six out of seven who had been operated on for AVSD had died; as did three out of four who had been operated on for TGA plus VSD; five out of six for Truncus Arteriosus; and four out of 11 for TAPVD.[15]

14 The tables also showed a comparison between mortality figures for children over 1 at Bristol between 1985 and 1988 and in the 1987 UKCSR, with the figures divided into groups: simple, moderate and complex surgery:[16]

Operations Bristol 1985–1988	Mortality rate % Bristol 1985–1988	Mortality rate % UK 1987
Simple: 100 (1)	1.0	0.5
Moderate: 206 (12)	5.8	5.7
Complex: 71 (19)	26.8	19.8

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[13] Figures taken from UBHT 0055 0033

[14] Figures taken from UBHT 0055 0036

[15] See Chapter 3 for an explanation of clinical terms

[16] Figures taken from UBHT 0055 0039 – 0040; figures in parentheses are for deaths

Chapter 24 – Concerns 1989

Concerns

1 In 1989 Dr Stephen Bolsin approached Professor Cedric Prys-Roberts, Professor of Anaesthesia at the University of Bristol, about his (Dr Bolsin's) developing concerns. In oral evidence Professor Prys-Roberts indicated that while he was unable to give a precise date:

> 'I can remember clearly the encounter in 1989 because Stephen Bolsin had only recently been appointed.'[1]

2 Professor Prys-Roberts stated in his evidence that Dr Bolsin:

> ' ... expressed his concerns to me about problems in managing small babies following cardiac surgery by Mr Wisheart. He was concerned that the mortality in this group of patients was much higher than he had been accustomed to as a Senior Registrar at the Brompton Hospital, in London. I advised him that rather than create waves with little credible evidence, he would be better advised to collect prospective data on babies and children who he anaesthetised for cardiac surgery in Bristol, so that he could develop a clearer picture of what was going on.'[2]

3 In oral evidence Professor Prys-Roberts confirmed that Dr Bolsin's concerns were 'based on his experience of anaesthetising patients'.[3]

4 Asked about the phrase 'create waves', Professor Prys-Roberts said:

> 'Steve was a person who wanted to broadcast everything and make the whole world aware of what was going on right from the outset. He was not somebody who was introspective about these things. My concern at that stage was that he would say something which he might later regret without having the evidence to back it up and I suggested to him – because I think this is proper medical practice – that what he should do would be to keep records of what he was doing so that at a later date, if things turned out to be as they certainly have done, he would have evidence in the form of a logbook, in the form of other data that he may have collected on a prospective basis, but this was a personal thing. We all keep – I say "we all", I keep a personal logbook of every anaesthetic that I give and I follow up the patients. I think this is proper medical practice and I was advising Steve to do the same.'[4]

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[1] T94 p. 1–2 Professor Prys-Roberts

[2] WIT 0382 0002 Professor Prys-Roberts

[3] T94 p. 3 Professor Prys-Roberts

[4] T94 p. 5 Professor Prys-Roberts

5 Dr Bolsin said that he could not remember the date of the 1989 meeting but speculated:

> 'I suspect it may have been possibly at the time of the Annual Report, or something like that.'[5]

6 Dr Bolsin issued a report of his first year in post on 18 September 1989.[6] He said:

> '… I think that what I was interested in, in the Annual Report, was producing a mechanism whereby we could all constructively review results as they were presented on, let us say, an annual basis, and I think that one of the things that I would have expected, the kinds of meetings that I had outlined as being required in that first Annual Report would have been, "Let us look at bypass times and cross-clamp times and see how they compare with neighbouring centres or centres somewhere else". So I was looking for a framework of acceptability, I was not looking at a hostile document that was going to point up all the serious shortfalls in the Unit as I saw it, because I did not see that as being necessarily a constructive stage at the end of the first year of my contract.'[7]

7 He described the development of his concerns:

> ' … which would have included some mortality data and I suspect probably the report for 1989/90 which you have just shown us, which would have, I think, probably confirmed the concerns that I had. I think what developed in Bristol, in my mind, was the perception of a service that was under-achieving in terms of the outcomes that it should have expected for its paediatric cardiac surgical operations, particularly in the under-1 age group. That was not something that came as a flash of light, it was not a sudden examination of a statistical table, it was not suddenly looking at confidence limits not overlapping; it was a gradual growing awareness of a potential or real problem.'[8]

8 In a letter dated 27 September 1989 Dr Robert Johnson, consultant anaesthetist and Chairman of the Division of Anaesthesia, acknowledged the report and offered support to Dr Bolsin on matters such as '… combined morbidity and mortality meetings between anaesthesia and cardiac surgery'.[9]

9 Dr Bolsin stated that:

> '… throughout my training I had kept a logbook of the patients that I had anaesthetised. I now began to record the outcomes on the patients that I was anaesthetising in the cardiac surgery unit in order to attempt to find the nature of

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[5] T82 p. 68 Dr Bolsin

[6] UBHT 0061 0011 – 0017; *'1st Annual Report of Dr SN Bolsin'*. (This was the only such report issued)

[7] T80 p. 97–8 Dr Bolsin

[8] T80 p. 96 Dr Bolsin

[9] UBHT 0061 0018; letter from Dr Johnson to Dr Bolsin dated 27 September 1989

the problem (if there was one) in the results of paediatric cardiac surgery. The audit commenced in September 1989 and provided some initial assessment of the mortality rates for operations within the paediatric cardiac surgery unit.'[10]

Reports of the performance of the PCS Service in 1989

10 The Unit's *'Paediatric Cardiology and Cardiac Surgery Annual Report'* 1989/90 included tables showing mortality rates for open-heart operations on children aged under 1 year in 1989, and compared this with the UK mortality figure for 1988:[11]

	Patients	**Mortality rate %**
Bristol 1989	40 (15)	37.5
UK 1988	708	18.8

11 This was the first time since reports of this sort began that the UK mortality had dropped below 20%.

12 The Unit's *'Bristol Cardiac Surgery Annual Report'* for 1989 included figures for individual open-heart operations on children aged under 1:[12]

Operations Bristol 1984–1989	**Mortality rate % Bristol 1984–1989**	**Mortality rate % UK 1988**
AVSD (complete): 13 (8)	61.5	19.6
TGA + VSD: 7 (5)	71.4	37.8
Truncus Arteriosus: 8 (6)	75.0	62.9
TAPVD: 16 (7)	43.8	23.4
TGA (Senning): 26 (0)	0.0	10.1

13 As regards open-heart surgery on those over 1 year of age, the *'Bristol Cardiac Surgery Annual Report'* for 1989 included a table, with the figures divided into groups: simple, moderate and complex surgery:[13]

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[10] WIT 0080 0108 Dr Bolsin

[11] Figures taken from the tables at UBHT 0133 0085 and UBHT 0133 0086; *'Paediatric Cardiology and Cardiac Surgery Annual Report'* 1989/90; figures in parentheses are for deaths

[12] Figures taken from the table at JDW 0003 0079; *'Bristol Cardiac Surgery Annual Report'* 1989; figures in parentheses are for deaths

[13] Figures taken from the table at JDW 0003 0081 – 0082; *'Bristol Cardiac Surgery Annual Report'* 1989; figures in parentheses are for deaths

Operations Bristol 1989	Mortality rate % Bristol 1985–1989	Mortality rate % UK 1988
Simple: 36 (0)	0.7	0.56
Moderate: 60 (9)	7.9	7.7
Complex: 14 (4)	27.1	18.2

14 The table also noted that the mortality rate for moderate operations in Bristol for 1989 was 15%. The mortality rate for complex operations at Bristol in the same period was 28.6%.

15 The comparisons between mortality rates in Bristol and the UK were made in the table annexed to the Annual Report. The figures correspond with the returns that the Unit made to the UK Cardiac Surgical Register.[14]

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[14] UBHT 0055 0191; Unit return to the UK Cardiac Surgical Register

Chapter 25 – Concerns 1990

Concerns

Concerns raised by Dr Stephen Bolsin

1 Dr Bolsin, consultant anaesthetist, agreed that his memory for dates and details was not always reliable.[1] He thus could not give the Inquiry any certain date at which he began to gather data about the paediatric cardiac surgical services.

2 Dr Brian Williams, consultant anaesthetist and Chairman of the Division of Anaesthesia 1990–1992, referring to a meeting between himself and Dr Bolsin in the summer of 1990, stated in his written evidence to the Inquiry that Dr Bolsin: 'had no data at the time'.[2]

3 Dr Bolsin himself said:

> '… there was the 1989[3] data, which indicated that we had twice the national average mortality, and it became apparent that there was a possible link between what I had observed as a distinct comparison between the Brompton and Bristol performance and a mortality rate and we then needed to start to look at what were the operations in this mortality rate in which we were achieving a higher mortality rate.'[4]

4 On 7 August 1990 Dr Bolsin sent a letter to Dr Roylance, then the District General Manager, Bristol & Weston District Health Authority (B&WDHA).[5] The second and third paragraphs of this letter dealt with statements which Dr Bolsin considered to be misleading in the appendix to the application for trust status made by the United Bristol Hospitals (UBH). In the fourth paragraph, Dr Bolsin wrote:

> 'Finally, as a paediatric cardiac anaesthetist, I would have thought that the management directive to improving quality of patient care should have attempted to address the unfortunate position of the South West Regional Cardiac Centres' mortality for open heart surgery on patients under one year of age. This, as you may or may not know, is one of the highest in the country, and the problem should be addressed.'

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[1] T80 p. 3; T80 p. 30; T80 p. 140–1 Dr Bolsin

[2] WIT 0352 0026 Dr Williams

[3] This was not available within the Unit until after 31 December 1989. Dr Bolsin must therefore have been talking of a time which at the earliest was in 1990

[4] T82 p. 40–1 Dr Bolsin

[5] UBHT 0052 0290; also UBHT 0061 0019 which is an earlier draft of the same letter dated 25 July 1990. See T80 p. 90–1 for Dr Bolsin's explanation of the differences between the letters

5 Dr Bolsin ended the letter:

> 'I look forward to your reply, which I hope will help to persuade me of the benefits of Trust status for the Cardiac Unit.'[6]

6 Dr Bolsin was asked whether, in writing this letter, his purpose was to question Dr Roylance on some of the aspects of the application for trust status. Dr Bolsin replied:

> 'I think it is more specific than that. What I am actually doing is saying: "You have made some statements in a document which is an appendix to an application for Trust status and deals specifically with cardiac surgery. I am an anaesthetist who has a particular interest in cardiac surgery. I think there are 2 wrong statements in the appendix and I also want you to know about another problem".'[7]

7 Dr Bolsin emphasised that the letter related to paediatric cardiac surgery, rather than being purely a response to the application for trust status. He said: '... it is all in the context of the application for Trust status with specific respect to the Cardiac Unit'.[8]

8 Dr Bolsin said that, by using the phrases 'to address the unfortunate position' and 'the problem should be addressed', the letter was asking for specific action to be taken over 'the problem' with paediatric cardiac surgery. He expected Dr Roylance to confirm whether the allegation was true and then indicate any specific ways in which it could be resolved:[9]

> 'I think it [the letter] actually asks for a solution to a raised concern. Yes, there is a problem, or there is a perceived problem of a mortality rate in paediatric cardiac surgery in the South West Regional Cardiac Centre, and I think it should be addressed. So it is more than raising a concern, it is actually saying, "I think you should do something about this, please".'[10]

9 Dr Bolsin said that this was especially the case as he requested on two occasions in the same paragraph that the problem be addressed, thereby emphasising the request.[11]

10 He continued:

> 'I think my expectation at that time was that this concern which is being raised – which is about a serious problem; it is not the length of a scar or the duration of a hospital stay, this is about the most serious outcome for a medical intervention –

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[6] UBHT 0052 0290; letter from Dr Bolsin to Dr Roylance dated 25 July 1990

[7] T80 p. 93 Dr Bolsin

[8] T80 p. 99 Dr Bolsin

[9] T80 p. 99 Dr Bolsin

[10] T80 p. 99–100 Dr Bolsin

[11] T80 p. 101 Dr Bolsin

> should have been taken up by somebody at the Executive level and they should have put it out on the table and said, “Okay what is the reality behind this concern?”
>
> ‘... I think I would have expected possibly the cardiologists, probably the surgeons, possibly the anaesthetists, with the General Manager as he was then, or another independent person, to have said, “This is a very serious allegation, let us have a look at the results and see if there is any justification in the comment that is made”.’[12]

11 Dr Bolsin said that he believed that, having had a chance to review all the documentation, he had seen the data from the 1989/90 Annual Report before writing his letter.[13] He therefore had the relevant information to make specific reference to the problem of excess mortality in the letter:

> ‘I believe that what I am saying to the Chief Executive is not, “I cannot get any information”, because that request is not made in the last paragraph; what I am saying to him is, “There is a problem and I have seen evidence of a problem, and I have seen evidence of a problem in the under-1 age group”, and I am also saying, “You must address this problem”.’[14]

12 Dr Bolsin addressed the letter to Dr Roylance, and sent copies to various others, probably on the advice of Dr Trevor Thomas, a consultant anaesthetist at UBH and Chairman of the Medical Audit Committee.[15]

13 Dr Thomas saw it as:

> ‘… a letter which Dr Bolsin was writing principally to point out deficiencies or errors in the application for Trust status.
>
> ‘That was the primary purpose of the letter. I know that Dr Bolsin had been disappointed in not getting some equipment which he mentioned specifically in the letter, so he brought me the original to look at.’[16]

14 He continued:

> ‘He showed it to me and said he was going to send it to the Chairman of the Health Authority, and did I think that was right or an appropriate destination for it.

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[12] T80 p. 101–2 Dr Bolsin

[13] T80 p. 107–12; this data is summarised at the end of this chapter

[14] T80 p. 111 Dr Bolsin

[15] T80 p. 116–18; WIT 0080 0108 – 0109 Dr Bolsin

[16] T62 p. 144 Dr Thomas

> ‘I advised him on that draft. I changed the English a little and I said that since he was primarily concerned with the Trust status application, the letter should go to Dr Roylance who was the Executive[17] and who was in the process of putting together the application or who had put together the application for Trust status.[18]
>
> ‘... I also advised him that he should send a copy to the then Chairman of the Health Authority, Mr Mortimer, because he had included as his final paragraph or sentence, a comment on the mortality ... for open-heart surgery on patients under 1 year of age.’[19]

15 Dr Thomas said that by addressing the letter properly, Dr Bolsin was pursuing the correct path in that he was discussing the matter with colleagues:

> ‘He was alerting the District General Manager and the Chairman of the Health Authority, and so the people who could address the problem had been informed of it.’[20]

16 One of the parties to whom a copy of the letter was sent was Mr Christopher Dean Hart, a consultant ophthalmologist, as the Chairman of the Hospital Medical Committee. Mr Dean Hart stated in his written evidence to the Inquiry:

> ‘I heard of no complaints or anxieties about cardiac surgery in Bristol in the course of Trust Board meetings. Nor had I previously at Health Authority meetings which I had attended. I am certain that had I done so, or had Dr Bolsin come to me with his concerns, I would have taken action, just as I had in other difficult cases where clinical performance had been in question. Dr Bolsin did not directly mention to me his specific concerns about the results of paediatric cardiac surgery at any time, whilst I was Chairman of the Hospital Medical Committee, or Medical Director, or subsequently.’[21]

17 Further:

> ‘I believe that anybody receiving complaints about another colleague has an absolute duty to have the matter investigated.’[22]

18 He later continued:

> ‘I was not aware at the time of anything that might have prevented a consultant expressing concerns about the performance of a fellow colleague; ... However, looking back on it, I can now see that it might have been a daunting proposition for

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[17] In fact, he did not become the Chief Executive of the Trust until April 1991, but he was the District General Manager and the anticipated Chief Executive

[18] T62 p. 144 Dr Thomas

[19] T62 p. 145 Dr Thomas

[20] T62 p. 146 Dr Thomas

[21] WIT 0093 0014 Mr Dean Hart

[22] WIT 0093 0015 Mr Dean Hart

> a newly appointed consultant to have forced the issue of the surgeons concerned with the Chief Executive. I am only sorry that I was not consulted as Medical Director or Chairman of the Hospital Medical Committee.'[23]

19 Dr Bolsin's evidence was:

> 'Within a short time of receiving the letter Mr Dean Hart telephoned me while I was working in cardiac theatres and asked to see me immediately. I left the operating theatre and met Mr Dean Hart in the medical staff coffee room in the Post Graduate Education Centre. He asked me what the meaning of the letter was and why I had written it. I explained that Doctor Trevor Thomas had helped me to draft the letter and was aware of the contents. I also confirmed that I was worried about the mortality rate for small children and babies in the BRI paediatric cardiac surgery unit. Mr Dean Hart explained that he had once been put in a similar situation as a junior consultant and that he believed I had been manipulated by a senior colleague.'[24]

20 Dr Bolsin went on to say:

> 'I believe that Mr Dean Hart has forgotten that he was consulted by a junior consultant, who did find it a "daunting proposition". Mr Dean Hart initiated that contact/consultation after I had sent a letter to Doctor Roylance and he had received a copy of that letter. … as far as I know [Mr Dean Hart] undertook no investigation of the paediatric cardiac surgical performance.'[25]

21 Dr Bolsin also stated in his written evidence that the meeting with Mr Dean Hart concentrated on why he had sent the letter to Dr Roylance and the reasons for Dr Thomas' involvement:

> 'There was little recognition of a serious problem within the Department of paediatric cardiac surgery but there was much more concentration on a possible high-level game of medical politics involving me as a pawn.'[26]

22 Mr Dean Hart subsequently accepted, in his written comment on Dr Bolsin's statement, that he must have met with Dr Bolsin at the time, but stated:

> 'If Dr Bolsin had been very concerned at the time that I should be properly briefed about his concerns about paediatric cardiac surgery, then I think that he might well have considered using a stronger line of approach. A copy letter to two other colleagues, where the matters raised were in the last paragraph of a three paragraph letter mainly about his opposition to Trust status, did not suggest that the matter was

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[23] WIT 0093 0015 – 0016 Mr Dean Hart

[24] WIT 0093 0017 Dr Bolsin

[25] WIT 0093 0017 Dr Bolsin

[26] WIT 0080 0109; see also T80 p. 121 Dr Bolsin

> the prime issue of his letter, but rather that it provided additional support on his views on Trust status.'[27]

Mr Dean Hart added that, had he wished to criticise Dr Bolsin, he would have seen him in his office at the Bristol Eye Hospital, rather than in the open, public forum of the Postgraduate Education Centre, which '… was not a venue for other than relaxed conversation'.[28]

23 Dr Bolsin agreed that the meeting was 'relatively amicable', although he said that he was very much ordered out of theatre and was 'in some dread' as to what might be said to him. He also agreed that since the meeting was held in the common room, there could well have been other people around, but said that in fact there were not. Dr Bolsin did not accept Mr Dean Hart's point that it was not the sort of forum in which he would expect to be criticised.[29] He stated:

> 'My disappointment was that he did not really take the concerns expressed in the letter seriously, and I think that that was again possibly a failing of mine in not saying to him, "Well, actually, Mr Dean Hart, you have completely misread the letter and I have serious concerns". But I was not senior enough or confident enough to be able to take that role in that conversation.'[30]

24 Dr Bolsin explained that, in his view, Mr Dean Hart had misinterpreted the letter as being about opposition to trust status:

> '... I do not think he has interpreted it correctly, because the letter was not opposition to Trust status, it was dealing specifically with the appendix to the application for Trust status vis-a-vis cardiac surgery, so it was not in general opposition to Trust status, which is unfortunately it seems the sort of "dustbin" it has been put into ... It was a very specific letter dealing with the appendix to an application for Trust status with respect to cardiac surgery. I would have said that putting those three paragraphs into a letter, sending it to the District General Manager, to the Chairman of the Hospital Medical Committee and to the Chairman of the Health Authority was a reasonably strong expression of a problem which needed to be addressed.'[31]

25 Dr Bolsin said that Dr Roylance dealt with the letter in a similar manner to Mr Dean Hart, reading it in the same way as being to do with the application for Trust status rather than expressing a separate concern:

> 'I think he [Dr Roylance] phoned me up, and took possibly a similar line to Dr Dean Hart that Trust status was going to be good for the unit or whatever,

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[27] WIT 0080 0099 Mr Dean Hart
[28] WIT 0080 0099 Mr Dean Hart
[29] T80 p. 122 Dr Bolsin
[30] T80 p. 123 Dr Bolsin
[31] T80 p. 118–19 Dr Bolsin

> but did not really deal with my perception of the problems, which was that there was a higher mortality rate in the under 1 year old children in Bristol compared to the rest of the country.'[32]

26 Dr Bolsin said that Dr Roylance's tone of conversation was 'dismissive', and thus he was not able to press his concerns:

> '... I was not really in a position to be able to say "Hang on a sec, I really think you should call a meeting of everybody involved and we really have to go through these results". It was not that type of conversation. It was a very one-sided conversation to me in a cardiac theatre at the time and I did not have a lot of input … .'[33]

27 Dr Bolsin said that this was the only contact which he had with Dr Roylance on the matter of his concerns about paediatric cardiac surgery until 1994.[34]

28 Dr Roylance was asked about the letter in his oral evidence in the following exchange:

> 'I rang Bolsin up and talked to him about this letter and I asked him to talk to the Chairman of the Medical Committee about its contents. I knew at the time of a widespread wish to appoint a paediatric cardiac surgeon and to consolidate the service at the Children's Hospital.
>
> 'I told Dr Bolsin, as I did everybody, I tried to tell them very honestly about the influence and the impact of Trust status, that Trust status would neither facilitate nor hinder our attempts to improve paediatric cardiac surgery.
>
> 'Q. You saw this as a letter about Trust status?
>
> 'A. It was about Trust status. I spoke to him about it. You have to read the final thing: "I look forward to your reply which I hope will help to persuade me of the benefits of Trust status for the cardiac unit". It was part of a quite massive consultation with the consultant medical staff.
>
> 'Q. In that last large paragraph, the one beginning "Finally ... ", he is describing the comparative mortality at Bristol and the rest of the country. Was he, did you know, right to say that the mortality of the under-1s in Bristol was one of the highest in the country?

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[32] T80 p. 119 Dr Bolsin

[33] T80 p. 120 Dr Bolsin

[34] T80 p. 121 Dr Bolsin

> ‘A. No, I was accustomed to this sort of exaggerated statement to support the improvements that individuals wanted. Please, I did talk to him. If I misunderstood this as anything other than a letter about the effects of Trust status, he did not disagree with me at the time and I actually — I know this was about Trust status.’[35]

29 Dr Roylance was asked in the following exchange whether the matter referred to in the fourth paragraph of Dr Bolsin’s letter was a separate matter which needed to be addressed:

> ‘A. Yes, but the final paragraph is saying he would like me to reply to these three things to persuade him of the benefits of trust status; that is the thrust of the letter, and the answer is that I could not tell him that trust status was going to address the final issue.
>
> ‘The first two issues were exceptions he took to the application that we had circulated for consultation because the appendix which had been written by the operational services, in other words, the cardiologists and the cardiac surgeons had written those appendices and he took exception to what they said. I could not arbitrate on that. I referred him back to his colleagues through the Chairman of the Medical Committee.
>
> ‘Q. The reference to a specific category, the “open heart surgery on patients under 1 year of age”, might suggest there were figures available, might it not?
>
> ‘A. I do not know why.
>
> ‘Q. It is a specific category, it has been singled out for some reason?
>
> ‘A. I do not follow that, I am sorry.
>
> ‘Q. The suggestion that it is one of the highest in the country led to your saying to him as I understand it “take your anxieties to Mr Dean Hart, the Chairman of the Hospital Medical Committee and explore them there”?
>
> ‘A. Yes.
>
> ‘Q. You understood that there were separate anxieties, anxieties which went beyond the question and issue of Trust status that he was expressing, did you?
>
> ‘A. I knew of the anxieties beforehand, I did not need a letter to know that there was a wish widely through the Trust, not involving everybody in the Trust, but widely in the Trust, a wish to improve paediatric cardiac surgery. He knew that and I knew that.

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[35] T88 p. 67–8 Dr Roylance

> ‘His question is “Will Trust status change our ability to address that?” I told him it did not, we still had the same issue.’[36]

30 Dr Roylance explained in the following exchange that he did not ask Dr Bolsin for his evidence that mortality was ‘one of the highest in the country’:

> ‘A. Because we were discussing Trust status, not figures within paediatric cardiac surgery; that is the nature of the conversation. I have to say that he did not address the same issue to me again until halfway through 1995.
>
> ‘Q. So you never thought because you took this letter as being about Trust status, that there was an assertion here in this penultimate large paragraph that needed either to be verified by statistics or figures or at any rate taken further by you?
>
> ‘A. No, he did not ask me to, I mean, we were discussing at that stage solutions, not evidence to support solutions. What he actually said is “one of the worst”. That meant to me – I am trying to find the exact words – “it is one of the highest in the country”, “one of the highest”.
>
> ‘That suggests to me that there are several in the band of outcome as Bristol. In other words, we were one of those units. Of course he and I would always want us to be at the gold standard or above it. I mean I understood that and I understood the solution and he understood the solution.
>
> ‘Q. You say the solution was a paediatric cardiac surgeon and the amalgamation of the sites?
>
> ‘A. Yes, that was the advice I had at the time and I accepted it, yes.’[37]

31 Dr Bolsin described in his written evidence to the Inquiry the response which his letter evoked from Mr Wisheart:

> ‘A couple of days later Mr Wisheart asked to see me in his office and when I went in I noticed my letter to Dr Roylance was on his desk. On the basis of this letter he proceeded to advise me that I would not be secure in my future in Bristol if I continued to take information about the paediatric cardiac surgery unit to outsiders and he considered Dr Roylance to be an outsider. The tenor of the meeting was of an angry Mr Wisheart rebuking a young consultant who had dared to complain about his unit outside unit Meetings.
>
> ‘The effect of this meeting on me was to confirm my impression that I would not be able to take complaints about the performance of paediatric cardiac surgery through this route in future. This was a very lasting and deep impression on a young and impressionable consultant. There was little doubt in my eyes that Mr Wisheart

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[36] T88 p. 70–1 Dr Roylance

[37] T88 p. 73–4 Dr Roylance

> was prepared to carry out his threats and this belief has been demonstrated to be justified by subsequent events.'[38]

32 According to Dr Bolsin, the meeting lasted about ten minutes or so.[39] Dr Bolsin told the Inquiry that:

> 'The tone of the meeting was that Mr Wisheart was very angry that a young consultant had taken results of the unit outside of the unit and expressed them to non-cardiac colleagues ...'[40]

33 Dr Bolsin referred to: '… a red-faced Mr Wisheart talking very angrily to me about the consequences of taking incidents outside the Unit'.[41]

34 Dr Bolsin said that he understood that in saying if he valued his career in Bristol he would not undertake 'that type of action' again, Mr Wisheart was referring to raising concerns about results and raising them outside the Unit as two specific matters.[42]

35 It was Mr Wisheart's evidence that this meeting did not take place.[43] Dr Bolsin expressed the view that there was a possibility of some 'corporate amnesia' beginning to develop about some of the events in the late 1980s and early 1990s, citing Mr Dean Hart's not remembering his meeting with him (Dr Bolsin) as an example.[44]

36 Dr Bolsin referred[45] to the evidence of Sister Kay Armstrong. This was in relation to a change of attitude she perceived between Mr Wisheart and Dr Bolsin. In her written evidence, Sister Armstrong said:

> 'I was aware, because Dr Bolsin told me, that when he first raised his concerns about our results there was a 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 threatre and there was not the usual "chit-chat" that they would sometimes engage in.'[46]

37 Mr Wisheart told the Inquiry that Dr Roylance did not telephone him, and neither did any of the others to whom copies of Dr Bolsin's letter were sent.[47] When asked

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[38] WIT 0080 0109 Dr Bolsin
[39] T80 p. 127 Dr Bolsin
[40] T80 p. 127 Dr Bolsin
[41] T82 p. 175 Dr Bolsin
[42] T80 p. 133–4 Dr Bolsin
[43] T94 p. 128 Mr Wisheart
[44] T80 p. 138 Dr Bolsin
[45] T80 p. 138 Dr Bolsin
[46] WIT 0132 0060 Sister Armstrong
[47] T94 p. 125–6 Mr Wisheart

whether he thought that the letter was an appropriate route by which to express the concerns raised in it, he replied:

> 'It was certainly a route. I would have thought it would have been appropriate also for him to raise it with his more immediate colleagues. I certainly would not dream of saying he should not have drawn it to the attention of Dr Roylance. I think what I would say is, I would have been surprised that he would have done that without drawing it to the attention of his more immediate colleagues, I think that would be the right way to put it.'[48]

38 Mr Wisheart confirmed that when he talked of drawing the letter to the attention of 'his more immediate colleagues' he meant to his attention.[49]

39 Mr Wisheart told the Inquiry that, for his part, he had: '... absolutely no recollection of seeing this letter or any of the consequences that I have since become aware of that are stated to have followed it ...'.[50]

40 Mr Wisheart was asked about Dr Bolsin's account:

> 'Q. It is suggested by Dr Bolsin that indeed he did speak to you some time in the autumn after this letter was written and you were hostile to him with a copy of the letter on your desk, in effect telling him off for approaching matters in this particular way. That is his recollection; did it happen?
>
> 'A. I do not believe it did.'[51]

41 Mr Dhasmana, who at the time shared an office with Mr Wisheart, told the Inquiry that he had no knowledge of the letter and that Mr Wisheart was very open regarding matters which concerned the Unit.[52] Mr Dhasmana said:

> 'I believe if he had any concern with paediatric cardiac surgery, expressed to him directly or indirectly, he would have mentioned it to me.'[53]

42 In particular, Mr Dhasmana said that had Mr Wisheart received such a letter as the one from Dr Bolsin to Dr Roylance, he believed that Mr Wisheart would normally have discussed it with him.[54]

43 Dr Roylance told the Inquiry, in the following exchange, that he did not show the letter to Mr Wisheart:

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[48] T94 p. 126–7 Mr Wisheart
[49] T94 p. 127 Mr Wisheart
[50] T94 p. 127 Mr Wisheart
[51] T94 p. 128 Mr Wisheart
[52] T86 p. 88 Mr Dhasmana
[53] T86 p. 89 Mr Dhasmana
[54] T86 p. 89 Mr Dhasmana

> ‘Q. Mr Wisheart was not one of the nominated recipients; did you send him a copy?
>
> ‘A. No.
>
> ‘Q. Did you tell Mr Wisheart of the letter?
>
> ‘A. No.
>
> ‘Q. Did you speak to anyone else as you recollect about that particular letter?
>
> ‘A. I think the then Chairman of the Division of Anaesthetics spoke to me some time later, Dr Brian Williams.’[55]

44 The other two people to whom copies of the letter were sent were Mr Geoffrey Mortimer, as Chairman of the Bristol & District Health Authority (B&DHA), and Dr Brian Williams, as Chairman of the Division of Anaesthesia.

45 Dr Bolsin said that Mr Mortimer did not speak to him about the letter.[56] Dr Williams did. Dr Bolsin described Dr Williams’ reaction:

> ‘He was pretty horrified by the letter and wanted to know why on earth I had done it. He did not understand that I had spoken to Trevor Thomas about the letter before I had even sent it, and when I explained that, he still I think could not quite understand what I was doing sending off this letter. But I explained what was in the letter and he seemed more — I would not say contented, but he seemed to accept what I said.’[57]

46 In his written evidence to the Inquiry, Dr Williams stated that he ‘expressed concern’ at Dr Bolsin’s decision to send the letter without any prior discussion of the issues. Dr Bolsin had explained that Dr Williams was on leave at the time and that he had discussed the matter with Dr Thomas.[58] Dr Williams stated that:

> ‘I confirmed my own and the Directorate’s support for his objective to improve paediatric cardiac mortality, at the same time pointing [to] the difficulties we might face as a result of the somewhat confrontational style to his letter.’[59]

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[55] T89 p. 101 Dr Roylance

[56] T80 p. 124 Dr Bolsin

[57] T80 p. 124 Dr Bolsin

[58] WIT 0352 0026 Dr Williams

[59] WIT 0352 0026 Dr Williams

47 Dr Williams stated that he subsequently raised the subject of the letter directly with Mr Wisheart:

> 'When I met with Mr Wisheart he expressed annoyance at the content, style and distribution of Dr Bolsin's letter.'[60]

48 Mr Wisheart told the Inquiry that he had no memory of this conversation with Dr Williams taking place.[61]

49 Dr Williams further stated that he discussed the content of the letter with other cardiac anaesthetist colleagues, who also expressed concern at the level of paediatric cardiac mortality, and that he reported back to the Chief Executive, Dr Roylance, on the content of all his discussions.[62]

50 Dr Bolsin told the Inquiry that shortly after sending the letter, he was advised to keep a low profile, so far as raising questions about paediatric cardiac surgery in the way in which he had chosen was concerned:

> '... in 1991, [at] a meeting of cardiac anaesthetists with the Director of Anaesthesia and the President of the Association of Anaesthetists, … Dr Baskett, a cardiac anaesthetist, said "Steve Bolsin should not be the vehicle for criticism of the paediatric cardiac surgery service". Peter Baskett, who is a territorial army officer, actually said "Steve has to keep his head down. He has had enough flack from this letter", and Brian Williams and Chris Monk have to take this on.'[63]

51 Dr Monk told the Inquiry that the advice to Dr Bolsin was that the letter was an inappropriate way forward and one which had upset colleagues.[64]

52 He went on:

> 'I cannot recall this letter being discussed at the meeting. The effect of the criticism of Dr Bolsin in raising it this way may well have been discussed and, therefore, Dr Bolsin's profile would have been higher than perhaps was thought suitable to raise the paediatric switch programme with Mr Wisheart.'[65]

53 Dr Monk continued:

> 'It was taken forward, and the task was given to Dr Williams and myself, as Liaison Consultant. The form in which it was taken forward was not discussed.'[66]

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[60] WIT 0352 0027 Dr Williams

[61] WIT 0352 0038 Dr Williams; T94 p. 132 Mr Wisheart

[62] WIT 0352 0027 Dr Williams

[63] T80 p. 139 Dr Bolsin

[64] T73 p. 84–5 Dr Monk

[65] T73 p. 86–7 Dr Monk

[66] T73 p. 88 Dr Monk

54 Dr Williams stated:

> ‘My recollection is that no-one supported the way in which Steve Bolsin had raised the issue but all were fully supportive of his efforts to obtain appropriate data to assess the problem more accurately in an endeavour to improve results.’[67]

Concerns expressed by South Western Regional Health Authority (SWRHA)

55 In November 1990 Miss Catherine Hawkins, Regional General Manager, SWRHA, received feedback from her District General Managers about concerns[68] which they had with the Bristol Service.

56 Miss Hawkins told the Inquiry that she had a meeting with colleagues from Exeter towards the end of 1990:

> ‘What would have happened was that the AGM [Assistant General Manager] for those areas would have been coming back to talk with my officers about what should go on the agenda for discussion, so there would have been informal contacts about “When I was discussing this, I picked up ...”. So that would have been happening round about October time.’[69]

57 Miss Hawkins said that the concerns expressed were:

> ‘… the contracting was not satisfactory, services they did not feel very happy with and that they were considering moving contracts at the first available opportunity. … the first contracts would have been arranged by Region, which is why we would have been reviewing at this stage whether they were satisfactory or not, because districts had not set up a contracting mechanism. They were doing that during 1991, ready to take over in 1992.’[70]

58 Miss Hawkins agreed that the dissatisfaction was with the process of contracting and the difficulty of getting a price and agreement from the business managers.[71]

59 As regards her raising those concerns with Dr Roylance, she said:

> ‘They would have been a part of his review as a provider unit. Because they would have been still District Health Authority controlled in 1990, they would have still had a formal review with us.’[72]

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[67] WIT 0352 0037 Dr Williams

[68] T56 p. 92–3 Miss Hawkins

[69] T56 p. 88 Miss Hawkins

[70] T56 p. 89 Miss Hawkins

[71] T56 p. 90 Miss Hawkins

[72] T56 p. 93 Miss Hawkins

60 She went on:

> '… I cannot possibly believe that I have had that information and not conveyed it to him at a review.'[73]

61 Miss Hawkins summed up the position as she saw it in 1990 and 1991, in the following exchange:

> 'Q. And why did you have reservations?
>
> 'A. Because I do not think, if you get grumbles coming and then fading and then coming again, and then fading, coming again, it is like a rumbling appendix, something is wrong; something is not quite right. You may not be able to put your finger on it or discover it, but it needs monitoring and watching.
>
> 'Q. So you had this unease and you conveyed the unease to the DHSS,[74] did you?
>
> 'A. I would have conveyed that to the Trust team from the Department, who were assessing at that time whether these acute or community units should go forward for Trust status, and I would not have thought it was something to stop them going forward to Trust status, but it would have been something to register with them because they were going to be monitoring them.
>
> 'Q. So you let them know so they could keep an eye on it?
>
> 'A. Yes, because Trusts were not finalised or agreed until the end of March 1991, but they needed to be aware that maybe there was something that needed to be kept an eye on – not the least that if other districts decided to move their cases from there, then part of that unit would not be viable. That had big financial implications.'[75]

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[73] T56 p. 93 Miss Hawkins

[74] Department of Health

[75] T56 p. 83–4 Miss Hawkins

Report of the performance of the PCS Service in 1990

62 A table prepared in the UBH and supplied to the Inquiry gave figures for open-heart operations in 1990:[76]

Operations – Over-1s	Mortality rate %
95 (16)	**16.8**

Operations – Under-1s	Mortality rate %
39 (5)	12.8

63 The number of open-heart operations had dropped from 150 in 1989 to 134 in 1990.

64 Detailed tables, showing different procedures, were produced for the over-1 age group for the purposes of comparison.[77] Of the 'complex' operations performed between 1985 and 1990, 30.8% of patients died following surgery in Bristol. The figure for the UK for 1989 was shown as 18.2%.

65 A further table showed 30-day mortality figures for open-heart surgery for the under-1s between 1984 and 1989, and 1990, compared with the mortality rate in the UK for 1984–1988, as reported by the UK Cardiac Surgical Register:[78]

	Operations	Mortality rate %
Bristol 1984–1989	143 (46)	32.2
Bristol 1990	39 (5)	12.8
UK 1984–1988	2,777 (590)	21.2

66 A further table sought to analyse open-heart surgery on the under-1s by procedure. Eight deaths out of 13 in the 'AVSD (complete)' group were shown for the period from 1984 to 1989: in 1989–1990 there were no deaths in five operations. No operations were performed for the diagnosis 'TGA plus VSD' in 1989–1990. One operation had been performed in 1989–1990 for 'Truncus Arteriosus':[79] the patient died.[80]

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[76] Figures taken from Table 1 at UBHT 0055 0082; figures in parentheses are for deaths

[77] Figures taken from Table 5 at UBHT 0055 0086

[78] Figures taken from Table 7 at UBHT 0055 0088; figures in parentheses are for deaths

[79] See Chapter 3 for an explanation of these clinical terms

[80] Figures taken from Table 8 at UBHT 0055 0089

67 Closed-heart surgery on children over 1 year of age was reported to have a mortality rate of 2.4% over the six years from 1985 to 1990 inclusive, compared with the UK 1988 rate of 2%. In the under-1s, a 9.9% mortality was recorded compared with 6.2% in the UK in 1988.[81]

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[81] Tables 9 and 10 at UBHT 0055 0090 and UBHT 0055 0091

Chapter 26 – Concerns 1991

Concerns

Accreditation of a training post in cardiology by the Royal College of Physicians

1 On 17 January 1991[1] Dr Elliot Shinebourne, a paediatric cardiologist at the Royal Brompton Hospital, visited Bristol Royal Hospital for Sick Children (BRHSC) as a representative of the JCHMT[2] in order to assess the establishment of a senior registrar post in paediatric cardiology.[3] After the visit Dr Shinebourne recommended that the training post not be accredited, 'essentially because of the split site'.[4]

2 Dr Robin Martin, consultant cardiologist, told the Inquiry about his application for a senior registrar post in paediatric cardiology:

> 'A. … I applied to the Joint Committee on Higher Medical Training for approval of a post … it might have been 1990 when I actually made the application. We were visited by Dr Shinebourne to look at the potential setup of the post that we proposed and the training opportunities that it gave. …
>
> 'Q. … His recommendation was that there should not be accreditation; am I right?
>
> 'A. Yes, that is correct.
>
> 'Q. The basis for that was what?
>
> 'A. I think he accepted that we had plenty of cardiological throughput and training opportunities. As I remember, his main objection, or main concern, was the separation of the two sites for surgical care and it is an important part of training for the senior registrar, as it was then, the specialist registrar, to have input and participation in post-operative care of open-heart cases. That is specified in the training programme. He was concerned that that would not be feasible.'[5]

3 Dr Stephen Jordan, consultant cardiologist, explained in the following exchange:

> 'A. My recollection is that they had no problems with the investigational side but they did not like the fact that there was no open-heart surgery on the same site, that is the Children's Hospital, and there was no involvement or there was no planned involvement in post-operative care which they considered was an essential part of training.

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[1] UBHT 0195 0015; programme for the day, addressed from BRHSC to JCHMT

[2] Joint Committee on Higher Medical Training of the Medical Royal Colleges

[3] Approval was needed from the Royal College of Physicians (RCP) before a post could be designated as a training post

[4] T90 p. 27 Dr Joffe

[5] T77 p. 45–6 Dr Martin

> 'Q. There is no reason particularly why you should, Dr Jordan, have considered the evidence Dr Shinebourne gave at the GMC hearings. He said there "The paediatric cardiologists in Bristol were pretty much divorced from post-operative care" … That was one of his two main concerns: one was the split site for surgery and the other was a lack of involvement in post-operative care?
>
> 'A. Yes.
>
> 'Q. The hypothetical senior registrar in paediatric cardiology who might be appointed, when he or she came to the hospital Dr Shinebourne's concerns would be they would not be properly exposed, if you like, to the surgery and to the post-operative care?
>
> 'A. That is correct.'[6]

4 Dr Hyam Joffe, consultant cardiologist, told the Inquiry about the lack of support for the consultant paediatric cardiologists:

> '… we did not have a regular substantive post as senior registrar [in paediatric cardiology] until 1992 or 1993. And of course this put us all under great duress. We had applied, I think, two or three times and … the penultimate [visit], was when Dr Shinebourne came to visit Bristol.'[7]

5 Dr Stewart Hunter, consultant in paediatric cardiology, told the Inquiry how the senior registrar post was eventually approved:

> 'A. …There had been a previous visit about a year before by a Dr Shinebourne from the Brompton Hospital, and he had decided not to give full approval because of the problems which he considered in the split-site geography: that it was difficult, he felt, to maintain a good level of supervision of the junior staff between the two sites. The people at the Children's Hospital then asked the JCHMT if they could have a follow-up visit, because they had by then plans to first of all move more onto the children's site, but also that they had plans in the long term to join the two sites together. I therefore made the follow-up appointment. I personally did not feel that the two-site geography invalidated the training process. I have other views about the management of patients, but it did not invalidate the training process, and I said so, as a result of which, the senior registrar post in paediatric cardiology was accredited following my visit.'[8]

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[6] T79 p. 159–60 Dr Jordan

[7] T90 p. 58 Dr Joffe

[8] T60 p. 117 Dr Hunter

Audit meeting 28 July 1991

6 On 28 July 1991 there was a meeting of the Paediatric Cardiac Surgical and Anaesthetic Group. Dr Christopher Monk, consultant anaesthetist, described this as one of a series of meetings which had been held at which the paediatric cardiologists, paediatric cardiac surgeons and paediatric cardiac anaesthetists met to discuss the performance of the Unit and the treatment protocols for children. He told the Inquiry that the meetings were used as a forum to look at ways in which they could develop the service and to reflect upon any problems encountered in the past year.[9] This particular meeting was between the surgeons and the anaesthetists to discuss the specific problem of pulmonary hypertension.[10]

7 Dr Jordan expressed the view that such meetings were 'regular but infrequent informal meetings' which took place in people's houses, which were not ever minuted.[11] On this occasion, however, Dr Stephen Bolsin, consultant anaesthetist, produced minutes of the meeting. The introduction to the minutes stated:

> 'By way of introduction to the meeting, Mr Wisheart provided tables of open and closed cardiac surgery results for the Bristol Paediatric Unit. Comparisons were made in this data for mortality in the Bristol Cardiac Unit in 1990 and the UK national average in 1988. Mr Wisheart said that he thought that the tables demonstrated that the problem which had thought to have been reaching crisis proportions in the Bristol Unit, when put in context, was actually not as serious as had been thought.
>
> 'Dr Bolsin said that he thought that the data in the tables in which the Bristol mortality was higher than the UK average for 2 years prior, vindicated the vigilance of the anaesthetic staff in recording their mortality data and vigorously pursuing requests for a combined meeting. This point of view was supported by Dr Burton, Dr Masey and Dr Monk.'[12]

8 Dr Bolsin described his approach to the meetings as follows:

> 'The meetings in people's houses did not have agendas and I was trying to formalise this type of discussion because I felt this was a point at which we could actually begin to constructively decide what we were doing well and what we were doing badly and if we were doing something badly then to make sure we did not keep on doing it badly.'[13]

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[9] T73 p. 92–3 Dr Monk
[10] T73 p. 93 Dr Monk
[11] WIT 0099 0019 Dr Jordan
[12] UBHT 0061 0146; Dr Bolsin's covering letter and distribution list is at UBHT 0061 0145
[13] T80 p. 160 Dr Bolsin

9 Dr Bolsin said that the Group did not accept the minutes. He explained that by saying 'vindicated the vigilance of the anaesthetic staff in ... vigorously pursuing requests for a combined meeting' he was indicating that he was pleased that, as anaesthetists, they had been able to bring about this combined meeting where they had been able to share figures.[14]

10 Asked about the terminology of his minute, Dr Bolsin said:

> 'I think I am summarising certainly the feeling of Dr Burton, Dr Masey, Dr Monk and myself that the anaesthetists had now managed to get hold of some data which indicated we were probably improving some of our operative records but it may be some of the others were staying the same.'[15]

11 Dr Bolsin said that the position he took at the meeting was that he would not, on his own, want to put forward data, make a complaint, or make a criticism. He said this was because he had been advised that was not the way to go about it and, following what he saw as his having been warned off by Mr Wisheart,[16] he had been advised to keep his head down. He said that he was happy to take the lead in representing a common point of view with the other anaesthetists:

> 'I was not prepared to say it on my own, I was only prepared to document it with the support of the others.'[17]

12 Dr Bolsin said that the phrase attributed to Mr Wisheart, 'Mr Wisheart said that he thought the tables demonstrated that the problem which had been thought to have been reaching crisis proportions in the Bristol Unit,' referred to the fact that in 1989 the results showed that, for open-heart surgery on children under 1 year, Bristol had a mortality rate which was twice the national average:[18]

> 'I think what that was referring to was the fact in the preceding year there had been this very clearly expressed concern which had got to the level of the District General Manager about a national average mortality in the under 1 years – mortality at Bristol which was twice that of the national average and we now had figures presented at this meeting for the first time in which the mortality rate had dropped down to ... probably a third ...
>
> 'This was very reassuring and I think that moves us into paragraph 2 where we are talking about this vindicating the vigilance of the anaesthetic staff in recording their mortality data and Dr Masey and I both recorded our mortality data in logbook form and also minuted their "vigorously pursuing requests for a combined meeting".'[19]

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[14] T80 p. 166–7 Dr Bolsin
[15] T80 p. 166–7 Dr Bolsin
[16] See Chapter 25
[17] T80 p. 169 Dr Bolsin
[18] T81 p. 2–3 Dr Bolsin
[19] T81 p. 3–4 Dr Bolsin

13 Dr Bolsin added:

> 'There was a degree of satisfaction on my part. I think we come back to the point that these minutes were not accepted by the Group, but certainly what I wanted to document was my satisfaction at having identified a problem which may have been of crisis proportions or certainly close to, that vindicated the vigilance of the anaesthetic staff in recording their mortality data and asking for meetings and that this seemed to have improved the mortality rate.'[20]

14 Dr Bolsin was asked about the fact that the minutes were not accepted by the Group:

> 'I thought I was reflecting what the Unit told me, but I was subsequently told after producing these minutes that they were not representative and I was not to produce them ever again.'[21]

15 Dr Bolsin was asked whether it was phrases such as 'vindicated the vigilance' and 'vigorously pursuing' that led to the minutes not being accepted:

> 'It is a very long minute, it goes over three or four pages and I am not sure what it was about the minutes that were particularly offensive to the people who objected to it to me, which were Mr Wisheart and Dr Masey. What I was trying to do was encapsulate a meeting that probably went over three or four hours and I felt they were useful phrases in encapsulating the feelings that certainly I was expressing and I thought I was capturing in other people at that meeting.' [22]

16 He continued:

> 'I do not think any particular phrases were picked out, I think it was "We do not want this minuted and we do not want you to take minutes in future", that was the message that I received from Dr Masey and Mr Wisheart.' [23]

17 Asked whether the minute may have been viewed as provocative, Dr Bolsin said:

> 'I do not think it is particularly provocative in view of the historical context in which the data that was presented at the meeting was placed. If you say "Here is a mortality rate twice the national average, here is a mortality rate that is a lot better", certainly something has to be vindicated in bringing down that rate and if it happens to have been the anaesthetists who believed that their data collection has helped them to achieve that fall in mortality rates along with other changes in management, which are discussed later in the minutes, then I would not see that as

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[20] T81 p. 5 Dr Bolsin

[21] T80 p. 160 Dr Bolsin

[22] T81 p. 5–6 Dr Bolsin

[23] T81 p. 6 Dr Bolsin

> being provocative, I would see that as what you said earlier on, as being self-congratulatory and I would allow that group to be self-congratulatory.'[24]

18 In his written statement to the Inquiry Dr Bolsin stated that:

> 'The first [PCS audit] meeting I attended was unminuted with no agenda and consisted mainly of a general overview of progress within the Unit without addressing key areas of under performance. At the next meeting I attended I took notes and circulated minutes of the meeting at a later date ... The minutes were deemed by Mr Wisheart and Dr Masey to have not corresponded with their memory of the audit meeting and I was told that I would not be required to take minutes of audit meetings in future. This rebuff to my constructive approach to the problem of performance in the paediatric cardiac surgery unit led me to believe that there was unlikely to be a constructive approach to audit in the near future. My attendance at the meetings was reduced as I did not believe they were a useful path to quality improvement for the future and my efforts to achieve constructive change were neither recognised nor welcome.'[25]

19 Mr Wisheart commented on Dr Bolsin's statement:

> 'I do recall the unease with which his minutes of the meeting of 28th July 1991 were received ... At the subsequent meeting, as I remember it, this was expressed by his anaesthetic colleague or colleagues but not by me, although I did agree with them. The reason for unease was that the minute contained a partisan element which had not been present at the meeting. To describe this incident as a "rebuff" leading to the conclusions referred to above, is to magnify a minor incident out of all proportion.'[26]

20 Dr Bolsin responded in his oral evidence:

> 'Mr Wisheart obviously has a good memory for minor incidents and I think that being asked not to take minutes again of that type of meeting is more than just a minor incident, that is actually a major change in policy and I think that to me could be interpreted as a rebuff.
>
> 'I think we are moving into the area of semantics but here we have the senior paediatric cardiac surgeon saying that he remembers there was some unease at that meeting about the taking of minutes or the future taking of minutes and I think that confirms what I said, which was that I believe I was seriously ordered not to take minutes of future meetings.

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[24] T81 p. 6–7 Dr Bolsin

[25] WIT 0080 0108 Dr Bolsin

[26] WIT 0080 0319 – 0320 Mr Wisheart

> 'I think if somebody says at a meeting "This is simply not good enough" I think that is probably a phrase that is worth documenting. I personally do not necessarily support the production of anodyne minutes, I produce minutes which reflect the conclusions and the opinions expressed at the meeting and I think that is just me and my minute taking. I think if you want me to change my minute taking, fine, tell me what you think is wrong with my minutes, but do not say "We do not want these meetings minuted" or "We do not want these meetings minuted by you".'[27]

21 When Dr Sally Masey, consultant anaesthetist, was referred to the minutes during her oral evidence to the Inquiry, she told the Inquiry that they 'do look familiar' and it was 'my impression that I have seen them before', although she could not remember whether it was an agreed minute of the meeting or not.[28]

22 Concerning Dr Bolsin's statement that he was told not to produce any further minutes, there was the following exchange with Dr Masey:

> 'Q. If I suggested to you that Dr Bolsin has said that he was asked not to produce any more of these notes, what would you say?
>
> 'A. I would have no comment to make on that. I do not recall myself asking him not to do this.
>
> 'Q. Do you recall asking him to do it or not to do it?
>
> 'A. I do not recall either of those.'[29]

23 Mr Janardan Dhasmana, consultant cardiac surgeon, agreed that the introduction to the minutes was expressing a sense of relief that was held by the whole Unit that the figures for 1990 showed a considerable improvement, the success being ascribed to the management of pulmonary hypertension.[30] He disagreed, however, that there was a 'crisis' in the Unit:

> 'Q. … is it right until the 1990 results came out there had been a sense that there was something of a crisis in the Unit because the outcomes were not as good as they should be?
>
> 'A. No, I would not say that. I would say concern, but not "crisis".

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[27] T81 p. 7–10 Dr Bolsin

[28] T74 p. 72 Dr Masey

[29] T74 p. 73 Dr Masey

[30] T86 p. 68 Mr Dhasmana

> ‘Q. So you take issue with the words “crisis proportions”?
>
> ‘A. I think “crisis” is a little bit of an exaggeration, I would say, but of course there is a concern, and the concern would be there, if you have the mortality which appears to be on the high side, even if you put a statistical range on it.
>
> ‘Q. If we look on, the problem, when put in context, missing the words “crisis proportions”, was not actually as serious as had been thought. Is the problem referred to there the problem that Bristol’s results were out of step with the UK’s if one looked at the 1989 data and earlier?
>
> ‘A. I would accept that.
>
> ‘Q. The context is the context provided by the 1990 results?
>
> ‘A. The improvement noticed, yes.’[31]

24 Mr Dhasmana reflected on the accuracy of the minute:

> ‘Q. … when you read the minute through, did you think that it was a fairly accurate record of what had been discussed, or not?
>
> ‘A. I mean, looking back, what I know now and various things, I am getting into looking very critically about the use of the word “crisis” and the use of the word “vigilance” and things like that. But at that time, I mean, I saw it and I did not really notice any difference, or —
>
> ‘Q. So it did not strike you at the time as being out of place?
>
> ‘A. No.’[32]

25 Mr Wisheart was asked whether at the meeting he had used words to the effect that the problem had reached crisis proportions. There was the following exchange:

> ‘A. The quick answer is that I cannot remember, but I think it is probably unlikely. I think that this is probably an interpretation of what I said. But I mean, I cannot recall, so I cannot be sure.

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[31] T86 p. 69–70 Mr Dhasmana

[32] T86 p. 71–2 Mr Dhasmana

> ‘Q. Had you, then, allowing for an element of hyperbole, been suggesting that the results had been grim but now looked as though they were better?
>
> ‘A. I think what is reflected by this phrase, whether I used the words or not, is the fact that in 1988 and in 1989 the results in the under-1s had been disappointing, previous years having been as we discussed, I believed, acceptable.
>
> ‘So we had been recognising and discussing those particular problems and that is what is reflected here. Whether the words are accurate or not I do not think is particularly important, but that is what we had been dealing with.’[33]

26 Dr Monk was asked whether the words ‘thought to have been reaching crisis proportions’ were an accurate reflection of what was said at the meeting. He replied:

> ‘I do not recollect that we were describing it as a crisis, and I think that this is a recollection put in the terms of Dr Bolsin’s own thoughts on that meeting. It was not a meeting of such heat or emotion that we would be going around saying: “We have a crisis”, and, therefore, that would not be my recollection of the tenor of the meeting.’[34]

27 Dr Monk did not agree that Dr Bolsin’s minute was saying that, if there had been a crisis, it was now over, and people were more prepared in retrospect to talk about it. Instead, he said that what he took the minute to be saying was that the problem was not as serious as had been thought.[35]

28 He did, however, agree that, from the fact that they were at this meeting discussing how to improve outcome, it could be deduced that Mr Wisheart was aware of the figures and of the problems of high mortality rates.[36]

29 Dr Monk was asked if he knew how poor the surgeons or anaesthetists had thought, prior to this meeting, that the figures probably were:

> ‘The anaesthetic opinion on the performance of the Unit varied between individuals. There was a spectrum of opinion, and it was expressed by the anaesthetists differently, and there was a range with, I suspect, Dr Bolsin on one end of the spectrum and others at the other end, and, therefore, our own perceptions of the performance varied markedly.
>
> ‘Q. Where were you in the spectrum?
>
> ‘A. I was closer to the Bolsin end than the other side.’[37]

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[33] T94 p. 86–7 Mr Wisheart

[34] T73 p. 96 Dr Monk

[35] T73 p. 96–7 Dr Monk

[36] T73 p. 97 Dr Monk

[37] T73 p. 99 Dr Monk

30 Dr Jordan, who was not present at the meeting, said that he himself never saw any data about paediatric cardiac surgery in Bristol compiled by Dr Bolsin, either directly or through a third party.[38] He was asked whether he could think of anything that might have been happening at the time that could justify the reference to a problem as reaching 'crisis proportions', but actually was not as serious as was thought. He replied:

> 'I was not aware of anything that could remotely be described as "assuming crisis proportions" ... that related to cardiology or cardiac surgery at that time.'[39]

Autumn 1991

31 Professor Prys-Roberts, Professor of Anaesthesia, University of Bristol, stated in his written evidence to the Inquiry that in October 1991 Dr Bolsin had a further discussion with him:

> 'Dr Bolsin … showed me some preliminary data which he had gathered between 1989 and 1991. These data, for paediatric cardiac operations at the Bristol Royal Infirmary, appeared to show a higher mortality than in other cardiac units. I cannot remember precise details because Dr Bolsin did not give me a copy of the data. I suggested that he should continue to keep accurate records of prospective cases, and their outcome; and that he would then be able to make comparisons between his data, and those of other anaesthetists, who were known to him, who were involved in paediatric cardiac surgery in the UK and elsewhere. I did not regard this as a "secret" or "confidential" audit, as has been suggested by others, nor did I "sanction" such a process in any official capacity. I had no authority to do so.'[40]

32 Dr Bolsin was asked about the date of this meeting and replied:

> 'I am not going to deny that this conversation took place, but I cannot remember it. I mean, it fits in with the events. I was collecting data and showing it to just about everyone. I showed it to Dr Clements and a lot of other people and this is consistent with my actions at that time.'[41]

33 On 11 October 1991 Professor John Norman, Department of Anaesthetics, University of Southampton, wrote to Professor Prys-Roberts:

> 'Three of your younger cardiac anaesthetists have approached Tom Abbott – one of our cardiac team – to say they are extremely worried about the results of cardiac surgery in Bristol and the conduct of bypass. They claim the mortality in Bristol is very much higher than that in other centres. I believe some concern has also been expressed in other quarters. The anaesthetists are apparently unsure as to how to proceed.

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[38] T79 p. 95 Dr Jordan

[39] T79 p. 97 Dr Jordan

[40] WIT 0382 0002 Professor Prys-Roberts

[41] T82 p. 67–8 Dr Bolsin

> 'Without instituting any formal enquiries, Tom Abbott is very willing to help. From his private discussions with the team, it seems to be partly a matter of establishing good protocols and standards.
>
> 'Would you be willing to use your good offices to get your cardiac team to discuss matters with Tom. It may be that if they, as individuals, could come over and see how things are done here and for Tom to spend some days across in Bristol. Some advice may resolve the problems.
>
> 'I hope you don't find this intruding into local affairs but your colleagues are worried about the service and if it can be helped by advice from Tom, we are only too willing to help.'[42]

34 Professor Prys-Roberts described Professor Norman as:

> '… a Professor of Anaesthesia in Southampton who was a close colleague of mine in the sense we have worked together in the Royal College of Anaesthetists a great deal and he was expressing here a view that had concerned him.
>
> 'John Norman, as you can see in the letter, expressed the concern and offered the help of Tom Abbott who was a senior consultant involved in cardiac anaesthesia in Southampton, which was one of the centres which was reputed at that stage to have very good results especially in paediatric cardiac surgery, and I did not show the letter, but I discussed the contents of the letter with Dr Peter Baskett.'[43]

35 As a result of the letter, Professor Prys-Roberts had a conversation with Professor Norman:

> 'I had a discussion with John, an informal discussion about it, and he said he did not know who the three specific people were, but that Tom Abbott had approached him.'[44]

36 Professor Prys-Roberts said that he did not speak to Dr Abbott personally.[45]

37 After considering the letter Professor Prys-Roberts said:

> 'I spoke to Dr Peter Baskett who is one of the senior cardiac anaesthetists and said I had this letter from John Norman and that Tom Abbott, who Peter Baskett knew perfectly well, had offered to be of assistance if assistance was needed and Peter said, yes, he would contact Tom Abbott and that is the last I heard of it.'[46]

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[42] WIT 0382 0006; letter from Professor Norman to Professor Prys-Roberts dated 11 October 1991

[43] T94 p. 25–6 Professor Prys-Roberts

[44] T94 p. 26 Professor Prys-Roberts

[45] T94 p. 26 Professor Prys-Roberts

[46] T94 p. 26 Professor Prys-Roberts

38 Professor Prys-Roberts said he did 'not specifically' ask Dr Baskett what he had done in response to the issue that had now been raised. He said that if any further follow-up needed to be made it would have had to be made through Dr Baskett.[47]

39 Professor Prys-Roberts described his reaction to the letter:

> 'It simply made me more aware of things that I knew were concerning Dr Bolsin and I was not sure – when it said "three of your young cardiac anaesthetists" I was not sure whether that was people who were existing in Bristol at that time or people who had been in Bristol and moved to Southampton. It was simply another expression of concern.
>
> 'I had spoken to Steve Bolsin, I had spoken with the other cardiac anaesthetists off-the-cuff in the corridor and said "There is a growing perception of a problem; do you think there is any aspect of this which is directly related either to the anaesthesia which is being given or to the intensive care of the patients afterwards?" and the answer was a resounding "No" from all of them. My perception was there was a problem which was manifest in, not only a death rate but a complication rate within the Unit which was causing concern to the people in the Unit. As I was not a cardiac anaesthetist and not involved in the clinical service, they were not asking me to become involved other than simply to keep Steve Bolsin advised as to how to go about things.'[48]

40 In response to a query from the Chairman as to whether Professor Prys-Roberts had drawn a conclusion about surgical involvement and disregarded without sufficient evidence the possible involvement of other specialties, Professor Prys-Roberts said:

> 'No, I would not want to give that impression that I was saying there was not any other involvement, I simply asked my colleagues "Do you believe that there is any reason why this should be an anaesthetic problem?" In that event if they had said "Yes", one of my first reactions, I would say we ought to have a meeting about it and set up a research programme to try and find out what mechanisms relating to either anaesthesia or intensive care might be responsible for such events.
>
> 'The reason I did not suggest having a meeting with Mr Wisheart was that at that stage I was largely concerned with helping Steve Bolsin to get his own act together, find data … I mean I was aware (I cannot be specific about it) that the cardiac anaesthetists in general had expressed concerns and that those concerns had not been fully appreciated, irrespective of the concerns Steve Bolsin was expressing to me.

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[47] T94 p. 27 Professor Prys-Roberts

[48] T94 p. 27 Professor Prys-Roberts

> 'The cardiac anaesthetists at that time would have been Dr Geoffrey Burton who was certainly doing paediatric anaesthesia, Dr Baskett to my recollection was not, he was mainly doing adult stuff. Dr Sally Masey had recently arrived, Dr Bose, Dr Short – they were not involved in the paediatric side. There was a cardiac team.
>
> 'I think all of them had expressed concerns at some stage. You know one meets over coffee or after a departmental meeting and somebody would say "Steve is going on about this process, what do you think about it?" and so on … I cannot be certain they were not expressing their own concerns as well. Geoffrey Burton I knew rather better than the others in the sense being a paediatric anaesthetist myself I would see him and I was sharing some lists with him on previous occasions so that I would have discussed it with him. But I cannot recall precisely the details that you are trying to find out at this stage.'[49]

41 Dr Bolsin was helped with processing the information he had collected by Dr Andrew Black, senior lecturer in anaesthesia at the University of Bristol. Dr Black stated in his written evidence to the Inquiry that he had some knowledge of past concerns:

> '… Professor Jean Golding told me that, when she took up her Chair in paediatrics in Bristol in the mid 1980s, it was widely recognised that Bristol Paediatric Cardiac Surgery was not all that it should have been.'[50]

42 Dr Black explained:

> '… I became involved in the issue of paediatric cardiac surgery in Bristol through my friendship and working collaborations with Dr Stephen Bolsin … .'[51]

43 Dr Black stated:

> 'By late 1991, I became aware of Dr Bolsin's substantial concerns over standards of performance. At about the same time, Dr Ian McKenzie, a staff specialist paediatric cardiac anaesthetist from the Royal Children's Hospital in Melbourne, was spending a sabbatical in Bristol and was working with me on a study of postoperative pain in adults. He visited the paediatric cardiac surgical theatres on a number of occasions and seemed surprised and alarmed by what he saw.'[52]

44 Dr Black indicated:

> 'I have an interest in the application and interpretation of multivariable modelling approaches in medicine, having published, amongst other things, one of the relatively early (1980) accounts of the application of multiple logistic regression to a medical topic. Logistic regression is now heavily used for identifying explanators

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[49] T94 p. 28–30 Professor Prys-Roberts

[50] WIT 0326 0012 Dr Black

[51] WIT 0326 0008 Dr Black

[52] WIT 0326 0012 – 0013 Dr Black

> of outcome for the purposes of risk stratification and outcome prediction. I cannot now recall whether my discussions with Dr Bolsin began with his general interest in setting up an audit system for risk-stratified accounting for variations in outcome from Adult Cardiac Surgery between cardiac surgical centres … or with his specific concerns over paediatric cardiac surgery in Bristol. In either case, discussion of the one led fairly quickly and naturally to discussion of the other.'[53]

45 Before embarking on the exercise with Dr Bolsin, Dr Black indicated that he:

> '… made a point of discussing with Dr Bolsin the desirability or otherwise of informing Mr Wisheart and Mr Dhasmana of what we intended. Dr Bolsin gave reasons why this would only impede what we both believed was a necessary task. Our prime objective in setting out to compile our own figures was simply to force more open and honest discussions within our Trust. We believed this would inevitably follow the disclosure of our results, however they turned out.'[54]

46 Dr Bolsin was asked:

> 'Q. … is it right that you never directly, or personally, showed the data which you had collected and analysed, together with Mr [Dr] Black, to any of Mr Dhasmana, Mr Wisheart, Dr Joffe, Dr Jordan, Dr Martin, at least before February 1995?
>
> 'A. Yes, that is true.'[55]

47 Referring to the sources of information that he used, Dr Black indicated that there were two sources: '… that could very easily have been accessed by anyone who is minded so to do'.[56] He stated that:

> '… The principal source was a notebook started in October 1991 by the Bristol Heart Circle … The second and complementary source was the computer print out of the perfusionists' log. Between them, these two sources contained the patients' names, dates of birth, hospital numbers, types of operation, details of the conduct of cardiopulmonary bypass and outcome of almost all of the paediatric cardiac surgical operations carried out at the Bristol Royal Infirmary since October 1991.'[57]

48 In addition, Dr Black stated that the operations registers in theatre and the intensive care admissions book were checked 'to ensure completeness of case inclusion'[58] and hospital notes were retrieved from the Medical Records Department in Bristol and checked when it was necessary to fill in any details missing from the two principal registers.

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[53] WIT 0326 0009 Dr Black
[54] WIT 0326 0013 Dr Black
[55] T80 p. 6 Dr Bolsin
[56] WIT 0326 0014 Dr Black
[57] WIT 0326 0014 Dr Black
[58] WIT 0326 0014 Dr Black

49 Helen Stratton, Cardiac Liaison Nurse at the BRI, said that to assist in her work she kept details of patients in a book which included '… the date of the operation, the date the child was extubated or taken off the ventilator, the date they were moved through to the nursery, the date they went home and the date they died, if they had died.'[59]

50 Miss Stratton went on:

> 'I lent it to Dr Bolsin when he was collecting his audit, as he was finding it quite difficult to find accurate information, data, dates of birth, dates of operations, and I lent it to him and Andy Black and one of his assistants when they were collecting their audit.'[60]

51 Mr Edward Caddy, who retired as Chief Clinical Perfusionist in June 1994, also supplied information to Dr Bolsin:

> 'I gave Dr Bolsin access to the perfusionist records for each individual patient, which were kept in my office at that time. I was aware that he was looking at by-pass times and outcomes. I was not involved in the actual analysis. I was interested to see what information he might obtain from other centres, for example, as to their by-pass times, but I never saw such information. In other words, I thought that Dr Bolsin was looking at comparative data between Bristol and other centres, but I did not see any such data, I did not know what data Dr Bolsin actually obtained, and I did not see any analysis.
>
> 'I believe that Dr Bolsin was drawing the conclusion that Bristol had relatively long by-pass times, especially in the more complex operations. I was not aware of the detail as to which procedures, I cannot now recall exactly what I may have known at that time.
>
> 'I am unable now to recall when it was that I lent the perfusion records to Dr Bolsin.
>
> 'I did not discuss with anyone else what Dr Bolsin was doing.
>
> 'I never saw Dr Bolsin's results, even in draft. I do not know when he did his audit, or when it was completed, or to whom he may have shown it. In other words, apart from giving him practical assistance by giving him access to the records that I had, I was not involved to any further extent in what he then did with that information.'[61]

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[59] T46 p. 161 Miss Stratton

[60] T46 p. 162 Miss Stratton

[61] WIT 0143 0036 – 0037 Mr Caddy

52 Sometime in 1991, probably in the autumn, Dr Bolsin spoke to Dr John Zorab, Director of Anaesthesia and Medical Director at Frenchay Hospital, Bristol. In his written evidence to the Inquiry Dr Zorab described the meeting and its outcome:

> 'It was sometime in the autumn of 1991 that a colleague of mine at Frenchay (who was a friend of Dr Bolsin) told me of his (Dr Bolsin's) anxieties at the mortality rate of children undergoing cardiac surgery at the BRI. At the time, I had not met Dr Bolsin but my colleague had apparently suggested that he (Dr Bolsin) might like to have a word with me as I had had some experience of "medical politics". In due course, and quite by chance, I met Dr Bolsin. We introduced ourselves and I said something to the effect that I believed he wanted a word with me.
>
> 'I have no detailed recollection of the conversation except that Dr Bolsin expressed his anxieties and asked if I had any advice. I pointed out that the problems were completely outside my "patch" as I worked at a different hospital and had little or no contact with those in the BRI Paediatric Cardiac Unit. In addition, I had no facts or figures. Although Mr Wisheart and I were both the Medical Director of our respective Hospitals, our occasional meetings were confined to management matters.
>
> 'At that time, however, I was the representative of what was then the Board of the Faculty of Anaesthetists (now the Royal College of Anaesthetists) on Council of the Royal College of Surgeons (RCS). As such, I had come to know Sir Terence English who was President of the RCS and, of course, a distinguished cardiac surgeon. I told Dr Bolsin that I knew Sir Terence well enough to appraise him *informally* of the problem but that I could not see that there was anything else I personally should or could do.
>
> 'Therefore, I did not take the matter up with anyone else and, in accordance with the request from Sir Terence (letter, 27 July, 1992), I treated the matter as confidential. As I said in my letter to Dr Bolsin (27 March, 1995), I thought I had done as much as was appropriate for me to do.
>
> 'As regards the outcome of my "efforts", I thought that the letter from Sir Terence to me (27 July, 1992) indicated that the matter had been referred to the appropriate authorities and that I had taken appropriate action.'[62]

Concerns expressed by South Western Regional Health Authority (SWRHA)

53 Also in the autumn of 1991, the SWRHA carried out interim reviews of the District Health Authorities (DHAs) and Family Health Service Authorities (FHSAs). On 20 November 1991 Miss Catherine Hawkins, Regional General Manager, SWRHA, wrote to Dr Roylance:

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[62] WIT 0296 0002 – 0003 Dr Zorab (emphasis in original)

> 'I have just finished the interim reviews of DHAs and FHSAs Region-wide and, at all but one review, we heard how poorly Bristol Trust is now performing on Cardiac Surgery contracting, and as a consequence, some are shifting their contracts this coming year, others plan to shift them in 1993.
>
> 'Without exception the Business Managers were identified as "problems" in the negotiation.
>
> 'As currently, we at Region are reviewing Cardiac Units and our needs, and the fact we have invested in Bristol to serve the region and not just Avon – I would more than welcome your comments and action if you feel you are not in sympathy with the current rate and quality of performance of the Cardiac Unit.
>
> 'I am sure Mr Wisheart would like to be made aware of the gross dissatisfaction Region-wide.
>
> 'As a poor reputation takes an age to redress, perhaps we can act now to prevent further deterioration and syphoning off to Oxford and London?
>
> 'Sorry to be the bearer of "bad news".'[63]

54 In her oral evidence Miss Hawkins explained the background to this letter:

> 'It is the comments that we have had when doing the district reviews in relation to the fact that we were moving into Trust status; contracting was a major issue; they were not happy with the handling of their contracts; they were not happy with the service being provided, they thought they would get better services elsewhere; they really felt that when they had moved into purchaser/provider separation, their purchasers would want to shift away from the Bristol Royal Infirmary.'[64]

55 Miss Hawkins said that prior to the letter being sent, she had spoken to Dr Roylance:

> '… what we have to bear in mind is that just before I sent this letter, I had had a dialogue with Dr Roylance.'[65]

56 She explained:

> '… because it was at that meeting that I told him. I mean, I would not just send him a letter out of the blue. We did actually have a discussion about what I found. I said to him, I am going to write to you officially and I want you to take it to Mr Wisheart to draw his attention to the fact that this Unit is not performing satisfactorily on all fronts.'[66]

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[63] UBHT 0038 0430; letter from Miss Hawkins to Dr Roylance dated 20 November 1991

[64] T56 p. 87–8 Miss Hawkins

[65] T56 p. 91 Miss Hawkins

[66] T56 p. 91 Miss Hawkins

57 She said that:

> ‘What I was seeking to achieve was to raise the fact with Mr Wisheart that not only was contracting an issue, but that the general quality of performance of this Unit appeared to leave something to be desired, and were there explanations for that that he could actually quantify to Dr Roylance. Because if we had that, we could either go back and reassure purchasers, or the Unit themselves could have done that in their contracting scenarios. And of course, it is a fact that if your business manager is not doing the best for the Unit, then the Medical Director should be having a say in that. That is what Clinical Directors were for.’[67]

58 She said further:

> ‘It was written to support Dr Roylance in a difficult situation because he had been, to my knowledge, trying to sort the problems out within that Unit over a period of years and it appeared that it still was not quite right. So it was actually in support of the Chief Executive.[68]
>
> ‘With the demise of one consultant, taking on another, looking for a Chair of Cardiac Surgery and trying to get investment, and with a paediatric pathologist on the cards, all those things he had been trying to achieve: very difficult in a teaching authority where money is short, but he was trying.’[69]

59 Miss Hawkins, when asked what she meant in her letter by the words ‘... more than welcome your comments and action if you feel you are not in sympathy with the current rate and quality of performance of the Cardiac Unit,’[70] said:

> ‘If in fact he [Dr Roylance] investigated and he was not satisfied with what he heard, I expected him to come back and say, “I believe that the current rate and quality of service is bad and it is for all these reasons ...”, and then we would have picked it up in a different way.’[71]

60 The following exchange expanded on Miss Hawkins’ view as to possible interpretations of the intention behind the letter:

> ‘Q. If it was to be suggested that those who dealt with the letter and responded to it viewed this as a letter about contracting and not about the quality of outcome of surgery, how would that strike you?
>
> ‘A. I would have said it was a clever sidestep.

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[67] T56 p. 95 Miss Hawkins

[68] T56 p. 95–6 Miss Hawkins

[69] T56 p. 96 Miss Hawkins

[70] T56 p. 96 Miss Hawkins

[71] T56 p. 96 Miss Hawkins

> 'Q. From what you are saying, Dr Roylance was well aware of the motive behind the letter; indeed, you say you wrote it to him to help him to deal with the problem that he had.'[72]

61 Miss Hawkins said:

> 'When I had a reply from Dr Roylance, I believed it was not addressing the real issue, although I cannot remember what the reply was.' [73]

62 Miss Hawkins gave her view as to what the 'real issue' was:

> 'The real issue is that there seemed to be general dissatisfaction in a major part of the region which the Unit Medical Director appeared to be disregarding.'[74]

And:

> 'As I have said to you, the point being that cardiac surgery was not high on everyone's agenda but questions were being asked; if we do not like certain units, can we move? Implicit in that is the fact that they would have been looking at services like cardiac services.'[75]

63 Dr Roylance replied to Miss Hawkins' letter on 3 January 1992:

> 'Thank you for your letter of 20th November. I am very grateful to you for conveying to me the opinions they expressed to you. Only Exeter District Health Authority has voiced such concerns directly to us. I have had the opportunity of discussing the matter in depth and would like to repeat what James Wisheart has said to me:
>
> "1. Volume.
>
> "The present unit was opened in September 1988 with the funding for 675 open heart operations per year. Each year since then the target number has been significantly exceeded. Seven hundred and twenty eight operations were performed in 1989 (the first full year of working) and 696 in 1990. In the first half of the present financial year (with continuation contracts from the previous years) in excess of 360 operations have been carried out. Further, for each purchaser in the South West the number of operations done at the half year point is within + 4 of the target number, with the exception of Bristol and District which was further over target at that date.

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[72] T56 p. 96–7 Miss Hawkins

[73] T56 p. 97 Miss Hawkins

[74] T56 p. 97 Miss Hawkins

[75] T56 p. 97 Miss Hawkins

“It is clear that each purchaser is receiving the volume of work contracted, in many cases more than the contracted volume.

“2. Cost.

“The Cardiac Unit has carried out its work within the allocated/contracted sum of money in each of these years. Further, our prices compare favourably with eg. Oxford, Southampton, St George’s and Leeds.

“3. Quality (medical). The outcome of our work is at a quality level similar to that expected nation-wide, as documented in the UK Cardiac Surgical Register.

“Quality of Care (organisation: e.g. waiting times).

“Waiting times for surgery is the least satisfactory part of the service we offer. The ‘waiting time’ is the legacy of the old ‘waiting list’, which for the Cardiac Surgical Unit reflected the fact that facilities in the South West (ie. in Bristol) have met about half the calculated need throughout the last decade, and this situation remains the same following the 1988 expansion; a conservative estimate would suggest that 1400–1500 operations are needed annually for citizens of the South West region, and this estimate is likely to be revised upward in the next year or so. The excess of demand over provision is illustrated by the fact that although immediately after the expansion the number waiting and the time of waiting fell for 6–9 months, by the second half of 1989 the number of referrals were rising rapidly, so that by 1990 the numbers waiting were greater than before the expansion. At present only a small percent wait over a year, but for our patients this is too long, the average time to operation is approximately 6 months.

“Contracting has highlighted this issue and I believe offers a solution. Whereas in the past we sought to offer a service to allcomers in the South West – hence the long waiting list, we now have a commitment defined by the contracts. Therefore, we are monitoring new patients coming onto the waiting list – so that for each purchaser these shall match the number contracted for, and being operated. Once that balance is established we shall be in a position to make a ‘one off’ effort to reduce the waiting times, without simply ‘sucking in’ more patients. This is what we have been planning and beginning to implement over the last two months.”

‘The situation is not helped by a similar problem of over referral to a Cardiology Department.

‘My personal view is that we must all decide what to do about the potential of over referral to services. We must all attempt to increase the service funded by purchasers and agree protocols to reduce referrals to that level.

‘In parenthesis I would point out that waiting times perceived by purchasers probably include wait for cardiac catheter *plus* wait for operations.

> 'I am satisfied that the true quality of the service is, under the current stress, of a very high order. The immediate improvement in areas of waiting times could only be achieved by a more overt selection of cases to be accepted for treatment. This would precipitate a similarly overt rejection of those excess of the funded workload. I fear this would be currently politically unacceptable.
>
> 'I would be only too pleased to discuss this directly with you if you have any time to see me.'[76]

64 Miss Hawkins indicated in her evidence that, in her opinion, Dr Roylance's reply did not deal with the 'real issue'. She explained:

> 'Because it was statements actually saying that everything was all right when in fact what was being conveyed back was that it was not, and therefore we were at a dichotomy between two opinions. That did not sit easily with me because it did not seem to address what the final outcome of treatment was all about. It is all right to have a throughput, but I was not absolutely confident that we were getting the best results, particularly if people were waiting a long time to go in for operations.'[77]

65 The following exchange further explored Miss Hawkins' view in the light of Dr Roylance's response:

> 'Q. If the outcome, at the top of the page, was "at a quality level similar to that expected nation-wide"; if, in other words, you could look at the UK Cardiac Surgical Register and compare the results at Bristol with that, then your doubts about the length of time that children or others, adults, may have waited for an operation would be resolved, would they not?
>
> 'A. If a cardiologist tells you that he is not happy, even if it is through a third party, that he is not happy with the outcomes, then there is something wrong in that service because he appears to be happy with other units.
>
> 'Q. But other units he has not sent his cases to?
>
> 'A. That he used to send his patients to.
>
> 'Q. Why should the customer always be right?
>
> 'A. I do not think in that sense I would perceive the cardiologist as the customer. I think he was the agent acting for the customer.

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[76] UBHT 0038 0426 – 0428; letter from Dr Roylance to Miss Hawkins (emphasis in original)

[77] T56 p. 98 Miss Hawkins

> ‘Q. What he may seem to be saying is that, because these concerns had been expressed, they had to be right; no smoke without fire?
>
> ‘A. No, I think they had to be thoroughly investigated, and I was not at ease with this, that it had been properly investigated.’[78]

66 Miss Hawkins went on:

> ‘I actually did not feel confident in this and I wanted to speak to Mr Wisheart myself to see what he had to say. So I did go to the unit myself … shortly after receipt of the letter.’[79]

67 In the following exchange, Miss Hawkins said that she spoke to Mr Wisheart ‘within the week’ of receiving Dr Roylance’s letter and went on to describe the content of their discussions:[80]

> ‘Q. You spoke to Mr Wisheart. Do you recall when exactly this was, because the letter from the BRI to you was dated 3rd January 1992?
>
> ‘A. No. I know it was one afternoon. I have not got my old diaries, I am afraid.
>
> ‘Q. Roughly how long after getting the letter?
>
> ‘A. It would have been within the week, I think.
>
> ‘Q. What was said?
>
> ‘A. Mr Wisheart showed me around the Unit and I spoke to nurses and technicians and a few of the patients. Then, when we finished, I said to him that I was concerned by the fact that cardiologists, through their DGMs [District General Managers], were actually raising concerns about outcomes. We did discuss — he did tell me that some of the cases that they had were very difficult. Some were being referred too late and that age-related situations could affect good outcomes. I did say to him that he needed to be more discerning in the type of cases that he attempted; that obviously he needed to be competent, and confident, that the cases he was treating would produce the best outcomes; that he was having problems with referral, he needed to speak to cardiologists to make sure that referral rates and timings were much more appropriate to the type of treatment to be given.

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[78] T56 p. 98 Miss Hawkins

[79] T56 p. 99 Miss Hawkins

[80] T56 p. 100 Miss Hawkins

‘Q. Did he say anything about the overall figures and how they compared with elsewhere?

‘A. He thought that they were performing satisfactorily, and I said that with the best will in the world, you may think that within a Unit like this, where you might all be reinforcing your own opinions, but if external agents who are going to contract with you perceive that you are not doing well, a reputation lost is very hard to get back and therefore you need to get on board with your purchasers to ensure that you deliver the service that they require.

‘Q. So he essentially was denying the problem, was he?

‘A. I think he was saying that it was not a big problem.

‘Q. You said a moment ago that he said that they were doing satisfactorily at Bristol. In your statement you say in the second sentence of the last big paragraph on page 4: “He admitted they [the outcomes] could be better ...” How do I reconcile those two statements?

‘A. Because of the fact that he said at the time that they were having too-late referrals, age could make a difference, be it at the young end of the scale or the other end of the scale. If they got patients that were too old, for example, ... that could have a bad outcome and that could be affecting outcomes and that is when we entered the dialogue about, then, you need to be discerning about age relation, that you get them in time and that people are referred properly and that you change this perception that purchasers have.

‘Q. Did he actually say anything about the outcomes being such that they should or could do better?

‘A. I recall that he said, yes, they could be better if these things were changed.

‘Q. So in other words, the results were satisfactory for the cases they were dealing with, as opposed to the results were not satisfactory and in any event, there were these problems?

‘A. Yes, against the fact that he thought that they were having much more difficult cases than many units had and therefore the outcomes were reasonable, set against those sorts of criteria.

‘Q. Was there anyone else with you on that visit?

‘A. No, I went on my own because I felt that if we needed to speak within four walls, then we should have that opportunity.

‘Q. … Mr Wisheart, for his part, does not recall this visit, or any such visit, after the letter. Are you sure you are right about that?

‘A. I know what I know happened.

‘Q. If you look at the paragraph at the top: “... I recall advising him [Mr Wisheart] that if the BRI shortly achieved trust status and districts did not value the quality of the service the unit offered, they would shift their cases elsewhere.“ Is that what you recall telling him during the course of this conversation?

‘A. No, that is a misquote, actually. It is the gist of what I did tell him that the districts, in contracting, would shift their contract and he would actually lose money for their service.

‘Q. What about the words “if the BRI shortly achieved trust status”?

‘A. No, that should actually read “the BRI having achieved trust status” that the purchasers would now be able to shift whereas before they could not, because the Region actually controlled the contract.

‘Q. I appreciate things were done at a rush when you made your statement.

‘A. Yes.

‘Q. Did you check your statement over, though, before you signed it?

‘A. I checked it quickly off the fax and phoned back with five amendments.

‘Q. Because the BRI in fact achieved trust status in April 1991.

‘A. Yes.

‘Q. So if this conversation took place in 1992, it could not have taken place as described in your statement?

‘A. I remember it happening because 1992 is the year I left and I was actually tying up ends before I was going to go.

‘Q. And this is one of the ends, is it?

‘A. Well, when you have purchasers who are going to be a major threat to a major unit within a teaching hospital, it is not something that I wanted to leave for somebody else.

‘Q. You were inclined to accept the explanation that he was giving you?

‘A. I am not a cardiac surgeon so I was not in a position to judge, but it sounded feasible that if you actually get late referrals and the age is a problem and the case is very difficult, then you would not have as good outcomes as if everything else was put in a correct order.

‘Q. So not being a cardiac surgeon, did you take any further advice on it?

‘A. I actually felt, from our talk, that he did intend to address those issues, particularly talking to the cardiologists in trying to sort the problem out.

‘Q. So you thought it required no further action on your part?

‘A. Having had the conversation with Dr Roylance and with Mr Wisheart, having had a reply from them, having put an audit person in there to begin to sort audit out, I really felt that we were on the road now to being able to evaluate, in fact, what the real outcomes were.’[81]

68 Dr Roylance was asked in some detail about the letter of 20 November 1991:

‘Q. This letter involved, did it not, questions of quality performance?

‘A. Yes, but I do not think it involved questions of clinical outcome.

‘Q. What did you understand to be meant by “quality of performance”?

‘A. At the time – this is the early days of the Trust, the relatively early days of the Trust, and we were making enormous efforts to measure everything in terms of service that could be measured in order to improve it. It is very difficult to define a term, but these were all the facets of healthcare excepting the outcome, the clinical outcome of the service: how long people waited on waiting lists, how long they waited in outpatients before they were seen by a doctor, how long they waited in the admissions area before they were taken into hospital, food and all the other things, all that mass of supporting service, the environment in which clinical care was given, which I think there was (quite properly) anxiety at the time that they had been sacrificed to the altar of clinical care from the altar of clinical outcome and there was an immense effort at that time. So when we used the term “quality” at that time we were talking about things which eventually got swept into the charter mark negotiations; that is what “quality” was.

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[81] T56 p. 99–105 Miss Hawkins

‘Q. That is the way you read it you say?

‘A. No, you must not say that it is the way I read it; I discussed this with Catherine Hawkins, I knew precisely what the problem was and this was a letter which she wrote in order to be supportive of me in trying to resolve the situation. That was the way we worked; I used to see her once, twice a week about issues and we discussed this. I have explained to you that we had a problem when we created a Trust of the very substantial underfunding of adult cardiac surgery. That was then transferred from regional funding, which was at least a straightforward discussion with Region – it was not very productive for the reasons we have discussed – but now that money had been delegated to all the districts in the South West who had individually to agree contracts with us for cardiac surgery, and the money they got did not match the service they required and we had difficulty in transferring from the previous centrally funded service to this system of contracts with a whole series of local districts.

‘Q. You asked Mr Wisheart to draft you a reply to this?

‘A. Yes.

‘Q. He produced three drafts. Shall we have a look at them? UBHT 38/432: if we go right down to the bottom of the page, it is the first draft “Quality”. He has looked at the expression “Quality” used in Catherine Hawkins’ letter. He divides it, as we will see, into “(a) Outcome (Medical)” and “(b)” – go to GMC 4/48 for the next page – “Quality of Care (Organisation: e.g. Waiting times)”. Go back to UBHT 38/432, the foot of the page: “Outcome (medical). The outcome of our work is at a quality level similar to that expected nation-wide, as documented in the UK Cardiac Surgical Register.” He is reading it as a question not only of quality of performance in the wider sense, but also in terms of quality of outcomes?

‘A. Yes, I did not dispute that and at that time, and I believe still, the clinicians in the service believed that outcome (medical) as he said was infinitely more important than this new influx of non-clinical/non-medical care measures of quality.

‘Q. He gave you three drafts and he gave you the right to choose between them?

‘A. Yes.

‘Q. You did not disabuse him you say of his view of quality but you did change or amend his drafts to make one of your own. We pick that up at UBHT 38/426.

‘A. Yes, on this situation I picked out the relevant part of his longer suggested letter and put it in inverted commas so there was no question that that was his view; that was one of the things that Catherine Hawkins was rather anxious I should ascertain and I topped and tailed that contribution.

‘Q. If we have a look at UBHT 38/427 because this is your final editing of his drafts. You include in your reply what he says about “quality (medical)” so you were adopting it?

‘A. No, I was transmitting information he wished me to give to the Regional General Manager. I do not see that as changing the basis of Catherine Hawkins and my original conversation and what we were addressing.

‘Q. If your letter was not about quality in that sense at all, why respond to it in those terms?

‘A. I was quoting James Wisheart’s response and I do not think there was any reason to take that element out of it.

‘Q. Your letter in response to hers contains, in part, a response which is off the point but which you included simply because Mr Wisheart drafted that for you?

‘A. No, but I do not think Mr Wisheart would have thought it was off the point and I was not going to suggest to him that suddenly his wish to maintain high quality of outcome was irrelevant. I am sorry, but I saw no reason – and see no reason now – why I should have edited that statement. ...

‘Q. Dr Roylance, a little while after this letter from Miss Hawkins, you got a letter from the South West Regional Health Authority from a Mr Wilson [Arthur Wilson, Regional Treasurer, SWRHA, 1984–1993]. Can we look at that? It is UBHT 38/411. The date in the top left-hand corner is misleading, 31st January 1991. I think I can say that for two reasons: it has your date stamp on it dated 7th February 1992, as you can see on the left-hand side and in the first paragraph of the text it talks about published professional advice in November 1991. So I think we can date this letter as 31st January 1992. I will show you in a moment your reply to it. That letter comes. If we scroll down: “With regard to the advice on the development of a second cardiac centre and additional catheterisation services, I am now working with those from the south of the region on proposals.” He is writing to invite you to produce a proposal for cardiac services that takes into account (a) increased capacity; (b) unification of children’s services; (c) steps to meet quality and cost concerns of purchasers. Pausing there, did you read this letter as talking about quality in the sense that you had understood Miss Hawkins’ earlier letter to be talking about quality?

‘A. I cannot be certain. I do know at that time the medical profession as a whole were restive about the quality measures as applying to everything but the business we were in, which was getting patients better. Therefore, I do not know to what extent the letter I had written had influenced the writer of this in writing this. I need to see the supporting papers he says he has sent, or I think he has sent. So I cannot tell whether Arthur Wilson had moved forward as we were trying to move everybody forward at that time.

‘Q. Your reply to him is at UBHT 38/406. That enables you to see the reference at the top.

‘A. Yes, it does help.

‘Q. Can we go back and look at the reference and you can let us into the secret of what you get from that?

‘A. “AM” is the typist, “JDW” is the source of the information, and “JR” means I signed it.

‘Q. We go to the second page, 407, the first paragraph, about seven lines down: “However, we were confused and disappointed to see the repetition of the statement that ‘some district health authorities are dissatisfied with the service from Bristol on both cost and quality grounds ...’ as we believe that this is both unfounded and potentially damaging to us. Surprisingly, in the next section of the same paragraph it is stated that ‘there are no waiting list pressures’; as I stated in my letter to the RGM, waiting time is the glaring problem.” Is your letter to the RGM part of the same correspondence we have been looking at in response to Catherine Hawkins’ letter to you in November 1991?

‘A. Yes, I think this is the next stage of having written back to Catherine, that there is a consideration of whether they were going to increase the funding to adult cardiac surgery. This is the first step in that sort of negotiation. I think that there is a confusion here – at this distance I cannot tell you where on the spectrum it was – because I do know that in management circles quality had nothing to do with patient outcome. In consultant circles that was not happily accepted – not that the non-clinical quality measures were not important, but they were not the most important and we were doing our best to keep introducing into the conversation that the purpose of a contract was not waiting time in outpatients, but patients getting better.

‘Q. We can go on in the paragraph beginning “Just one purchaser ...”. Let us look at the full paragraph: “Just one purchaser (Exeter) has complained to us and that is specifically about waiting times. The Regional Committee in Cardiac Services had no issue to raise with UBHT other than waiting times. As a consequence, I am not quite sure what you have in mind for the comparative exercise in quality and therefore would need to discuss with you the whole issue before offering specific advice or suggestion. If medical outcomes are an issue, then authoritative advice would be needed which could be obtained by inviting the Royal College of Surgeons, the Society of Cardiothoracic Surgeons to nominate a suitable senior person; if an assessment by mid-March is needed it might be best for the RHA or the RHA with the UBHT ...” It goes on. At least a paragraph of your response, albeit drafted on information received from Mr Wisheart, appears to be about quality issues in the outcome sense?

‘A. No, there is an “if” outcomes issue. This is trying to clarify a confusion. I think it confirms what I have just said to you, although I have not read this recently and that was, there was at that time a concept of quality within the Health Service within this new general management function which had been imported from Sainsburys, Marks & Spencers and elsewhere, that total quality management should be done, and the managers were instructed to measure all what I call the “non-clinical” elements of the service to ensure that patients were being properly treated, but they specifically excluded patient outcomes, what the people in service thought was the business we were in. There was a conflict at that time. When we have statements from Region to say they are unhappy about quality measures, there is an issue there, what quality measures are you talking about? And if medical outcomes are an issue — not “they are, it is accepted”, but if they are an issue, then there is an indication there of the proper way of addressing such an issue, which is what I would say this shorthand was activating the proper professional approach to an issue of that nature.

‘Q. The proper professional approach you identify in your letter is that if there is an issue, we will need to have an outside report on it.

‘A. That is right. Because of the new concept of competition which was more fictional than real, it is suggested here that to take the nearest units, Oxford and Southampton, to come and make a comment on whether they think patients should go to Bristol or Southampton or Oxford was not a constructive way forward.

‘Q. It is a bit like asking your competitors to say whether they are proper competition?

‘A. I do not know how much they were competitors, but certainly there was an encouragement in those years that we should pretend we are all competing.

‘Q. If one goes back to the letter which sparks this off, the letter of 31st January, UBHT 38/410 … what led to the detailed discussion as to whether it might be necessary to have some sort of outside investigation was the suggestion by Mr Wilson that you might produce a proposal for cardiac services taking into account steps to meet quality and cost concerns of purchasers, whatever that meant.

‘A. That was the issue: what did it mean?

> ‘Q. If you go overleaf, because I think it may also have been this you were responding to, UBHT 38/412, the first paragraph: “In addition, in order to ensure that the best quality standards are identified and built in, I am asking for your support and co-operation in commissioning an agency to carry out a comparative appraisal [this I think is where the idea comes from] of these standards between yourselves and other centres.” That is what gives rise to you saying, “Is it outcomes? If it is, this is the way to go about it”?
>
> ‘A. Yes, and in fact there is the implication, which there always was at that time, that we would rather occupy our time on outcome measures of quality than the other elements of quality.
>
> ‘Q. What you appear to be recognising in these two letters is that if there were a serious concern about the outcome measures resulting from cardiac surgery, that the appropriate step would be some form of appraisal or investigation by outside authorities who were truly independent and could give you another view?
>
> ‘A. That is right. It is reminding Arthur Wilson, and through him the people concerned, that managerial issues were my concern, professional issues were the concern of the profession.
>
> ‘Q. Does it follow that if any such concern had been expressed about a particular aspect of cardiac surgery, such as paediatric cardiac services, to you at this time, 1991/92, that you would have suggested the same professional route, that is an appraisal by outside independent experts?
>
> ‘A. Depending on who said it, I would have either suggested it or enacted it, if you follow me. It depends who said what to whom. If anybody had brought to my attention a concern about quality, then I would have referred that to those who could advise me. Could I remind you, I was a Fellow of The Royal College of Radiologists and had been on their Council, and I was quite accustomed to the responsibilities of Royal Colleges for quality. I would have had no difficulty and no hesitation to use the Royal College as the assessors of quality, and not management.’[82]

69 Counsel to the Inquiry asked Mr Peter Durie, Chairman of the United Bristol Healthcare NHS Trust (UBHT) from April 1991 to June 1994, about Miss Hawkins’ letter of 20 November 1991. Mr Durie said there was pressure on the South West providers in relation to the volume of cardiac operations, but that he did not recall problems of quality of performance:

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[82] T88 p. 77–89 Dr Roylance

‘Q. I think you have had a chance to see this letter, have you not, Mr Durie? This is the letter from Catherine Hawkins to Dr Roylance?

‘A. Yes, I have, thank you.

‘Q. When did you first see this letter?

‘A. I think I saw it for the first time yesterday.

‘Q. Forgetting about actually seeing the physical piece of paper, were you aware that Catherine Hawkins was expressing views of this nature in 1991?

‘A. I certainly do not recall it, but I could well have been told at the time. It would not have been of the greatest surprise, because if you look, what she is complaining about in that letter…: “... how poorly Bristol Trusts are now performing on cardiac surgery contracting”. It was known that the South West had traditionally put less money into cardiac surgery than the country as a whole, and therefore, there was not the facilities to undertake all the operations that if the rest of the country was right, should be occurring in the South West. So there were pressures on the provider because the provider was not apparently saying “Yes, send all your people” because they did not have the facility to do it, so far as I know.

‘Q. So there is a complaint about not enough operations being done?

‘A. Yes.

‘Q. If you look in the third paragraph, the last sentence: “I would more than welcome your comments and action if you feel you are not in sympathy with the current rate and quality of the performance of the cardiac unit.” That is a different point, is it not?

‘A. Yes, it is.

‘Q. So you would have been aware of that point as well?

‘A. I am not sure. As I say, I did not see the letter and I am not sure what I was told. … There were ongoing problems and debates between purchaser/provider all the time. I do not recall being told it, but equally well, it could have been something the Chief Executive felt he need not tell me.’[83]

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[83] T30 p. 89 Mr Durie

Report of the performance of the PCS Service in 1991

70 A table prepared in the UBH and supplied to the Inquiry showed that there had been 46 open-heart operations on children aged under 1 year in 1991. Fourteen patients had died, giving a mortality rate of 30%. The overall Bristol mortality rate for children under 1 in the period 1984–1991 was recorded as 28.5%. The UK mortality figure for 1990, with which these figures were compared, was 15.8%.[84]

71 The table also included figures set out by procedure for open-heart operations on children aged under 1:[85]

Operations Bristol 1984–1991	Mortality rate % Bristol 1984–1991	Mortality rate % UK 1990
AVSD (complete): 9 (2)	37.0	15.9
TGA + VSD: 1 (0)	62.5	22.2
Truncus Arteriosus: 3 (2)	75.0	57.7
TAPVD: 5 (3)	45.5	7.3
TGA (Senning): 8 (1)	2.1	5.9

72 As regards open-heart surgery on those over 1 year of age in 1991, a table showed a total of 93 operations carried out, with the figures divided into groups: simple, moderate and complex surgery:[86]

Operations Bristol 1991	Mortality rate % Bristol 1985–1991	Mortality rate % UK 1990
Simple: 24 (0)	0.5	0.5
Moderate: 51 (9)	10.0	3.9
Complex: 18 (4)	28.0	12.6

73 The table noted that the mortality rate for moderate operations in Bristol for 1991 was 17.6%. The mortality rate for complex operations at Bristol in the same year was 22.2%.

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[84] Figures taken from the table at UBHT 0055 0114

[85] Figures taken from the table at UBHT 0055 0114; figures in parentheses are for deaths. See Chapter 3 for an explanation of these clinical terms

[86] Figures taken from UBHT 0055 0117 – 0118

Chapter 27 – Concerns 1992

Concerns

Concerns raised in relation to the position of Chair of Cardiac Surgery at the University of Bristol

1 In late 1991 Mr Martin Elliott, a consultant cardiothoracic surgeon, was invited to apply for the Chair of Cardiac Surgery at the University of Bristol. The initial approach was made by Mr Wisheart and was followed by an approach from Professor John Farndon, Professor and Head of Division of Surgery. Mr Elliott was interested in the opportunity and visited Bristol on a number of occasions to discuss the position, including having a meeting with Mr Durie, the then Chairman of the Trust.[1]

2 Mr Elliott's discussions with Mr Durie concerned, amongst other things, the 'split site' issue.[2] Mr Elliott was particularly concerned regarding the split service between the BRI and the Bristol Royal Hospital for Sick Children (BRHSC).

3 In his written evidence to the Inquiry, Mr Elliott stated:

> 'Mr Durie outlined the structure of the new Trust organisation, and the financial arrangements. He stated that there was no way that resources could be made available to correct the split site issue in the short or medium term (I can't remember whether we discussed what this meant). I had said that there might be a possibility of getting new business (more patients) from neighbouring regions (Wales, the South West) if we were able to develop a high quality service, but that would be impossible without the Children's Services being centralised away from the BRI. I also pointed out that this would free up resources to increase throughput of, and potentially income derived from, adult practice.
>
> 'Mr Durie made it quite clear that in his view it would be up to me, as the new incumbent, to generate the income to pay for the changes required. I thought that this was not going to be possible. Making the changes was the only rational way to improve both service and income, and the only way to generate a basis for safe, modern neonatal cardiac surgery. I thought it was wrong to place the burden of income generation from clinical practice on the new Chair holder. Changes had to be made BEFORE any income could be generated.

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[1] WIT 0467 0003 and WIT 0467 0007 Mr Elliott

[2] See Chapter 9

> 'In retrospect, I wish I had been louder and more obviously astounded. The approach suggested by Mr Durie now strikes me as absurd, particularly since the internal market has proved temporary. I should have made more of the quality issue, and been less seduced by the flattery of being offered a Chair and the negotiations surrounding it. Faced with a management ethos like this it is easy to imagine why the clinicians had failed to persuade the higher levels of the Health Authority that a change was required.'[3]

4 Professor Prys-Roberts gave his view of the thinking behind seeking to recruit Mr Elliott:

> '… it was seen at that stage — how can I put it, it was a belief that there was a solution to what people already saw as a problem by appointing another paediatric cardiac surgeon who would be an academic and the resolution of both those events would improve paediatric cardiac surgery and some of the problems related to it like the moving from the BRI up to the Children's Hospital and so on.'[4]

5 On 3 January 1992 Mr Elliott wrote to Mr Wisheart indicating that he had decided not to apply for the Chair of Cardiac Surgery at Bristol. Mr Elliott wrote:

> 'I have decided not to apply. My reasons are as follows:
>
> '… I have lingering doubts about the security of the paediatric volume for [*sic*] a worry about the separation of cardiology from cardiac surgery which would I think take some time to resolve.'[5]

6 At Mr Wisheart's request Mr Elliott wrote a paper setting out his reasons in full for declining the Chair.[6]

7 Mr Elliott said, as one of three starred bullet points in his paper, that:

> 'The separation of open and closed paediatric surgery must be inefficient, and is potentially dangerous.'[7]

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[3] WIT 0467 0007 Mr Elliott (emphasis in original)

[4] T94 p. 32 Professor Prys-Roberts

[5] JDW 0003 0102; letter dated 3 January 1992 from Mr Elliott to Mr Wisheart

[6] WIT 0467 0011 – 0027; Mr Elliott's paper *'The Chair of Cardiac Surgery in Bristol'*

[7] WIT 0467 0013; Mr Elliott's paper

8 Dr Roylance was asked about this paper in his oral evidence to the Inquiry:

> ‘Q. If a consultant who has the respect of a number of clinicians, as Martin Elliott it would appear did, of the sort to attract him [to] … a post, writes to the Clinical Director, or Associate Clinical Director of the service, and says, “I think this is dangerous or potentially dangerous in some respects”, would you, as the Chief Executive, expect to be told of the danger or potential danger?
>
> ‘A. Yes, I would expect Martin Elliott to tell me. I cannot perceive of the circumstance where somebody visiting Bristol and finding a service he thought was dangerous was not sharing that view with me. I do not understand the hypothesis behind that.
>
> ‘Q. If he tells the Medical Director rather than you directly, would you expect the Medical Director to pass it on?
>
> ‘A. If he had, yes.’[8]

9 And further:

> ‘Q. … this is a clinical expert in particular in the field of paediatric cardiac surgery, who is describing the present arrangement as potentially dangerous, is it not?
>
> ‘A. Yes.
>
> ‘Q. So if you had seen this, if you had known of this at the time, you would have taken the steps you told us earlier you would do if any respectable and reputable source identified an aspect of the service as being dangerous or potentially dangerous, would you?
>
> ‘A. I certainly discussed this with them. It was used as evidence of the now urgent need to achieve the two steps we were doing. I think the advice at the time, which was rather late in the day in terms of we were already producing a solution, is that nobody was able to identify any child who had actually suffered from this potential danger. We were unable to establish any real danger. I do not know whether that sort of conversation — clearly it was the sort of talk we had, because Bristol was not the only unit in which that sort of separation exists.
>
> ‘Q. Can I remind you of what you said earlier this morning? I asked: “Suppose you had a letter or document from a reputable and respectable source which suggested that the way in which paediatric cardiac surgical services was being delivered was dangerous, potentially dangerous, to the children, would you have taken some action as Chief Executive?” You said: “Absolutely. I would have activated the proper professional pathways to deal with that situation.” I asked you what they would

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[8] T88 p. 102 Dr Roylance

have been and you said: “They would have been the local people to start with, who would not have gone behind anybody’s back, but in the sense that I think I understand your question, I would have referred it to the appropriate Royal College or Royal Colleges to get their professional advice, to ask them to advise me, because that, in my view, at that time was their responsibility.”

‘A. Yes, that is absolutely true.

‘Q. So had you known of these words at the time they were written, because you did not see them for a while, is that the action that you would have taken?

‘A. When I did see them, I did discuss what, in everybody’s view, was potentially dangerous. It does not say it is dangerous, he says it is potentially dangerous. What was the potential? As I say, the advice I had, and was consensus advice, was that although the quality of care in terms of the peace of mind of parents and so on had a lot to be improved, in terms of patient outcome, there was at the time no evidence that the separation itself was an issue. And it was at a time when we were pushing through the solution to the problem. So I think in terms of timing and in terms of statements, clearly by the time any review had been set up and done, we would have actually changed the situation. There is a timescale to what you are talking about. I am quite sure by the time we had achieved any proper external review of the situation, the situation itself would no longer exist.

‘Q. So the answer is, is it, that had you known of this at the time, you would have taken the steps you identified to me earlier this morning?

‘A. Yes.

‘Q. When you did become aware of it, you already had matters in hand and it would have taken so long to have the inquiry, that by then, anyway, the position would have been remedied.

‘A. Yes, but I have to go back to your original concept. This says “potentially dangerous”, it does not say “dangerous” and he could have said “dangerous”, but he did not. He says there is the potential for danger. That is rather different from a clear statement that a dangerous situation is being tolerated. It is quite different.

‘Q. I did put the questions to you in both terms of “dangerous” and “potentially dangerous” this morning.

‘A. Well, if I had failed to observe at the time the difference, I would like to correct that omission now. I actually think that the suggestion that there are circumstances which are potentially dangerous is very different from somebody saying it is dangerous.

> ‘Q. When you came round to assessing the potential for danger —
>
> ‘A. I would not assess the potential danger. If I have given that impression, then I am sorry. I could not assess the danger; I could only take professional advice. There is a difference.’[9]

10 At almost the same time, Dr Bolsin again visited Professor Prys-Roberts:

> ‘Early in 1992 Dr Bolsin again expressed to me his continuing concern about the results of paediatric cardiac surgery … I told Dr Bolsin that I would speak informally to Dr Roylance … .’[10]

11 The meeting with Dr Roylance was the subject of the following exchange between Counsel to the Inquiry and Professor Prys-Roberts:

> ‘Q. Why was this data of a nature that you thought was appropriate to bring to the attention of Dr Roylance?
>
> ‘A. Simply because Steve asked me whether I could intervene in some way, and I said to him “Well, I will be seeing Dr Roylance” — I cannot remember whether he was the Chief Executive or the Chief Officer of the Health Authority at that stage.[11] I knew we were going to have two meetings and I said “Well, look, I will talk to him and try and persuade him that there is something to be concerned about and you may wish me to do that” and he said “Yes”. He was not willing for me to go and speak to Mr Wisheart directly because of the rebuff that he had had on a previous occasion.
>
> ‘Q. You have described a series of meetings with Dr Bolsin and cautioned us against trying to put them into rigid boxes of particular dates when you saw him frequently. You appreciate, I am sure, that Dr Roylance on his part denies any mention being made to him of figures …
>
> ‘A. Yes.
>
> ‘Q. … when you went to see him. Why is it that you can be confident that you had seen some sorts of figures, albeit handwritten and tabulated by Dr Bolsin by the time you had seen Dr Roylance rather than seeing them at a later stage when there was further discussion of the need to conduct an audit?
>
> ‘A. The main reason that I offered to speak to Dr Roylance was on the basis of the information that he had shown me and he could only have shown me data. I did not have a piece of paper to take to Dr Roylance, Steve did not want the piece of paper to go out of his hand. He had shown it to me, I was convinced. What I

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[9] T88 p. 93–7 Dr Roylance

[10] WIT 0382 0002 Professor Prys-Roberts

[11] Dr Roylance was by then the Chief Executive, UBHT

believe I said to Dr Roylance was "Dr Bolsin has data which I think you ought to look at and ought to be concerned about". My recollection is that he said he would do something about it.'[12]

12 Professor Prys-Roberts was asked about the nature of the data:

'Q. It follows, does it, whatever you had been shown by Dr Bolsin was only the most preliminary (if that) stage of assessing the performance of Bristol as opposed to that of other centres?

'A. Yes.

'Q. Was it genuinely, do you think, at a stage at which you could say that the data he was giving you was such as to raise a concern about mortality in Bristol?

'A. It raised a concern with me personally because I could see from the data at that time that things were clearly not as one would have liked them to be. On the previous occasion, 1989, when he first came to me, he had no data. Now he had some data, but the data, as I say they were not properly statistically analysed and so on, but one can look at a set of data and say "There is something there, we have to look at this" and my concern at that stage was simply to alert Dr Roylance to the fact there was something that really did need looking at rather than simply dismissing it.

'Q. But handwritten data of the sort you have just described with only tentative or preliminary conclusions and limited national figures available for comparison might be the sort of information that Dr Roylance would be justified in saying did not raise any concern?

'A. The fact that they are handwritten is neither here nor there.You can put the same data on a typewriter … it does not alter the nature of the data, it is the data, the way it is presented in tabular form and (if necessary) in detail. No, it certainly would not be the sort of information at that time that one would have said "This is hard evidence that Bristol is doing far less well". What I was seeing was soft evidence that gave me concern and my concern supported Dr Bolsin at that stage, and I was very keen that he was not being pushed into a corner persistently by people who [would] not listen to him and so I volunteered that I would speak to Dr Roylance about it.

'Q. (the Chairman): Can I be clear on what exactly was your state of mind at the moment, Professor? You say in answer to Miss Grey — and I am reading from the transcript: "I could see from the data at that time that things were clearly not as one would have liked them to be".

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[12] T94 p. 15–17 Professor Prys-Roberts

> ‘But you then say a little later on “My concern at that stage was simply to alert Dr Roylance to the fact there was something that did need looking at”.
>
> ‘Those are quite different propositions: one is there is a question; the other is there is a real need, real cause for concern. What is your evidence on that particular point?
>
> ‘A. I think I would say there was real concern in my mind at that stage.
>
> ‘Q. (the Chairman): Even though you have described the data as “preliminary”?
>
> ‘A. Yes.’[13]

13 Asked about the possible involvement of Mr Wisheart at that stage, Professor Prys-Roberts said:

> ‘A … I simply asked my colleagues “Do you believe that there is any reason why this should be an anaesthetic problem?” In that event if they had said “Yes”, one of my first reactions, I would say we ought to have a meeting about it and set up a research programme to try and find out what mechanisms relating to either anaesthesia or intensive care might be responsible for such events.
>
> ‘Q. (the Chairman): That is an intriguing response because, as regards the involvement of the surgeons, it did not seem to be your response to suggest “Let us have a meeting with Mr Wisheart”?
>
> ‘A. The reason I did not suggest having a meeting with Mr Wisheart was that at that stage I was largely concerned with helping Steve Bolsin to get his own act together, find data which you could then take either through — I mean I was aware (I cannot be specific about it) that the cardiac anaesthetists in general had expressed concerns and that those concerns had not been fully appreciated, irrespective of the concerns Steve Bolsin was expressing to me.’ [14]

Concerns raised by clinicians outside Bristol

14 There was evidence that there were at the same time rumours circulating outside Bristol. Dr GP Taylor was one of the few referring paediatricians who informed the Inquiry that he was aware of rumours in the early 1990s that, as he put it: ‘all was not well at Bristol’. He stated that he could not recollect the precise source of the rumour, but that it was significant enough for him to discuss with Dr Jordan. Dr Taylor said that he: ‘received reassurance [i.e. from Dr Jordan] that the situation was under review and that there was no cause for concern’.[15]

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[13] T94 p. 19–22 Professor Prys-Roberts

[14] T94 p. 28–9 Professor Prys-Roberts

[15] Consultant paediatrician, Royal Cornwall Hospital, Treliske, Truro; REF 0001 0042

15 Dr Jordan was asked about Dr Taylor's evidence.[16] Dr Jordan said:

> 'We used to have sort of what one might call general discussions and I cannot recall Dr Taylor standing out from other paediatricians that I did clinics with as particularly pursuing any sort of discussion of this sort.
>
> 'All I can say is that we did discuss very generally not only our plans but also our results and to some extent the discussion included a "warts and all" approach to it so it may well be I had actually, you know, talked about things that were of concern to us as well … for example that we still had not, right up to the time that I retired, got the cardiac surgery moved up the road. That is of particular importance to paediatricians because paediatricians are really very keen on the idea that children should be looked after in a paediatric environment.'[17]

16 Asked whether such a 'warts and all' discussion with paediatricians would have included discussion of particular procedures being carried out at Bristol, Dr Jordan said:

> 'I think it would only be if I was specifically asked. Bear in mind that if we are dealing with transposition with intact intraventricular septum … paediatricians … would see one case in every five years or something like that.
>
> 'I do not think it is reasonable to suppose that Dr Taylor specifically had a problem over his patients or indeed from any information that he would have got from what I might call reliable sources. … I think it would be very difficult for a paediatrician to form a view on his own about, for example, what our success rate was in [the] neonatal arterial switch operation.'[18]

Visit by the Supra Regional Services Advisory Group (SRSAG) in February 1992

17 As indicated in Chapter 7, at this time the BRI was a centre for Neonatal and Infant Cardiac Surgery (NICS) under the supra regional system.

18 Mr Stephen Owen, the Administrative Secretary to the SRSAG, visited Bristol on 6 February 1992. He recalled receiving some data on mortality during his visit, which he said he passed to Dr Halliday, Medical Secretary, SRSAG. A note of the meeting sets out the data.[19] Dr Halliday was asked about these figures:

> 'Q. … yesterday we were told by Mr Owen that he visited Bristol in February 1992. When he visited Bristol then, he was passed mortality figures which did not mean [a] lot to him, so he passed them on to you.

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[16] See also Chapter 11

[17] T79 p. 142–3 Dr Jordan

[18] T79 p. 144–5 Dr Jordan

[19] DOH 0004 0045; note of meeting, 6 February 1992

> ‘First of all, do you recollect that?
>
> ‘A. Yes. I mean, I was getting data fairly regularly, yes.
>
> ‘Q. The second question: do you recollect what, if anything, you did with those figures?
>
> ‘A. The difficulty is, as I have said, having figures in isolation, without the machinery to analyse it, is of no particular value. It would have been strange for me to be given — I mean, I was not given any figures with the suggestion that there was a problem here. I was given figures as I was on many visits. Sometimes my administrative colleagues would visit the units with the object of dealing with financial matters, and would be handed data. They would come back to me, or Dr Prophet,[20] and would hand us that data.
>
> ‘If, however, we were given the data and told that there was a problem with that data, that would be a different matter.
>
> ‘I have no recollection of any data being presented to me from Bristol with the caveat that there was a problem.
>
> ‘If there had been a problem, I would have clearly gone to the College for advice, but to be given data without the suggestion that there was a problem, would not have given me the opportunity to raise this with the College. I mean, it would be pointless me giving them the data from one year and saying, “What do you think of this?”’[21]

Further concerns expressed at Bristol

19 Professor Prys-Roberts met Dr Roylance on 14 February and 5 March 1992. Professor Prys-Roberts stated that on one of these occasions (probably the second),[22] he told Dr Roylance:

> ‘… that Dr Bolsin had been collecting data, and that in my opinion he (Dr Bolsin) was correct to express concern about the results of cardiac surgery in babies. I did not have the data with me but I told Dr Roylance that Dr Bolsin would be prepared to show them to him. Dr Roylance said that I should leave the matter with him and that he would deal with it. I had every reason to anticipate that Dr Roylance would investigate the matter more fully, and deal with it.’[23]

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[20] Senior Medical Officer, Department of Health
[21] T13 p. 113–14 Dr Halliday
[22] T94 p. 31 Professor Prys-Roberts
[23] WIT 0382 0002 Professor Prys-Roberts

20 Professor Prys-Roberts was asked about the meeting with Dr Roylance in the following exchange:

> ‘Q. If we turn back then to the point at which you spoke to Dr Roylance, can I ask you firstly: the meeting took place after you had already had a meeting, with others, with Dr Roylance either on the subject of the relocation of the University department or on the subject of special increments for teaching and research. We have had two dates, 14th February and 5th March and I think both you and Dr Roylance agree that of those two dates the latter is the more probable?
>
> ‘A. I think the latter is the more probable, yes …
>
> ‘Q. On the occasion you did speak to Dr Roylance, what did you say to him?
>
> ‘A. I believe I used the term “I am concerned about the way Steve Bolsin is trying to make the information known within the Trust and within the hospital that the paediatric cardiac mortality is higher than it should be. I am aware that you have prior knowledge of this and I am simply expressing a concern that I have seen data that Steve Bolsin has presented to me, I do not have the data with me, but Steve has told me that he would have been willing to show you, Dr Roylance, the data” and I believe I used the term which I tend to use as a sort of throwaway phrase, “this is not something that we should sweep under the carpet”.
>
> ‘Q. Dr Roylance for his part says that that is a phrase that he would have found offensive.
>
> ‘A. Yes, I have read that.
>
> ‘Q. What was his reaction to the phrase if you used it to him?
>
> ‘A. I do not recollect him appearing to be offended or appearing to be disturbed by what I said. He was a fairly taciturn person and he simply said to me “I note your concerns and I will deal with them”.
>
> ‘Q. What was the general tone of the conversation, then?
>
> ‘A. Friendly.
>
> ‘Q. Does the fact that Dr Roylance would find the use of such a term, he says, offensive but that the conversation apparently remained friendly not lead you to reflect a little on whether or not you in fact did use that term?
>
> ‘A. I cannot be certain that I would use the term, but I think I did use the term.

‘Q. Can you be confident that you would have mentioned figures or data to Dr Roylance?

‘A. No, I would certainly not have mentioned specific numbers to him. What I said to him is I had seen a collection of data which seemed to me to support Dr Bolsin’s contention that “there is a higher mortality than we should be happy to have in the BRI cardiac unit and I feel that you as the Chief Executive should know about it and maybe deal with it”.

‘Q. What was Dr Roylance’s reaction to the suggestion that he should deal with data or figures on higher mortality?

‘A. My recollection was that he said “yes” he would deal with it and I did not pursue as to how he would deal with it. I knew John Roylance very well as an individual and I expected him to do that.

‘Q. Did he not seek to explore with you exactly what sort of figures had been collected?

‘A. Not in detail because I had said that Steve Bolsin had the data; that he would be perfectly happy to share the data with Dr Roylance. One of the problems was that this meeting was relatively brief because Dr Roylance had another meeting to go on to but he had agreed to see me briefly after the end of the other meeting we had. This was an opportunistic way of talking to him about this concern of Steve Bolsin’s.

‘Q. Again Dr Roylance’s suggestion is that if anyone had suggested to him that there was data or figures that had been gathered on performance of the unit, that he would have regarded that as being a matter for the Trust Audit Committee or Dr Thomas and that he would want to pass that on as a “political hot potato” as rapidly as possible. Was there no discussion of such a course of action?

‘A. I have no recollection of any discussion of that nature at all.

‘Q. Why mention Dr Bolsin?

‘A. Because it was Dr Bolsin who had asked me to present the concern to Dr Roylance.

‘Q. Here Dr Bolsin had been rebuffed, you understood, in the past. Why bring his name to the attention of the person who at least (presumably) played some part, you might have thought, in that previous incident?

‘A. I am not sure I knew what John Roylance’s part in the previous rebuff had been. I believe (again this is simply my own personal opinion) that Bolsin had written to the Trust, Roylance had dealt with it and passed the information back to Mr Wisheart who had then spoken to Dr Bolsin; I was not part of that process at all,

> so I cannot give you any more detail than that. But I was not under the impression that it was Dr Roylance who had rebuffed Dr Bolsin in the first place.
>
> 'Q. Was there any discussion that you can recollect, then, of the appointment of a paediatric cardiac surgeon and the need for that?
>
> 'A. There had been a lot of discussion in that sort of period during 1991. I was not involved in it. There were discussions about appointing a Professor …
>
> 'Q. I was asking you specifically for your evidence in relation to the meeting with Dr Roylance, whether you recollect that subject being raised at that time?
>
> 'A. I do not recollect saying on that occasion that I was disappointed, but I may well have done, I simply do not recollect that.
>
> 'Q. Because you will appreciate that Dr Roylance's recollection is of a conversation about the need, indeed the urgency, of appointing a paediatric cardiac surgeon. Is it possible that the two of you did discuss that and that the explanation for this lack of agreement as to what took place was that both of you assumed it was necessary that that appointment should be made but from different perceptions of the reason why it was important?
>
> 'A. I would certainly agree with that last statement, but I do not recollect discussing that particular problem with John Roylance on that occasion because that was not my prime purpose in asking to see him after the other meeting. My prime purpose was to draw his attention to the fact that Steve Bolsin now had a set of data which I considered ought to be causing concern.'[24]

21 Dr Roylance was also asked about the meeting with Professor Prys-Roberts early in 1992 in the following exchange:

> 'Q. Do you recall Professor Prys-Roberts saying anything to you about data or figures that Dr Bolsin was collecting?
>
> 'A. No, no …
>
> 'Q. If Professor Prys-Roberts had been approached by Dr Bolsin and shown data, figures in respect of outcomes of paediatric surgery and you and he, that is you and Professor Prys-Roberts were discussing paediatric cardiac surgery, would you expect, given what you know of Professor Prys-Roberts, that he would have told you something about that?
>
> 'A. Yes, I would not describe Prys-Roberts and his relationship with me as reticent.'[25]

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[24] T94 p. 29–37 Professor Prys-Roberts

[25] T88 p. 117–19 Dr Roylance

22 Dr Roylance went on:

> '… if he said to me that Dr Bolsin had data about cardiac surgery, it is quite inconceivable that I would not have immediately referred the matter to James Wisheart and talked to him about it and I did not because I was not given that information.'[26]

23 Also, in the spring of 1992, Dr Bolsin went to see Kathleen Orchard, General Manager of the Directorate of Surgery at UBHT.[27]

24 In her written evidence to the Inquiry Ms Orchard stated that:

> 'Dr Bolsin told me he was concerned about some of the work being performed in the cardiac unit. I do not recall him making specific reference to paediatric cardiac surgery, nor to any particular surgical procedure. I recall that he was making comparisons between the performance for some procedures in the Bristol unit compared with other United Kingdom units. He indicated that he believed that the Bristol unit was below standard on the basis of comparative outcome data. I do not recall which particular procedures he was concerned about. I do not recall that he was any more specific than that, nor that his concern was anything more than a level of "worry". I certainly retain no impression from either what Dr Bolsin said to me on that occasion, or how he said it, that there was a serious problem with paediatric cardiac services.'[28]

'Private Eye'

25 In 1992 a number of articles were published in the *'MD'* column of *'Private Eye'* magazine.[29] These contained various criticisms of the cardiac services at the BRI. The author of the articles was Dr Phillip Hammond, then a GP trainee in Taunton. He described himself in his written evidence to the Inquiry as a 'whistle-blower's advocate'.[30] Although the *'MD'* column did not identify the author, Dr Hammond stated that he made no secret of his identity.[31]

26 Dr Hammond acknowledged that his evidence to the Inquiry was 'entirely second hand, as a journalist writing for "*Private Eye*".'[32] He told the Inquiry that he was not willing to identify the sources of his information.[33]

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[26] T88 p. 120–1 Dr Roylance

[27] From March 1991 to February 1993

[28] WIT 0170 0044 – 0045 Ms Orchard

[29] Dated 14 February, 27 March, 8 May, 3 July, 9 October and 20 November. See later in this chapter

[30] WIT 0283 0001 Dr Hammond

[31] WIT 0283 0009; WIT 0080 0011; WIT 0245 0007; T69 p. 33. Mr Dhasmana told the Inquiry that he was aware at the time the articles were published that Dr Hammond was *'MD'*, T86 p. 126. Others, who expressed a view to the Inquiry, gave evidence that they were not so aware: Dr Bolsin, T81 p. 101; Professor Stirrat WIT 0245 0007 and T69 p. 35; Sir Kenneth Calman, T66 p. 82; and the implication of Professor Angelini's evidence was that he did not know, T61 p. 58

[32] WIT 0283 0001 Dr Hammond

[33] T60 p. 47 Dr Hammond

27 Dr Hammond stated that in 1992 and 1993 he received information from a number of sources both within the UBHT and outside. The sources within UBHT included 'a senior nurse, a middle grade nurse, two consultants and at least half a dozen junior doctors …'.[34]

28 Dr Hammond stated that these sources suggested that problems with the paediatric cardiac service at Bristol were so grave that he should attempt to alter the referral pattern of the general practitioners he knew, to stop them sending children with complex heart conditions to Bristol. Dr Hammond was told that pressure was being put on referring doctors to support the Bristol Unit although they 'probably wouldn't send their own children for heart surgery in Bristol'.[35] Specific problems which were highlighted to him included:

- no action being taken to protect patients despite high mortality rates;
- no defined minimal standards;
- no obligation to conduct audit that allowed meaningful comparisons between units;
- no mechanism within or outside the profession to identify and act on unacceptable results;
- concerns not acted on in a way that would protect patients, despite the problems in the Bristol paediatric cardiac surgery Unit being well known in 1992, and despite concerns having been raised with Dr Roylance;
- parents of children undergoing heart surgery given information about success rates that did not reflect the Unit's own figures;
- operations taking a very long time compared to other units, and this was a factor that could adversely affect the outcome of operations.[36]

29 Dr Hammond explained that:

> 'Further information specifically related to cardiac surgery was gathered from doctors at other hospitals I either knew personally or met during 1992 at conferences, after dinner speeches and performances of *"Struck off and Die"*.'[37]

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[34] WIT 0283 0008 Dr Hammond

[35] WIT 0283 0004 Dr Hammond

[36] WIT 0283 0003 – 0004 Dr Hammond

[37] WIT 0283 0008 Dr Hammond. *'Struck off and Die'*: a stand-up comedy programme written and performed by Dr Hammond

30 Dr Hammond stated in his written evidence to the Inquiry that he did not know how those outside Bristol would have come to hear about what was said to be the problem at the UBHT, but it was his impression that:

> '… senior members of the specialty were discussing it amongst themselves and with their more senior juniors, especially those considering their next career move.'[38]

31 Dr Hammond stated that the fact that there were problems at Bristol 'was also well known amongst cardiac anaesthetists/intensivists I spoke to.'[39]

32 On 14 February 1992[40] and 27 March 1992,[41] articles were published in '*Private Eye*' that referred (amongst other things) to a lack of funding for cardiology and cardiac surgery in Bristol.

33 On 8 May 1992 a further article was published that read:

> 'Before the DoH bestows its mark of excellence on UBHT, it may wish to ponder the perilous state of its paediatric cardiac surgery. In 1988, mortality was so high that the unit was dubbed the "Killing Fields". Despite a long crisis of morale among intensive care staff, the surgeons persistently refuse to publish their mortality rates in a manner comparable to other units. And although Dr Roylance and the DoH are well aware of the problems, they won't recognise them officially. Recently, the unit failed to provide a paediatric cardiac surgery nurse for post-operative care because it was assumed the baby would not survive the operation. And although Liverpool surgeons have successfully operated on 160 babies with Fallot's tetralogy, a congenital heart abnormality, the Bristol mortality is between 20 and 30 percent. Hardly the stuff of commendations.'[42]

34 Dr Hammond gave evidence about this article in the following exchange:

> 'Q. Did you have any material other than the fact of what is probably this report,[43] what I have just shown you, to suggest that the Department of Health was well aware of the problem?
>
> 'A. No, although I was told that there was another Working Party on behalf of the Department of Health going around at that time, in 1992. I was not sure what stage they had reached in their deliberations.

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[38] WIT 0283 0005 Dr Hammond

[39] WIT 0283 0005 Dr Hammond

[40] WIT 0283 0014 Dr Hammond

[41] JDW 0003 0141; *'Private Eye'*, 27 March 1992

[42] SLD 0002 0003; *'Private Eye'*, 8 May 1992

[43] Interim Report of the Working Party July 1989

‘Q. It did not report until later.

‘A. Fine. My assumption was — one of my sources said, “This is a window of opportunity to bring it to the attention of this Working Party that is going around at the moment. They will read this, they will think we at least have to investigate this”. When I am saying “Working Party” I assume it then goes back to the Department of Health, but I did not know at that time the dates at which the Working Party reported so in fact the only evidence I had was the 1989 report.

‘Q. And “they won’t recognise them officially”. Did you know that they had been asked to do so?

‘A. No.

‘Q. The wording you use there might suggest that they had, might it not?

‘A. They might have been, I am not aware of anybody asking them to do so, other than me in this column.

‘Q. Because the “won’t recognise” gives the impression just as perhaps the “persistently refused to publish” may give the impression, that there is some deliberate silence being kept?

‘A. The official recognition would have come from the 1989 report when they said “these are very poor success rates but we are not going to look into it, we are just going to encourage them to increase the numbers”. They were not recognising the problem.

‘Q. You, for your part, were not an expert in cardiac surgery, or what results to expect?

‘A. No.

‘Q. And you would have imagined that whatever the Working Party constitution was, it would be composed of those who were?

‘A. Yes.

‘Q. If they had seen a problem themselves, you would have expected them to have drawn particularly focused attention to it, would you not?

‘A. My experience, and this also goes with biliary atresia, is that decisions at that time were made largely on output and that people did not look at outcomes carefully. In fact, they did not seem to mention outcomes. You talk about results, but they were keen on throughput and centres being established for geographical reasons. It is only recently I think with this government that anybody has put quality on the agenda and stopped counting numbers and waiting lists and actually looked at the quality of the service. So I think in that culture then, they did not look at the quality of the service. They did not think, "If this was my child would I want them to be treated in Bristol?" … You have to ask that question if you are on working parties like this.

'Q. The point I am going to ask you to comment on, if the Department of Health had commissioned a Working Party and the Working Party itself focused on throughput rather than outcome in terms of success rate, there would be no-one, would there, in the Department of Health who would be in a position to as it were, second-guess the doctors; or would there? The experts are saying, "Here we are, we need to increase the throughput", might the Department of Health officials at any rate not say, "Well, this is the medical advice we have; we are not in [a] position to know better"?

'A. You have put the graphs up on the screen, which presumably lay people around the country can see, certainly around the South West. You do not have to be a genius and have to have a degree in statistics to see a very significant outlier, one unit with very poor results.

'If I was in the Department of Health in a position where I was accountable for quality, I would say "I am not happy just to increase numbers here, I want that looked into". I do not think you need to be a specialist. The whole history of medicine is littered with specialists not getting the right answer. You cannot necessarily rely on expert opinion.

'Q. Can we go on to the next paragraph: "Recently the Unit failed to provide a paediatric cardiac nurse for post-operative care because it was assumed that the baby would not survive the operation." Where did that information come from?

'A. I honestly cannot remember.

'Q. "Although Liverpool surgeons have successfully operated on 160 babies with Fallot's Tetralogy". Just pausing there, where did that information come from?

'A. One of my sources has a handle on what was going on around the country.

'Q. One of your sources in Bristol?

'A. Yes.

> ‘Q. “A congenital heart abnormality, the Bristol mortality rate is between 20 and 30 percent, hardly the stuff of commendations.”
>
> ‘Who gave you the Bristol mortality rate of between 20 and 30 percent for Fallot’s Tetralogy?
>
> ‘A. I cannot be certain. It could possibly have been Dr Bolsin, it could possibly have been someone else. I cannot be certain.
>
> ‘Q. The someone else is “A N Other”?
>
> ‘A. Yes. I had another source so I was able to check between two sources, which to me I felt was enough to publish a story. In retrospect, I wish I had gone to John Roylance and Mr Wisheart, but for reasons I outlined in my subsequent statement, I was too frightened to do that at the time, but I felt that the two of them saying there was a problem was enough.’[44]

35 Mr Peter Durie, Chairman of the Trust Board, told the Inquiry that he had seen and discussed the *‘Private Eye’* articles informally with members of the Board:

> ‘I do remember myself and some other members talking informally about the *“Private Eye”* articles. … In general, there was concern that there was a criticism of what standards we were trying to produce.’[45]

36 Dr Roylance told the Inquiry he received a letter dated 22 June 1992 from Ms J Binding, Corporate Affairs, NHS Management Executive[46] enclosing a letter dated 24 May 1992 written by a parent whose child was about to have surgery at the BRI and who expressed concern about the reputation of the ‘paediatric cardiology’ unit after having read a ‘recent edition’ of *‘Private Eye’*.[47]

37 Dr Roylance’s evidence to the Inquiry included this exchange:

> ‘Q. … by the time you got this letter, if you had not seen [the article] you then saw it?
>
> ‘A. Yes.
>
> ‘Q. Because you needed to respond to it?
>
> ‘A. … I think before that I had seen it but I can guarantee when this [letter] arrived I would have seen [the article] then.’[48]

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[44] T64 p. 72–6 Dr Hammond

[45] T30 p. 35 Mr Durie

[46] JDW 0003 0134; letter from Ms Binding dated 22 June 1992

[47] JDW 0003 0135; letter to Mrs Virginia Bottomley dated 24 May 1992

[48] T88 p. 129 Dr Roylance

38 Dr Roylance explained that both he and Mr Wisheart '… were concerned about the misunderstanding that had been given to parents of the child …'.[49]

39 Dr Roylance replied to Ms Binding in a letter dictated by Mr Wisheart and signed by Dr Roylance dated 23 July 1992.[50] Mr Wisheart said that the letter attempted to convey the view that results taken as a whole were acceptable.[51] The letter stated:

> 'I am happy to report to you that [the parents of the patient] met Dr Joffe and Mr Wisheart together with Mrs Helen Vegoda our Paediatric Cardiac Counsellor, on Tuesday 21st July and had a full and very frank conversation. Each item raised in *"Private Eye"* of 8th May was fully discussed; in particular the results of Paediatric Cardiac Surgery in Bristol for children in general in the late 80s and for Fallot's Tetralogy in particular were discussed in detail, and we were able to inform [the parents] of the outcomes in Bristol in relation to the outcomes in the United Kingdom as a whole.
>
> 'Further we were able to discuss the specific procedure which [the child] will undergo in the near future namely the Fontan operation in which our overall results for the last five years are comparable to the United Kingdom results and in the last 18 months our results have been particularly good … our overall results are extremely close to the UK results … our results for Fallot's Tetralogy appear to be less good than the National results, chiefly because of an excess number of deaths[52] occurring in the treatment of this condition in 1990.'[53]

40 The letter also suggested that it was likely that paediatricians whose patients were treated in Bristol would in future have sent to them a 'regular report' on the results of Bristol's paediatric cardiac work.[54]

41 Dr Roylance accepted in evidence that the results for Fallot's Tetralogy enclosed with the letter to Ms Binding indicated that in 1990 mortality was high but he said he was reassured by clinicians ('probably' Mr Wisheart) that results had improved.[55]

42 Dr Joffe and Mr Wisheart were aware both of the article and the parents' concerns both before the letter from Ms Binding was received and before the meeting with the parents was arranged.[56]

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[49] T88 p. 130 Dr Roylance

[50] JDW 0003 0157 – 0158; letter from Dr Roylance to Ms Binding dated 23 July 1992

[51] T92 p. 31 Mr Wisheart

[52] T88 p. 134; Dr Roylance gave evidence that his understanding of the meaning of the term 'excess deaths' at the time was vague but that he now understood that: 'from time to time there is a poor run … in … low volume, high risk series …'. He added: 'I do not think anybody quite knows whether there is a local cause for it or it is just distribution of risk factors. Well, I do not know'

[53] JDW 0003 0157; letter from Dr Roylance to Ms Binding dated 23 July 1992

[54] Neither Dr Roylance nor Mr Wisheart could confirm in evidence whether that suggested course of action was subsequently implemented: T88 p. 133; T94 p. 143

[55] T88 p. 134 Dr Roylance

[56] JDW 0003 0147; letter from Mr Orme (consultant paediatrician, Exeter, Devon) to Dr Joffe dated 8 June 1992; SUB 0013 0266

43 Dr Hammond stated in his written evidence to the Inquiry that the figures that he quoted in the May 1992 article were provided by one of his sources within the UBHT. He would not identify the source, but said that it was not Dr Bolsin.[57]

44 Dr Hammond explained that he had put the figures that he had received from his source to Dr Bolsin, to confirm their accuracy, nine days before the May article was published.[58]

45 Contact between Dr Hammond and Dr Bolsin had come about after a junior doctor approached Dr Bolsin's wife, who worked in the Accident and Emergency Department at the BRI, because he was concerned about the mortality rates in paediatric cardiac surgery.[59]

46 Dr Bolsin stated that the junior doctor explained to Mrs Bolsin that Dr Hammond would be interested in hearing concerns about the BRI cardiac surgery department.[60]

47 Dr Hammond then contacted Dr Bolsin by telephone. As a result of that contact, Dr Hammond went to Dr Bolsin's house on the evening of 29 April 1992. Dr Bolsin showed Dr Hammond what he described as his 'very provisional'[61] log book data and expressed his 'impressions of high mortality in Bristol'.[62]

48 Dr Bolsin stated that he regarded it as possible that some of the data from the Bolsin-Black (Dr Andrew Black, Senior Lecturer in Anaesthesia, University of Bristol) analysis may have reached Dr Hammond from individuals with whom he had shared the analysis. Those possible sources included consultants at the BRI and Frenchay Hospital, local managers, local junior staff and Dr Bolsin's friends in Bristol 'and further afield', as well as his relatives.[63]

49 Dr Bolsin explained that he regarded Dr Hammond as a concerned trainee GP who may have wanted to influence his local colleagues to change their referral patterns for paediatric cardiac surgery.[64]

50 Dr Hammond stated that he considered Dr Bolsin to be a reliable source of information '… not just because of his consistency and clarity, but because I was told he was an acknowledged expert in clinical audit'.[65] Dr Hammond's impression of Dr Bolsin when they met was that he was 'clearly very stressed and under pressure' and 'very patient-centred in his analysis of the problem'.[66]

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[57] WIT 0283 0009 Dr Hammond
[58] T82 p. 42 Dr Bolsin
[59] WIT 0283 0009 Dr Hammond
[60] WIT 0080 0111 Dr Bolsin
[61] T81 p. 87 Dr Bolsin
[62] WIT 0080 0111 Dr Bolsin
[63] WIT 0080 0111 Dr Bolsin
[64] WIT 0080 0111 Dr Bolsin
[65] WIT 0283 0009 Dr Hammond
[66] WIT 0283 0009 Dr Hammond

51 In mid-1992 Dr Bolsin applied for a post in Oxford. On 22 June 1992 Dr Bolsin discussed his application with Professor Prys-Roberts and Dr Brian Williams, at that time the Clinical Director, Department of Anaesthesia, UBHT.

52 Dr Bolsin said that:

> ‘The outcome was that we made a deal, a gentlemen’s agreement, firstly he [Professor Prys-Roberts] said he would back me very strongly in Oxford, he would back me in Oxford; if I did not get the job, would I come back and collect the data on paediatric cardiac surgery in Bristol?
>
> ‘Q. Is it the case that by the time you spoke to Professor Prys-Roberts you had already spoken to Andrew Black?
>
> ‘A. I was working with Andy Black on the audit data collection.
>
> ‘Q. So there was data collection in process, albeit adult?
>
> ‘A. Yes.
>
> ‘Q. It was not Professor Prys-Roberts’s position, no doubt as you understood it, to commission any data, survey or anything of that sort?
>
> ‘A. No. It was a gentleman’s agreement.
>
> ‘Q. Do I understand that the proposal to collect data, to see what the figures showed, came from you rather than from him?
>
> ‘A. No, the proposal came from him and he said “On the basis of that data, you must either shut up or put up”, and I remember that phrase indelibly.’[67]

53 Professor Prys-Roberts’ recollection was different, as appears in the following exchange:

> ‘Q. Can I ask you to comment on that account of events, firstly the comment from Dr Bolsin … that the reference and data collection were a process of exchange of favours?
>
> ‘A. I think that is an entirely inappropriate statement for him to make. He asked me to give him a reference for a job in Oxford. I would normally give references for any trainee that I knew and it was a very unusual thing to be asked to give a reference for a fellow consultant because by and large fellow consultants did not move around, so once you got your consultant job you stayed there, so this was an unusual thing. I do not like the comment he makes in terms of “exchanging

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[67] T82 p. 63–4 Dr Bolsin

> favours”. There was no favour done. I gave him a reference because that is an entirely proper thing for an academic professor to do for a fellow consultant or for a trainee.
>
> ‘Q. He also suggests this is a request from you to start collecting the data as of that time, that is the beginning of this particular process; how does that …?
>
> ‘A. I do not recollect specifically asking him to collect data from that time. I think probably what I would have said to him was “If you do not get the Oxford job, what are you going to do? You are going to be back here in Bristol I think you should then concentrate more on collecting more data.”
>
> ‘Q. “A gentlemen’s agreement” was what Dr Bolsin described … in evidence to us, do you think that is appropriate?
>
> ‘A. I do not know what he means by “a gentlemen’s agreement”, there was certainly not an official involvement, we did not set up an official research study, it was not an official involvement of the University Department with what he was doing, I was simply offering him Andy Black’s services as a relative expert in statistics so …
>
> ‘Q. What do you mean, if I may stop you, by “offering Dr Black’s services”?
>
> ‘A. I suggested to Steve Bolsin: “the analysis of these data require[s] a statistical process. You may want to start by asking Andy Black about it because this looks to me like the sort of data collection which requires multivariate analysis in order to pick out the details. He is an expert in that. He may say “go elsewhere”.
> He did not.’[68]

54 In his written evidence to the Inquiry, Professor Prys-Roberts stated that by that time Dr Andrew Black:

> ‘… had agreed to assist Dr Bolsin with the statistical assessment of his data gathered between 1989 and 1992, and Dr Bolsin was proposing to collect further specific data relating to certain operations such as the “Switch” operation.
>
> ‘While I was aware that Dr Black and Dr Bolsin were analysing what data they had available, I did not consider that these activities in any way constituted an official involvement of either the University Department of Anaesthesia, or the University of Bristol, in a matter which was essentially a problem relating to an NHS service. For these reasons I saw no reason, at that time, to discuss these matters with Professor Gordon Stirrat, then Dean of the Faculty of Medicine.’[69]

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[68] T94 p. 51–3 Professor Prys-Roberts

[69] WIT 0382 0003 Professor Prys-Roberts

55 Professor Prys-Roberts was asked in the following exchange whether he had contacted Dr Roylance after the meeting on 22 June:

> ‘Q. … when you saw Steve in July 1992 did you have any further assurance to give him that the matter was being looked into or developed, investigated by the Trust?
>
> ‘A. No.
>
> ‘Q. Had you been back to Dr Roylance to check what was happening as a result of your conversation?
>
> ‘A. No.
>
> ‘Q. Did you ever at any time go back to Dr Roylance to follow that conversation up?
>
> ‘A. I do not think that I did. It has been suggested, I think it was Dr Bolsin who thought that I had telephoned Dr Roylance after seeing him and Dr Black on one occasion. I do not recollect doing that and Dr Black supports me in that recollection.’[70]

56 Dr Bolsin stated:

> ‘I was unsuccessful in my application for the post in Oxford and consequently returned to Bristol in the summer of 1992 and set about collecting the data, which Professor Prys-Roberts had requested.’[71]

Concerns raised with the SRSAG

57 The Working Party Report commissioned by the SRSAG had been completed and was delivered by Professor Hamilton, Chairman, Executive Committee of the Society of Cardiothoracic Surgeons and Chairman of the RSCE Working Party, to Sir Terence English with a covering letter dated 19 June 1992.[72]

58 The Report recorded that:

> ‘Following the first meeting of the present Working Party in February 1992, a questionnaire was sent out to the ten designated Centres and to Oxford and Leicester in addition. This requested returns for annual figures and mortality for the years 1998, 1989, 1990 and 1991, for all Neonates and Infants (under 1 year of age) who underwent open and closed heart surgery …’.[73]

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[70] T94 p. 49 Professor Prys-Roberts

[71] WIT 0080 0112 Dr Bolsin

[72] RCSE 0002 0162; letter from Professor Hamilton to Sir Terence English dated 19 June 1992

[73] RCSE 0002 0165; Working Party Report

59 The data received as a result was summarised in Table 1[74] appended to the Report.[75]

60 The Report addressed the question of the required number of designated centres for NICS. It recommended that:

> '… 9 Centres now be recognised for Supra Regional designation and funding … [they] are: Great Ormond Street, Birmingham, Liverpool, Leeds, Wessex, the Royal National and Brompton Hospital, Bristol, Newcastle and Leicester.'[76]

61 Sir Terence was asked for his reaction, initially, to the recommendation that Bristol continue to be designated. There followed this exchange:

> 'Q. What argument would you derive from the data and from what you have already told us as to your knowledge of Bristol, which would justify its continued designation as a centre for the neonates and infants?
>
> 'A. That it was functioning at a lowish level, certainly not the lowest; and that it was still regarded as being an important centre.
>
> 'Q. In terms of your own reasons for supporting it earlier: geography was not essential, and potential appears to be belied by the trend downwards?
>
> 'A. Potential still has not been realised, I agree.
>
> 'Q. Is it not the case that if you were to apply your own approach to it, you would have said, "Well, this trend really argues against there ever being a realisable potential here, now"?
>
> 'A. I certainly did not think that at the time that I received this report.
>
> 'Q. If you had the benefit of hindsight, do you think you might have taken that view?
>
> 'A. I think that I should have initially given a more critical analysis, or given more critical analysis to Table 1 of the Report, but I had asked a group of very responsible clinicians to look at this. They had accepted the terms of reference; they had collected a lot of data, come up with a report that I could understand their reasoning for wishing to continue to advise that the service be designated and how this could be achieved. And the recommendations to ask Guy's to either amalgamate with another London unit or fail to continue to get funding, and similarly, to ask Harefield to amalgamate with the Brompton or face withdrawal of

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[74] RCSE 0002 0169; Table 1 'Neonatal and Infant Cardiac Surgery' dated 23 June 1992

[75] RCSE 0002 0165 – 0166; *'Report from the Working Party set up by the Royal College of Surgeons of England on Neonatal and Infant Cardiac Surgery: Supra Regional Funding and Designation'* dated June 1992

[76] RCSE 0002 0167; Working Party Report 1992

> funding, and to recognise that Leicester was doing good work, these all struck me as being perfectly reasonable at the time.' [77]

62 On 2 July 1992 Sir Terence (as President of the Royal College of Surgeons of England (RCSE)) wrote a letter to Dr Halliday, enclosing the Hamilton Working Party Report, the conclusions of which at this stage he supported. His letter concluded:

> 'The Working Party collected a lot of data on which to base their recommendations and should be congratulated on a report which has the full support of the Royal College of Surgeons'.[78]

63 Sir Terence also wrote to Professor Hamilton on 2 July 1992, thanking him for a 'balanced and authoritative report' that had the full support of the RCSE.[79]

64 In a letter to the Inquiry received after the conclusion of oral evidence, Professor Hamilton stated that, although mortality was quoted in one of the tables 'it is possible that insufficient attention was given to these figures by the working party'.[80]

65 On 3 July 1992 there appeared a further article in *'Private Eye'*:

> 'Mrs Bottomley[81] claims that whistle-blowing "through the correct channels" will get results. Staff at the United Bristol Healthcare Trust (UBHT) have been whistling about the dismal mortality statistics in the paediatric cardiac surgery unit since 1988. … And while UBHT's chief executive, John Roylance, the Royal College of Surgeons and Duncan Nichol,[82] the chief executive of the NHS Management Executive are all well aware of the problem, they seem more concerned with silencing the blowers.
>
> 'In America, the mortality rate for arterial switch, an operation to connect congenitally transposed arteries from the heart is now 0 percent. Nearer to home in Birmingham, it is 3 percent. In Bristol, despite the fact that the operation has been performed since 1988, it is 30 percent. Sadly, consultant cardiologists at the Bristol Children's Hospital continue to refer patients to their surgeons "to support the local unit". As a recently retired and very eminent cardiac surgeon in Southampton says: "*Everyone* knows about Bristol".'[83]

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[77] T18 p. 126–7 Sir Terence English

[78] DOH 0003 0013; letter from Sir Terence English to Dr Halliday dated 2 July 1992

[79] RCSE 0002 0179; letter from Sir Terence English to Professor Hamilton dated 2 July 1992

[80] WIT 0044 0004 Professor Hamilton

[81] Virginia Bottomley MP, former Secretary of State for Health

[82] WIT 0351 0004. Duncan Nichol was the Chief Executive of the National Health Service Management Executive in England between January 1989 and March 1994. In his written statement to the Inquiry he stated: 'I had no personal knowledge and received no report of any concerns around paediatric cardiac surgical services at the Bristol Royal Infirmary.'

[83] SLD 0002 0005; *'Private Eye'*, 3 July 1992

66 Dr Hammond was asked by Counsel to the Inquiry about this article in the following exchange:

> 'Q. … the next one which deals with figures. It is the bottom left-hand column: "Mrs Bottomley claims that whistle-blowing through the 'correct channels' … will get results. Staff at the UBHT have been whistling about the dismal mortality statistics in the paediatric cardiac surgery unit since 1988."
>
> 'Just pausing there, in *"Eye"* 793 you had not said anything about staff having raised these concerns internally since 1988. … What was the basis for saying that?
>
> 'A. I would presume 1988 is the year that Dr Bolsin arrived at the Bristol Royal Infirmary?
>
> 'Q. That is right.
>
> 'A. So he told me that staff had been concerned. Whistle-blowing can be whistle-blowing among colleagues on a unit, it can be to the Chief Executive, it can be to the consultant. I do not mean whistle-blowing as in taking it outside the hospital. But if I mention 1988, I presume it is when Dr Bolsin arrived at the hospital and that was his view then.
>
> 'Q. So the source for it was probably what Dr Bolsin told you?
>
> 'A. Yes.
>
> 'Q. How many meetings did you actually have face-to-face with Dr Bolsin?
>
> 'A. I had one meeting face-to-face, and then I phoned him on perhaps four or five occasions over the course of 1992.
>
> 'Q. But not thereafter?
>
> 'A. No. I then, at the end of 1992, the beginning of 1993, moved to Birmingham to take up a lectureship and lost contact.
>
> 'Q. Which is why when you talk about what Dr Bolsin was doing in 1993 …
>
> 'A. It was taken from stuff in the print media already.
>
> 'Q. "While UBHT's Chief Executive … John Roylance, the Royal College of Surgeons, and Duncan Nichol, Chief Executive of the NHSME, are all well aware of the problem, they seem more concerned with silencing the blowers."
> "The problem" is what, dismal mortality statistics?

‘A. Yes. I had one anonymous source who when things were written in *“Private Eye”* about cardiac surgery would photocopy the columns and add comments and then circulate them to me, rather like the Brompton whistle-blower. My experience of whistle-blowers, if people whistle-blow anonymously, they tend to use scattered targets, so they will go as in the [case of] Brompton to this Inquiry, to *“Private Eye”* and to the Down’s Syndrome Association.[84]

‘There was one person I did not have a clue what the identity was who was photocopying the *“Private Eye”* columns, sending one copy to me and sending counter copies to various institutions. The one I remember most was Duncan Nichol, because I thought what an odd choice of person to send the column to, but it was clear to me this person did not know who was accountable for the problem either, so he was sending articles. The tone was written in a similar style to the Brompton tone, which is why I acted so quickly when I got the Brompton letter, so it was not in harsh, aggressive doctor-speak.

‘Q. I will come back and touch on the Brompton letter at a later stage, if I may, but here the source that was sending you photocopies of what was in *“Private Eye”* with comments appended and sending round a circulation list: do I take it that was not the same source as the source of the information, the other high level source to which you have already referred?

‘A. No, it was giving information such as “parents on the unit are told they are in the best hands, or they are in the best unit, or whatever, and the results do not seem to bear this out”, but they did not give me any specific figures.

‘Q. So that is the anonymous contributor by post?

‘A. Yes. It was completely anonymous, even to me.

‘Q. This article goes on: “In America the mortality rate for arterial switch, an operation to connect congenitally transposed arteries from the heart, is now 0 percent. Nearer to home in Birmingham it is 3 percent. In Bristol, despite the fact the operation has been performed since 1988, it is 30 percent. Sadly, consultant cardiologists at the Bristol Children’s Hospital continue to refer patients to their surgeons ‘to support the local unit’” and that is in quotes. Where did the figures come from?

‘A. Again, it would either have been Dr Bolsin or A N Other. They were the only two sources I had of figures.

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[84] An anonymous letter was received by Brian Langstaff, Q.C., Counsel to the Inquiry, alleging that there was a cause for concern in relation to the results of children’s heart surgery at the Royal Brompton Hospital. This letter was forwarded by the Inquiry to the Chief Executive of the Royal Brompton Hospital and the fact that this had happened, and that the Chief Executive had then ordered an inquiry, received media attention in August 1999. WIT 0283 0069; letter dated 1 June 1999

> ‘Q. Let me just move off this screen for one moment. Remembering the date, it is 3rd July 1992, … can we have UBHT 61/165 on the screen: “Hospital Medical Committee, Audit Committee, medical audit meeting report”. I do not know if you picked this up from having looked at the transcript, but in case you have not, I will take you through it. At this stage we have been told – there are records to demonstrate it – monthly audit meetings in respect of paediatric cardiac surgery or what is called “paediatric cardiology” here. Meetings, one of them chaired by Mr Dhasmana, and we can see those who were in attendance. Dr Bolsin is not one of them. The audit topic and criteria reviewed: “Results of arterial switch” done by Mr Dhasmana, that is what “by JPD” means, I think. “Findings and observations”: mortality similar to reported results, particularly if ... “consider earlier experience, higher mortality from VSDs and when in hospital for long time prior to switch. Action taken: persevere ...”.
>
> ‘That audit meeting appears to have looked at mortality for transposition of the great arteries with a ventricular septal defect, and concluded that the findings are similar to reported results, but presumably had figures in front of it, or may well have had figures in front of it. Did anyone talk to you about that meeting?
>
> ‘A. Not the meeting, no. I presume what you are going to go on to say is that the results that were published in *“Private Eye”* were similar to the results in that meeting, but I was not told specifically about the meeting, no.
>
> ‘Q. Were you told where the figures came from?
>
> ‘A. No.
>
> ‘Q. Do you know whether it was Dr Bolsin or your other source who gave you those figures?
>
> ‘A. No, I do not. I cannot say. Whatever the case, there must have been somebody ... if it was Dr Bolsin, there must have been somebody who had told Dr Bolsin because he was not at the meeting, but I cannot be sure which of my sources gave me that information.’[85]

67 Sir Terence English was asked during his evidence about the identity of the ‘eminent cardiac surgeon’ referred to in the 3 July article:

> ‘Q. Just pausing there, you knew the identity, did you not, of the eminent consultant surgeon who had just retired from Southampton?
>
> ‘A. I presume it was Sir Keith Ross.

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[85] T64 p. 77 Dr Hammond

> 'Q. It could not be anyone else, could it?
>
> 'A. No.'[86]

68 In 1986 Sir Keith Ross was elected to the Council of the RCSE and served for two years as the College's representative on the Council of the Royal College of Obstetricians and Gynaecologists. Earlier in the 1980s, he was one of the small group of surgeons who founded the Specialist Fellowship in Cardiothoracic Surgery in the Royal College of Surgeons of Edinburgh, which subsequently became the Intercollegiate Fellowship. In 1989 he was made a Fellow of the Royal College of Surgeons of Edinburgh and awarded the Bruce Medal. He retired in 1990.[87]

69 Sir Keith, in his written evidence to the Inquiry, stated that a meeting:

> '… of the Working Party [of the RCSE], which was held on Friday 8th May 1992 at the Royal College of Surgeons, was dominated by the perceived need to maintain the number of supra-regionally funded units at nine. Therefore, a great deal of time was taken up considering applications from Leicester and Oxford and also trying to find a solution to the Brompton/Harefield problem, which had resulted in the number of centres rising to ten. The problem presented at Guy's Hospital also received a great deal of attention. This did not prevent close scrutiny of the crude mortality figures in Table 1, which indeed showed that in 1989 and 1991 the Bristol figures were the highest recorded. However, in 1990 the Bristol mortality was only 13% for neonates and infants. Unfortunately, there is no comment on these facts in the Report itself, and at this stage it is hopeless for me to try and remember what discussion actually took place. It cannot be emphasised enough that the Working Party on 8th May 1992 was completely unaware of the situation evidently developing in Bristol, which, so far as the Royal College of Surgeons was concerned, came to a head with the arrival of Dr Zorab's letter dated 15th July 1992. On a purely personal note, I would add that this comment also applies to myself, whatever the implication of the hearsay evidence in *"Private Eye"*.'[88]

70 He stated further:

> 'I did not write to *"Private Eye"* and can see no reason why I should have done so. Nor have I had any direct contact with Dr Phil Hammond. I suggest that the real significance of the remark, ascribed to me by innuendo, has to be the implication that what is now perceived to have been a very serious situation in Bristol was so widely known that it would have included the members of our working party. Carried to its logical conclusion, the inference is that we chose to do nothing about it. This is manifestly absurd, because if the members of the working party had indeed had such information available to them, little else would have been discussed [at a meeting of the working party] on 8th May 1992. That this did not

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[86] T18 p. 134 Sir Terence English

[87] WIT 0031 0001 Sir Keith Ross

[88] WIT 0031 0006 Sir Keith Ross

> happen confirms the lack of available evidence beyond the crude mortality figures show in Table 1 of the report,[89] and perhaps helps to put the journalism into perspective.'[90]

71 On 2 July 1992 Sir Keith wrote to Mr Wisheart saying:

> 'I am writing to you in some distress because I have just been told of a comment about Bristol paediatric cardiac surgery, supposedly made by someone that could only have been me by inference, in *"Private Eye"*. Please accept my complete and unqualified denial of any such comment – not only have I *not* discussed your unit with anyone outside the Working Party on Supra regional recognition of paediatric cardiac units, I can honestly say I have no knowledge of your results. I can only assume that some malicious person who knows I sit on the Working Party has, for some reason best known to themselves, seen fit to ascribe this comment to me. As always in this sort of situation, there is nothing I can do except acquire an even deeper hatred of the behaviour of the press.'[91]

72 In his written statement to the Inquiry, Sir Keith stated:

> 'Finally, I stand absolutely by my comment made in a personal letter to James Wisheart dated 2nd July 1992. Of course, as a member of the working party I was aware of Bristol figures up until 1991, but when I wrote the letter to Mr Wisheart it was half way through 1992 and I had no idea whether the trend in his results was improving or deteriorating or staying about the same.'[92]

73 Dr Hammond stated in his written evidence to the Inquiry, in relation to the 3 July article and the quote 'attributable to' Sir Keith:

> '… I am unable to give full details as I have not yet been able to contact the source. However, I know from another source in Southampton that in 1992 and before, there were concerns about the poor results for complex paediatric heart surgery in Bristol. This was also the view that I received from sources in other centres at the time.
>
> 'I did not name Sir Keith Ross in the column because my source did not wish to name him. The aim was to bring the matter to the attention of a senior member of the specialty who could use his influential position as part of the 1992 Royal College of Surgeons Working Party to investigate the matter. As he was already retired, I felt there would be no threat to his career in raising concerns about Bristol … I was confident that the column would be brought to his attention, that he in

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[89] DOH 0002 0113; Working Party Report June 1992

[90] WIT 0031 0008 Sir Keith Ross

[91] JDW 0003 0130 – 0131; letter from Sir Keith Ross to Mr Wisheart dated 2 July 1992

[92] WIT 0031 0009 Sir Keith Ross

turn would bring the matter to the attention of the Working Party and that appropriate action to protect patients would take place.'[93]

74 Dr Hammond's views as expressed in the 3 July article were explored further in the following exchange:

'Q. Again, just focusing on what is said in the bottom of the left-hand column, "nearer to home in Birmingham, 3%". The source appears to be an individual with access to comparable or comparative information from different centres?

'A. Yes. Or it may be that I was given the information and I went to another source and said "Can you compare it to other centres for me", so it does not necessarily mean that the same source gave me the two bits of information.

'Q. Can you remember which?

'A. No.

'Q. "Sadly consultant cardiologists ... continue to refer patients to their surgeons 'to support the local unit'." That is in quotes. Is it in fact a quote?

'A. I do not know. I presume it was told to me as a quote, otherwise I would not have written it as a quote.

'Q. "As a recently retired and very eminent cardiac surgeon in Southampton says, 'Everyone knows about Bristol'." The "recently retired and very eminent surgeon in Southampton" is Sir Keith Ross, is it?

'A. I found out subsequently, yes.

'Q. Because you found out subsequently, that suggests he did not say this to you?

'A. No. But neither did he write to *"Private Eye"*, and say "I did not say that".

'Q. And given your own recent experience in relation to the *"Telegraph"*, you would not blame him for that, I take it?

'A. I would not. Having seen his letter to James Wisheart he was absolutely outraged by this, whereas I was not outraged by being misquoted by that journalist. If you were outraged by something, you would take action to set the record straight. I find it extraordinary that he did not.

'Q. He never spoke to you, never met you; is that right?

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[93] WIT 0031 0014 Dr Hammond

‘A. No, I have never met him.

‘Q. The quote which is attributed to him — how far does it take us? It talks about “everyone knows about Bristol”. Knows what?

‘A. My feeling was that he would not specifically have access to individual operation information; it was a general feeling that the journalistic tactic here was to find somebody in a very senior position who sat on either one or both working parties, who is in a position to act. This particular surgeon was chosen partly because he was retired and it was thought that there would be no threat to his career by raising concerns. And that I had a source in Southampton who said this was the general view at the time, that Bristol was known to have low numbers, no specialist heart surgeon, not the place you would want your own children to go.

‘Q. The process points you have been talking about …

‘A. My recollection of this particular statement is that I would have — written like that, it would probably mean this comment was made privately and was not meant for public consumption, but the reason I used it was to alert this particular person that there was a very severe problem here, knowing he was on the Working Party, knowing he would have to sign up to the recommendations of the Working Party having read this.

‘Q. Forgive me for a moment so I understand this. If the surgeon says “everyone knows about Bristol”, it follows whatever there is to be known, he knows?

‘A. Not necessarily, no. I would dispute that. I would think in general terms it was known within the paediatric cardiac surgery community in 1992 that Bristol had major problems.

‘Q. You may not be following the question. What I would like you to focus on is the words attributed to Sir Keith Ross, the words which are attributed to him in quotes, and you have told us that that must have been given to you as a quote because that is what you do, “everyone knows about Bristol”.

‘If the quote means that everyone knows that Bristol has particular problems, then he, the speaker, uttering those words, is recognising those problems by uttering those very words, is he not?

‘A. Yes.

‘Q. So this would be someone who knows, upon whom you are relying as a source of knowledge in your article?

‘A. I am not saying specifically that he knew the specifics of individual operations. I was told that he was – I believe he was on the original Working Party and so would have known that Bristol was a significant outlier then, and I believe he was on the current Working Party. That was the context in which I used the quote. I would also say that when I talked to people in other units, it was quite common for anaesthetists to be operating with a surgeon and to say, "Why has this baby bypassed Bristol?" Over the years I have had this general comment from the Hammersmith, Brompton, Guys, Southampton, Oxford and Cardiff as a sender, where anaesthetists have queried why babies are not going to Bristol. There have been some quite harsh comments which I could not possibly repeat because I think they would be libellous, and there were some general comments that for this sort of operation, you do not go to Bristol, as in "everyone knows about Bristol". I do not think that people would necessarily know specific results for specific operations, but my general feeling at that time is that it was known within the community that it was not the place, for example, to send your own children.

'Q. The point of the last few questions I have been asking you about the surgeon who was sending knowledge on which you rely in your article, is to ask what was the particular point in drawing the surgeon's own knowledge to his attention so he can do something, when the assumption is that he knows it already?

'A. From what I have just said, I do not think he knew the true nature of all the problems, but he should have known having been on two working parties that there was a problem with Bristol. This was a journalistic tactic to ensure that he took action.

'Q. So by "everyone knows", what is Delphic about it is the word which might come after "knows", as to "knows what about Bristol"?

'A. Yes. As I say, I am not a surgeon, but my few insights into this particular community is that they are quite close-knit and people speak and trainees speak at meetings and that was the general concession, that "everybody knows that Bristol has problems".

'Q. Do you accept what Sir Keith Ross has said to us, to the effect that he, for his part, did not have any knowledge that Bristol was under-performing?

'A. As I have said in my statement, I have not been able to identify the precise source of that particular piece of information, so I cannot confirm or refute; all I can say is that Sir Keith Ross never challenged that piece of information.'[94]

75 On 3 June 1992 the Bristol paediatric cardiac clinicians had held a meeting to review the results of the Arterial Switch operation.[95] Towards the end of that meeting Mr Dhasmana mentioned figures similar but not identical to those that subsequently emerged in the 3 July *'Private Eye'* article.

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[94] T64 p. 82 Dr Hammond

[95] UBHT 0061 0165

76 In July 1992 Mr Dhasmana's secretary gave him a copy of the *'Private Eye'* article that someone (not identified in evidence) had passed to her.[96] When he read it he discovered that the figures quoted were the reverse of those discussed in the June meeting. He said:

> '… what it quoted was, what surprised me, what I mentioned at the end of the meeting was quoted here the wrong way round … I had mentioned that at the end of the meeting, when we finished, somebody made a type of remark, "Okay, Janardan, what is the result nowadays in Birmingham?" because I did not really know, and the last results I had known was 5 percent, but I mentioned — "I am sure Birmingham would now be doing 0 percent" — it was a little light-hearted remark. Then it got a bit more serious. "And America?" — I said "I do know Castaneda, they got 3–5 percent". So in a way, when I saw this thing, I said "It is my words being quoted here, but it is the other way around" because I mentioned America 3 percent and Birmingham 0 percent. Here it says Birmingham 3 percent and America 0 percent. So it was my quotation which has been mentioned here, but of course it is the wrong way around.'[97]

77 Mr Dhasmana subsequently questioned all those present at the meeting of 3 June 1992[98] to seek to find out who was responsible for passing information from the meeting to *'Private Eye'*. No-one admitted responsibility.[99]

78 Mr Wisheart (who said he had a general perception at the time that adverse comments were being made about the performance of paediatric cardiac surgery), said he made: 'no effort whatsoever'[100] to discover who made the comments to *'Private Eye'* because:

> '… as Dr Roylance pointed out to me, but I think to a much wider circle also, that it was really an irrelevance who was the source of the information because we would not do anything about it anyway because if that was within their rights to do and so forth and we would not be taking any action as a consequence of that. So there was therefore no further reason to think about that and I think I had put it, if not out of my mind, at least to the back of my mind.'[101]

79 The July article had further consequences. On 15 July 1992 Dr John Zorab (Medical Director of Frenchay Hospital and a consultant anaesthetist) wrote to Sir Terence

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[96] T86 p. 119 Mr Dhasmana
[97] T86 p. 121 Mr Dhasmana
[98] UBHT 0061 0165; Medical Audit Meeting Report, 3 June 1992
[99] T86 p. 119 Mr Dhasmana
[100] T94 p. 145 Mr Wisheart
[101] T94 p. 139 Mr Wisheart

English at the RCSE. He enclosed a copy of the article from *'Private Eye'*.[102] His letter stated:

> 'Some time last autumn, I made one or two efforts to get to see you in order to discuss the delicate and serious problem of mortality and morbidity following paediatric cardiac surgery in Bristol. I have no vested interest in this and the problem is outside my immediate sphere of influence but great anxieties were being expressed by some of my colleagues at the Royal Infirmary. In the event, I never made contact with you and the matter passed from the forefront of my mind.
>
> 'Matters have come to a head once again and the enclosed piece from *"Private Eye"*, whilst possibly having some inaccuracies, quotes some statistics which have been confirmed elsewhere. One of the newer consultant cardiac anaesthetists feels that the mortality rate is too distressing to be tolerated and is job-hunting elsewhere.' [103]

80 On 21 July Dr Zorab's letter was forwarded to Sir Terence by Sir Norman Browse, (who had taken over from Sir Terence as President of the RCSE, Sir Terence having left office on 8 July).[104]

81 Sir Terence explained in the following exchange that the letter from Dr Zorab had acted as a 'stimulus' to him to go back to look at the data in the Working Party Report more carefully:[105]

> 'Q. When you were prompted by Dr Zorab's letter you then went back to Table 1 and looked at it more carefully?
>
> 'A. Yes.
>
> 'Q. What you looked at was, to you, disturbing?
>
> 'A. Now taken in conjunction with Dr Zorab's letter, yes.
>
> 'Q. Taken in conjunction with the letter, not just the figures on their own?
>
> 'A. No, because the figures … all they can do is to suggest that there could be a problem there, they are very crude. They are dealing with very small numbers. They fluctuate. It is of concern; it needs further investigation …

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[102] SLD 0002 0005; *'Private Eye'*, July 1992

[103] RCSE 0002 0188; letter from Dr Zorab to Sir Terence English dated 15 July 1992

[104] RCSE 0002 0191; letter from Sir Norman Browse to Sir Terence English dated 21 July 1992

[105] T17 p. 124 Sir Terence English

> ‘Q. And it was the combination of the figures on their own which required further investigation and the concerns relayed to you by Dr Zorab, that led you to suggest that these concerns were so great that Bristol should be de-designated as a centre?
>
> ‘A. Yes.’[106]

82 Sir Terence was asked:

> ‘Q. What it suggests is that unless someone had been prepared to complain, there would be no closer look?
>
> ‘A. Well partly, but also what it suggests was the great difficulty of making anything out of the mortality statistics that were provided as they were. They were very inadequate, incomplete, as I say, un-risk stratified, disaggregated, not coming from individual surgeons.’[107]

83 Sir Terence dictated a reply to Sir Norman on 25 July 1992, prior to his (Sir Terence’s) departure that day for Pakistan.[108] He also dictated a letter to Dr Zorab on the same day.[109]

84 The 1992 ‘Working Party Report’ was due for consideration by the SRSAG at its meeting on 28 July 1992. Sir Terence’s letter to Sir Norman stated:

> ‘Although I was aware that Bristol was not one of the best paediatric cardiac surgical centres, I had not appreciated that the situation was as serious as described by John Zorab. Bristol was included as one of the centres for designation. However, it is clear from a review of Table 1 in the Report[110] that their mortality statistics both for the infant age group and the older age group is worse than [those of] any other centre. David Hamilton agrees that sufficient attention was not paid to this by his Working Party.’[111]

85 Sir Michael Carlisle, then Chairman of the SRSAG, told the Inquiry that he did not see the letter from Dr Zorab until the Inquiry provided it to him in 1999, prior to his giving oral evidence.[112] Sir Michael thought that the letter ought to have been drawn to the SRSAG’s attention. He said:

> ‘A. I am appalled, if that sort of correspondence was around on 15th July? I cannot remember the date of that Advisory Group meeting.[113]

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[106] T18 p. 150 Sir Terence English

[107] T18 p. 115 Sir Terence English

[108] RCSE 0002 0193; letter from Sir Terence English to Sir Norman Browse dated 25 July 1992

[109] RCSE 0002 0195; letter from Sir Terence English to Dr Zorab dated 25 July 1992

[110] RCSE 0002 0169; Working Party Report 1992

[111] RCSE 0002 0193; letter from Sir Terence English to Sir Norman Browse dated 25 July 1992

[112] T15 p. 74 Sir Michael Carlisle

[113] The meeting was on 28 July 1992

> ‘The other point I have to say is that if this sort of information had been around, even on a person-to-person basis, without any member of the Advisory Group, whether he is the President of the Royal College of Surgeons or not, and it was not reflected to the Group, I would take a very strong view about that indeed.
>
> ‘I regard it, I have to say, I am sorry, I am trying to retain control of myself …
>
> ‘Q. Do not worry.
>
> ‘A. I would regard it almost as, forgive the business allusion again, as making investments when your company is insolvent. I think it is appalling. If that was the case.’[114]

86 Sir Terence told the Inquiry that he spoke to Professor Hamilton twice by telephone, probably on 23 and 24 July 1992.[115] Sir Terence’s contemporaneous handwritten notes of the conversations, produced for the Inquiry, indicate that he and Professor Hamilton discussed mortality rates for various procedures at Bristol.[116] The data discussed was not simply that in the Working Party Report but included other data of which Sir Terence was previously unaware.[117]

87 Professor Hamilton, in his letter to the Inquiry referred to above,[118] confirmed that he had two telephone conversations with Sir Terence, one on 23 and one on 24 July 1992. Professor Hamilton wrote:

> ‘Sir Terence suggested to me that he wished to alter the recommendations of the working party with respect to Bristol only, in the light of information he had received recently regarding the high mortality rate that was occurring in Bristol at the time. … I am sure that we discussed mortality … .’

88 Sir Terence and Professor Hamilton agreed that it should be recommended to the SRSAG that Bristol be de-designated. Sir Terence was asked:

> ‘Q. So I understand the basis upon which you were suggesting de-designation: was that because, as you emphasised throughout your evidence to us, that one would want to consider outcomes and mortality data and so on to see whether small numbers meant that a unit was not really viable, or was it because to allow Bristol to go forward might prejudice the chances of the others?
>
> ‘A. It was both, I think.’[119]

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[114] T15 p. 75 Sir Michael Carlisle
[115] T18 p. 151, p. 154 Sir Terence English
[116] WIT 0071 0047 Sir Terence English
[117] T18 p. 155–6 Sir Terence English
[118] WIT 0044 0004 Professor Hamilton
[119] T18 p. 152 Sir Terence English

89 Professor Hamilton and Sir Terence agreed that the latter should speak to Dr Halliday. Sir Terence telephoned Dr Halliday:

> ‘Q. Did you tell Dr Halliday that Bristol’s mortality record appeared so bad that it required investigation?
>
> ‘A. I believe I told him the content of my discussions with Professor Hamilton.
>
> ‘Q. Did you tell him about the Zorab letter?
>
> ‘A. Yes, I believe so.
>
> ‘Q. Did you tell him about the *“Private Eye”* article?
>
> ‘A. I do not know whether I did or not.’[120]

90 Subsequently, in written evidence to the Inquiry dated 2 December 1999, Sir Terence indicated that he did not, in fact, mention Dr Zorab’s letter to Dr Halliday.[121]

91 Sir Terence was told by Counsel to the Inquiry that Dr Halliday maintained that Sir Terence never said anything to him about mortality statistics. Sir Terence replied:

> ‘It was the only reason why I would have ever got into this. The report had gone on, gone through. The activity figures were all there. We were not questioning those. The whole issue of having to do something at such short notice arose through Dr Zorab’s letter and a review of mortality statistics and that was made absolutely clear to [Professor Hamilton and Dr Halliday] – and that was – I mean, again, the reason for Professor Hamilton reconsidering his position …’[122]

92 Later in his evidence, Sir Terence reiterated that he had spoken to Dr Halliday:

> ‘Q. I press you again on this. In the light of your obvious uncertainties as to what happened until you saw the documents, are you still sure that you said to Dr Halliday something about mortality statistics at Bristol and how disturbing they were?
>
> ‘A. Absolutely. There could be no other explanation of the correspondence and what I had said there.’[123]

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[120] T18 p. 157 Sir Terence English
[121] WIT 0049 0029 Sir Terence English
[122] T18 p. 160–1 Sir Terence English
[123] T18 p. 184 Sir Terence English

93 Dr Halliday's evidence to the Inquiry on 29 April 1999 concerning the conversation with Sir Terence was:

> '… he rang me either the night before the meeting or on the morning of the meeting,[124] and I am confident of that because we left the briefing of the Chairman to the very last minute, so that anything that arose that was relevant to the Group's discussion would be in his briefing. So that was normally completed about 24 hours before the meeting.
>
> 'Sir Terence said he could not be at the meeting, and I put it to him that he would not be particularly happy with the outcome, because it was my expectation that the Advisory Group would not accept the recommendations of the College, and that really we had very little alternative but to de-designate the service. Sir Terence asked me to make it known to the Advisory Group that since the Report had gone in, he now had reservations about Bristol. He was not specific, and I assumed he was referring to the ongoing problem that we have discussed so much and that was all.
>
> 'So at the Advisory Group I did report that Sir Terence had spoken to me; that I had told him what was likely to happen … and he had said he wanted his reservations about Bristol to be noted.'[125]

94 When he gave oral evidence for a second time to the Inquiry, Dr Halliday maintained that Sir Terence had not mentioned concerns about rates of mortality at Bristol:

> 'He never mentioned mortality at any time.
>
> 'For Terence English to have raised mortality in cardiac surgery to me would have really rung bells because, as you are probably aware, Sir Terence was the lead behind setting up the Society's Registry. He believed that the Registry was the only way in which you could carry out audit in cardiac surgery and in fact point blank refused to provide evidence to the Department other than in an anonymised form on cardiac surgery and for him to raise mortality with me would have really rung bells, but he never did so and he does not say now in this letter[126] that he did.'[127]

95 Sir Terence accepted that, save for his letter to Sir Norman Browse and a short reply to Dr Zorab, he did not put his concerns about mortality at Bristol in writing to the

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[124] Dr Halliday's recollection, that Sir Terence's conversation with him was on the day of the meeting or the day before, is not consistent with the contemporaneous correspondence. Sir Terence was in Pakistan from 25 July 1992. The meeting was on 28 July 1992

[125] T13 p. 87–8 Dr Halliday

[126] WIT 0049 0029 – 0033 Sir Terence English

[127] T89 p. 152 Dr Halliday

SRSAG, the Department of Health, the UBHT, the SWRHA or elsewhere. Sir Terence explained that the reason he did not do so was:

> 'I felt that the Medical Secretary of the Supra Regional Services Advisory Group understood our concerns, and that it was up to him to take it up with the Trust and if the Trust then wanted to look at matters further, they could ask us either directly or through the Supra Regional Services Advisory Group.' [128]

96 Sir Michael's recollection was that Dr Halliday had reported to the meeting of 28 July 1992 along the lines recorded in the minutes:[129]

> '… I think it was a telephone conversation – I cannot be absolutely sure – but he did report in those terms to the Advisory Group, the words, as far as I can recall, that were said there [i.e. in the minutes of the meeting].
>
> 'I have to say, my interpretation, to the best of my knowledge, was that the reasoning behind that was the difficulty in increasing volumes. …
>
> 'There was certainly nothing said about the quality of the service.'[130]

97 Dr Halliday was asked:

> 'Q. … did you ask him what the concerns were?
>
> 'A. He did not offer an explanation of his concerns and I assumed his concerns were the usual ones, that is that the referral rate and the throughput was low.' [131]

98 But, as Dr Halliday acknowledged: 'Everyone knew and had known for years about the referral rate and the throughput being low'. There was 'nothing new' in that point.[132]

99 Dr Halliday was asked:

> 'That would be, would it not, a very surprising reason for him [Sir Terence] at the eleventh hour as it were to telephone you and say "I have reservations about Bristol on those grounds"?'[133]

100 Dr Halliday replied in the following exchange:

> 'A. It was a very unusual telephone call. I mean I have received a Report written by the leading experts in Europe on a subject, blessed by the President as being an

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[128] T18 p. 165 Sir Terence English
[129] See later, paras 109 and 110, for the minutes
[130] T15 p. 73 Sir Michael Carlisle
[131] T89 p. 157 Dr Halliday
[132] T89 p. 157 Dr Halliday
[133] T89 p. 157 Dr Halliday

> authoritative report and, as he said in his letter, all the data that was available had been considered. He said that at the last paragraph of his Report, words to that effect. Then to ring me up and say "I want to withdraw the Report", it was an astonishing telephone call.
>
> 'Q. So you asked him why he changed his mind, presumably?
>
> 'A. No, no, it is not for me to question the President of the Royal College of Surgeons why he wants to withdraw a Report by his experts; that is a matter for him and the College. My concern was that we had the report of the College by the leading experts. It does not matter whether an individual is the President of the College or the Secretary of the College or any other office, it is only one opinion as opposed to all the experts involved in formulating that original Report. His view was only one view, but he could have taken Presidential action and withdrawn the Report. He could have insisted that that Report was withdrawn and I would have withdrawn it.'[134]

101 Dr Halliday, in evidence to the Inquiry, said that he told Sir Terence during their telephone conversation that it was not possible to withdraw the Report. Dr Halliday said that Sir Terence then responded:

> ' "If it cannot be withdrawn, I have major reservations[135] about Bristol and I want these reservations to be communicated to the Advisory Group" and I said, "Yes, I will do that".'[136]

102 Sir Terence insisted in his written comment on Dr Halliday's [supplementary written] evidence to the Inquiry that there was no question of his asking for the Working Party Report to be 'withdrawn'. He stated that what he wanted was that Bristol be removed from the units recommended for designation, because of the concerns he now had about its mortality data.[137]

103 In his oral evidence to the Inquiry on 7 December 1999, Dr Halliday maintained 'that Sir Terence was proposing to take unilateral action and withdraw the Colleges' Report'.[138]

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[134] T89 p. 157 Dr Halliday

[135] The minutes of the SRSAG meeting of 28 July 1992 refer to Sir Terence's 'reservations' without the qualification 'major'

[136] T89 p. 157 Dr Halliday

[137] WIT 0071 0067 – 0068 Sir Terence English

[138] T89 p. 155 Dr Halliday

104 Later in his evidence there was the following exchange:

> 'Q. 'So it was not withdrawal of the Report, it was amending the Report really rather than withdrawal?
>
> 'A. Yes, but what was to be achieved? Since 1987 the profession had been on warning that they were not meeting the Supra-regional Service criteria and we would have to de-designate. The profession argued they would be able to rationalise the service. So we gave them the benefit of the doubt and we asked them to do reports. They did reports and they did reports and each time they failed to bring about the rationalisation we had hoped for. We had reached the stage where the Advisory Group had decided there was no way back, this was the crunch time.
>
> 'The fact that he was going to take back his Report and amend it really had no great significance for the outcome of the Advisory Group meeting because all the criteria that had to be met were not being met.'[139]

105 Dr Halliday went on:

> '… Sir Terence as a member of the Advisory Group and an individual intimately involved in this speciality was well aware the Advisory Group had given the cardiac surgeons as much leeway as they possibly could to bring their house in order so that it could continue to be designated. Sir Terence knew that the crunch time was 1992 and to suggest that he wanted his Report back again to amend and then resubmit, there was not time to do that.' [140]

106 Dr Halliday said:

> '… I am not sure why we are sweating over Bristol. It did not matter at all to the outcome of the decision of the Advisory Group whether the College had recommended de-designation of Bristol or designation of Bristol because the problem we had was that there were already 13 units in England, there was one about to start in Wales and there were two in Scotland carrying out this work; the criteria of the Supra-regional Advisory Group [were] therefore not being met.
>
> 'Whether Bristol was a factor in this discussion or not was really quite irrelevant. Taking Bristol out, we still had 12 units in England, which was too many for a designated Supra Regional Service. You have to take in mind that this was a funding arrangement and only a funding arrangement.' [141]

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[139] T89 p. 160–1 Dr Halliday

[140] T89 p. 165 Dr Halliday

[141] T89 p. 169 Dr Halliday

107 Dr Halliday was asked whether Sir Terence was expressing the view that Bristol should be de-designated. Dr Halliday replied:

> 'Yes, obviously – when I say "obviously" no, I do not know. He was saying "I have reservations about Bristol" but he did not clarify that and he could have done. If I had been in his shoes having just received a letter from Zorab warning him that things were not well in Bristol, I think I would have offered an explanation to myself rather than me having to extract it from him.'[142]

108 Sir Terence, during an interview for the television programme *'Dispatches'*, broadcast on 27 March 1996, said that when, in 1992, he reviewed the results of paediatric cardiac surgery at Bristol, he found its mortality levels to be 'disturbingly high'.[143] He also told *'Dispatches'* that when he advised the Department of Health that Bristol should be de-designated, he was effectively advising that the SRS for NICS should cease in Bristol.

109 At its meeting on 28 July 1992, at which Sir Terence was not present, the SRSAG:

> '… noted the Royal College of Surgeons Working Group report which recommended that the service should continue to be designated and the number of designated units should be reduced from the current 10 to 9.'[144]

110 The minutes of the 28 July meeting continued:

> 'Dr Halliday reported that since receiving the Royal College of Surgeons report, he had been approached by Sir Terence English, who indicated that since submitting the report he now had reservations about the continued designation of the Bristol unit.
>
> 'The Advisory Group discussed the issue at length but concluded that it was unrealistic to expect to restrict the delivery of the service to those units for which the Royal College of Surgeons report recommended continued designation.'[145]

111 Sir Terence told the Inquiry that the fact that his concerns were expressed in this way was a cause of concern to him. Dr Halliday pointed out that the minutes of the meeting of 28 July 1992 do not seem to have been the subject of any amendment at the next meeting, in September 1992, which Sir Terence did attend.[146]

112 The SRSAG decided to de-designate the whole NICS stating that this was '… a fairer decision in terms of medical and surgical rights of patients than to restrict designation to a few surgical units.'[147]

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[142] T89 p. 159 Dr Halliday; there was no evidence before the Inquiry that Dr Halliday sought an explanation

[143] T17 p. 4–5 Sir Terence English

[144] DOH 0002 0099; minutes of the meeting of the SRSAG of 28 July 1992

[145] DOH 0002 0099; minutes of the meeting of the SRSAG of 28 July 1992

[146] WIT 0049 0012 Dr Halliday. The minutes of the July meeting were agreed as a 'correct record' DOH 0002 0155; but the issue is not so much what Dr Halliday reported in July as whether what he reported is what Sir Terence thought he was going to report

[147] DOH 0002 0099; minutes of the meeting of the SRSAG of 28 July 1992

113 There was the following exchange with Sir Michael Carlisle about the words in the minutes:

> 'Q. One of the difficulties that we have in making sense of what is said there is that the thesis, up until now, and the advice, has been that it is in a patient's best interests that there should be a designated service. It is contrary to a patient's interests that there should be proliferation of services, and it would be desirable to use whatever efforts one could, within obviously the limits of time, to restrict proliferation of services?
>
> 'A. Correct.
>
> 'Q. One appreciates that there may have to be a bowing to the inevitable, but is there any particular reason that you can help us, why is it described as a "fairer decision in terms of the medical and surgical rights of patients" than the continuation of a system with sufficiently few designated units to achieve the objects of the system?
>
> 'A. I have a little difficulty with that, in retrospect, I have to confess. I think it goes back to the proximity of service, the geographical element. I am sorry, I cannot help you more than that. I find it a slightly ambiguous paragraph myself, in retrospect.'[148]

114 Sir Terence said that he was unable to understand the logic of the reference to '… fairer decision in terms of medical and surgical rights'.[149]

115 Mr Steven Owen, the Administrative Secretary of the SRSAG from January 1992 to February 1996, was also asked about these words:

> 'I find it difficult to answer that question after this period of time, frankly, but I think it is simply a recognition that the nature of the service had changed, proliferation was widespread, and it was simply accepting reality. I think the de-designation decision itself was an acceptance of reality.'[150]

116 Sir Michael was asked what the SRSAG might have done had the Working Party recommended a greater reduction in the number of centres being funded by the SRSAG for NICS:

> 'Q. Suppose that Professor Sir Terence English's Working Party had come up with the suggestion that there are six names, six centres, which the Royal College

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[148] T15 p. 78–9 Sir Michael Carlisle
[149] T18 p. 168 Sir Terence English
[150] T12 p. 89–90 Mr Owen

recommended for continuing designation. Do you think that probably the Advisory Group would have said, "Okay, we will retain designation for those six"?

'A. I think it is highly likely.

'Q. So it follows, does it, that the real problem or the real cause of de-designation of the service was not the fact that it was a mature service and was not the input from Guy's, it was simply a function of numbers?

'A. It was proliferation.'[151]

117 In his supplementary statement to the Inquiry Dr Halliday stated that:

'My assessment of the likely outcome of the Supra Regional Services Advisory Group meeting [on 28 July 1992] was that the NICS service would be de-designated. The [SRSAG] had no alternative. In such circumstances Sir Terence's reservations were not important. Of course I had no way of knowing how serious these reservations were.'[152]

118 Dr Halliday continued:

'Had the NICS service continued to be designated but Bristol was to have been de-designated then Sir Terence's reservations would have been extremely important and the [SRSAG] would have wished to know in detail what these reservations were. I would therefore have been pressing Sir Terence for details. In the context of the [SRSAG] meeting however the details of Sir Terence's reservations were irrelevant.'

119 Dr Halliday told the Inquiry that July 1992 was when the SRSAG's involvement with NICS ended:

'A. No, it was de-designated in 1992. It was funded for two years after that, but that was not a matter for the Advisory Group.

'Q. It remained, did it not, the responsibility of the Advisory Group?

'A. No, it did not, no.'[153]

120 Professor Hamilton wrote to Sir Terence English on 3 August 1992. In addition to the two telephone conversations he had with Sir Terence in July 1992, prior to the SRSAG meeting, Professor Hamilton had also spoken to Sir Keith Ross (a fellow member of the

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[151] T15 p. 42–3 Sir Michael Carlisle

[152] WIT 0049 0034 Dr Halliday

[153] T89 p. 170. Dr Halliday explained that Chris Spry, a member of the SRSAG, organised a continuing funding arrangement with Regional General Managers for a transition period which lasted until the spring of 1994

Working Party) on the morning of Monday 27 July 1992. Professor Hamilton said in his letter to Sir Terence English:

> ‘I hope that you had a highly successful trip to and safe journey back from Pakistan, and are refreshed after a demanding but successful term as President.
>
> ‘Following our telephone conversations of Thursday evening, July 23rd and Friday afternoon 24th, I was not entirely happy about our agreement to take Presidential and Chairman’s action over the Working Party’s report. On reflection, I realised a possible specific source of “breach of confidentiality” which could arise, and a further feeling that the de-designation of one of the Units would probably “leak out” in the course of time. Also, the members of the Working Party were unanimous in their findings and gave considerable thought to their recommendations. Like you, I was unable to contact Keith Ross but did so early on Monday morning, [July] 27th, after he had returned home from holiday. He was equally concerned that we had changed the Report and suggested, on reflection, that we should both speak with Norman Halliday to reverse the decision and the instructions that you had given him. The report is an advisory document to be considered along with other letters and “reports” – both in … and heresay [*sic*] evidence no doubt, and as such, the Working Party could be requested by the Advisory Committee on Supra Regional Funding to *reconsider* the mortality figures of specific units (or unit), and possibly to amend its findings.’[154]

121 Sir Keith in his written evidence to the Inquiry stated:

> ‘It is safe to say that when David Hamilton telephoned me at home on 27th July 1992, when I had just returned from Scotland, I had no idea of the events leading up to the telephone call. I am sure David Hamilton did his best to explain the sequence of events, but under the circumstances (and I have no clear memory of the conversation), I must have agreed with his concern regarding the working group’s conclusions being altered. Whether he or I suggested telephoning Dr Halliday is immaterial but he had to be given our views. There was no way that I could have talked with Terence English, who was either in or on his way to Pakistan, nor was there time to reconvene the working party before the SRSAG meeting, which was due the next day or the day after. …
>
> ‘Finally, I have no recollection of suggesting to Dr Halliday that the working party could be requested to reconsider the mortality figures of specific units with a view to possibly amending its findings. I would like to think that I would have recommended this, but as explained above, this never happened.’[155]

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[154] RCSE 0002 0197; letter from Professor Hamilton to Sir Terence English dated 3 August 1992 (emphasis in original)

[155] WIT 0031 0006 – 0008 Sir Keith Ross

122 When he was shown Professor Hamilton’s letter of 3 August 1992 in the course of his first appearance at the Inquiry, Dr Halliday said:

> ‘This letter changes the whole context. My discussion with Sir Terence, or at least his discussion with me about his concerns about Bristol simply meant that he had reservations about Bristol and therefore he was not entirely happy with the Report from the College.
>
> ‘This letter would suggest that there appears to be more to it than that, and I cannot comment on that.’[156]

123 Dr Halliday accepted when he gave oral evidence for a second time that the letter suggests that the discussions between Professor Hamilton and Sir Terence had involved the issue of mortality findings.[157]

124 Sir Michael was emphatic that he had no knowledge of the contact between Professor Hamilton, Sir Keith Ross, Sir Terence English and Dr Halliday and knew nothing of the discussions suggesting alterations to the Working Party’s Report.[158]

125 After returning from Pakistan and learning what had occurred at the meeting of the SRSAG on 28 July 1992, Sir Terence had indicated, in correspondence with the Administrative Secretary and the Chairman, that he wished to speak to the issue of de-designation of NICS at the next meeting of the SRSAG, on 29 September 1992.[159]

126 Sir Terence spoke at the meeting, as was explored in the following exchange:

> ‘A. I think that at my last meeting of the Group, I certainly spoke to my concerns about the de-designation of the service. I do not think I did mention Bristol specifically at that time. That is where the matter rested. I then left the Group. I know that Professor Browse knew of my concerns, but I think he did not feel any need to take them any further forward, and indeed, should not have, unless I had specifically asked him to, and I did not.
>
> ‘Q. Because he left them with you?
>
> ‘A. Yes.
>
> ‘Q. So it was, as it were, your responsibility?
>
> ‘A. Correct.

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[156] T13 p. 90 Dr Halliday

[157] T89 p. 164 Dr Halliday

[158] T15 p. 77 Sir Michael Carlisle

[159] RCSE 0002 0200 (from Sir Terence to Mr Owen), RCSE 0002 0202 (Mr Owen’s reply) and RCSE 0002 0205 (from Sir Terence to Sir Michael). None of the letters made reference to problems at Bristol

> ‘Q. And you had expressed them orally to Dr Halliday, but not otherwise?
>
> ‘A. Right.
>
> ‘Q. And never, it seems, from what you have said, thereafter expressed those concerns?
>
> ‘A. That is right.
>
> ‘Q. Do you think, perhaps, that you ought to have done so?
>
> ‘A. I think it is a difficult question. I think that I probably should have written at least to the Chairman of the Group, Sir Michael, formally about it, if I had not brought it up to the open meeting, the last one I attended. I suspect that probably is what I should have done.
>
> ‘Q. Although it may be difficult now in retrospect to say why you did not, can you help as to why you might not have done?
>
> ‘A. I think I was very cross that the Group had failed to accept the very considered advice of the professional working party that they had commissioned. That may have had something to do with it.
>
> ‘Q. So you felt outwith the group?
>
> ‘A. I did, rather.
>
> ‘Q. You simply did not think about raising the issue anywhere else?
>
> ‘A. No. No. And would not. As I say, I think the right thing probably would have been to have written formally to Sir Michael.’[160]

127 Sir Terence said that after the 29 September meeting (his last as a member of the SRSAG) he felt that the matter was closed and beyond his further intervention.[161]

128 At the end of his oral evidence, in response to a question from the Chairman, Sir Terence said that, in retrospect, he should have done more to bring his concerns about Bristol to the attention of others. He said:

> ‘… I do accept the implied criticism, and indeed, the criticism that I should have done more to bring my concerns to the Supra Regional Services Advisory Group specifically about the mortality and the concerns expressed by Dr Zorab, than I did, and in retrospect I think I should have.’[162]

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[160] T18 p. 174–5 Sir Terence English

[161] T18 p. 187 Sir Terence English

[162] T18 p. 202 Sir Terence English

Data collected by Dr Bolsin and Dr Black

129 In July 1992 Dr Black's daughter began a tabulation of the data which had been collected by Dr Black and Dr Bolsin. As Dr Black described it in his written evidence to the Inquiry:

> 'This gave us a comprehensive data set of 233 patients who underwent operations with cardiopulmonary bypass between October 1991 and July 1992 … the handwritten tabulation contained patients' names, dates of birth, hospital numbers, dates and descriptions of operation and details of the conduct of cardiopulmonary bypass (bypass and cross-clamp times). It also contained information on the outcome in terms of death, survival and time spent in intensive care and hospital.'[163]

130 Dr Bolsin was asked about this exercise in the following exchange:

> 'Q. The data you collected was from the perfusionists, was it?
>
> 'A. No, this was a new data collection and it was undertaken by Andy's daughter in her summer holiday from University. We identified the patients from several sources. Andy did most of the data collection and collation, and he would give you a better opinion of it, but I can remember going to theatre logbooks to confirm operations that he and his daughter were picking up, and I think we may have got some data from the perfusionists, but there was another source and I cannot remember what it was at the moment.
>
> 'Q. So theatre logbooks, perfusionists. What was Dr Black's daughter doing? Was she looking at the records and making notes, or what?
>
> 'A. Yes, she would be extracting the data on length of time on intensive care, length of time intubated, length of time in hospital, duration of operation, length of time on bypass, duration of cross-clamp time, those kinds of detailed data.
>
> 'Q. What was she studying?
>
> 'A. She was studying at Reading University – I cannot remember, actually. Pass.
>
> 'Q. Was she employed by the Trust to do this job?
>
> 'A. I do not know. That was an arrangement between Andy and her, I think.
>
> 'Q. Because if it was an arrangement between Andy and her, there would, on reflection, be a breach of patient confidentiality, would there not?
>
> 'A. I am not sure if patient confidentiality was breached by this data collection.

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[163] WIT 0326 0014 Dr Black

> ‘Q. If somebody who is not an employee of the Trust, not authorised by the Trust to do so, is going through individuals’ medical records in order to extract details like cross-clamp times, bypass times and so on, that must be a breach of confidentiality, must it not?
>
> ‘A. I am not sure if she may not have been an employee of the University department. I do not know whether that has any bearing on what you have just said.
>
> ‘Q. Does it follow that you never made any enquiries as to why a student could properly be involved in an analysis of the sort you have described?
>
> ‘A. I certainly did not make any enquiries. I assumed that the probity of an employee of the University department, albeit a technician, in dealing with patient records, was reasonably bona fide.
>
> ‘Q. So you assumed that she was an employee who had the status to look at the records, without enquiring?
>
> ‘A. I certainly did not make any enquiries, no.’[164]

131 The information collected was, according to Dr Black:

> ‘… transcribed from hand-written notes (excluding patients’ names and hospital numbers) on a MINITAB worksheet on an Amstrad computer in the Department of Anaesthesia. Random samples from the spreadsheet were checked against the originals for transcription errors and when in 1995 the UBHT provided tables of death or survival by type of operation, the figures were checked against the UBHT figures for repair of VSD, Tetralogy of Fallot and AVSD.’[165]

132 Dr Bolsin indicated:

> ‘Where there was doubt about the diagnosis and operative procedure one of the paediatric cardiologists was consulted to verify the data. This was Dr Alison Hayes, who had recently been appointed to the Bristol Royal Children’s Hospital.’[166]

133 Dr Black then went on in his written statement to describe the exercise in some detail:

> ‘There were 69 different descriptive titles for the operations carried out over the period. These needed to be classified as far as possible into the categories recognised and used by the UK Paediatric Cardiac Surgical Registry. Finding a suitably qualified independent person to do this took Dr Bolsin some time. The classification was not undertaken until 1993, and was carried out by Dr Alison

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[164] T82 p. 69–71 Dr Bolsin

[165] WIT 0326 0014 – 0015 Dr Black; see Chapter 3 for an explanation of these clinical terms

[166] WIT 0080 0112 – 0114 Dr Bolsin

Hayes, a consultant paediatric cardiologist who had relatively recently been appointed in the UBHT.

‘All but 39 of the 233 cases were classifiable reasonably confidently into 19 nationally recognised categories, the remainder being unclassifiable because of absent or incomplete information. I entered the classification codes into an added column in the spreadsheet using hand-written instructions about the correspondence. I compiled tables of death or survival by nationally recognised category of operation in the age groups above or below one year. (Copies of these tables were referenced in and included with my submission to the GMC.) They allowed the mortality rates in the Bristol Royal Infirmary to be compared with the corresponding national rates for 1989 and 1991, as obtained from the UK Paediatric Cardiac Surgical Register. I also tabulated the times on cardiopulmonary bypass, the cross-clamp times, days to extubation, days in ICU and days in hospital for each category of operation in Bristol. No national comparator figures are available for the period in question. (A copy of this table was referenced in and included with my GMC statement.)

‘Our records showed 42 deaths in 233 cases, giving an estimated overall mortality of about 18%. The overall mortality rate presumably reflected both the cross-section of types of operation and patient that were taken on and the way in which those cases were managed. For most of the types of operation, including the “switch” operation that came into prominence later, the numbers of cases undertaken in Bristol in the audit period were too small to allow meaningful comparison with the figures in the National Registry. There were, however, 5 categories of operation in which the numbers seemed large enough to make worthwhile comparisons with the national figures.

‘For atrial septal defect and Fontan repair, the mortality rates gave no cause for concern, but there did appear to be some cause for concern in the other 3 types:

‘1. for repair of VSDs, there appeared to have been 6 deaths overall in 47 operations, an estimated mortality rate of 12.7% compared with a national average of 3.4% in 1991.

‘2. for operations for Fallot’s tetralogy, there appeared to be 8 deaths in 29 cases, an estimated overall mortality rate of 27.5% compared with the national figure of 6.8% for 1991.

‘3. for operations for AVSD, there appeared to be 5 deaths in 18 operations, an estimated overall mortality rate of 27.7% compared with the national figure of 13.9% for 1991.

‘Taking together the mortality figures and the supplementary table on times spent on bypass, in ICU and in hospital, it seemed to us that there had indeed been cause for concern at a time when this was not being openly admitted by the surgeons or

> the management of the hospital. I gave a copy of the tabulations to Dr Bolsin who gave a copy to Professor Gianni Angelini, the incoming Professor of Cardiac Surgery. I also showed the tabulations to Professor Cedric Prys-Roberts, the head of the University Department of Anaesthesia. I retained some indirect contact with subsequent events through my academic contacts with Dr Bolsin and Professor Angelini. I understood from them that the results of our audit had been presented in appropriate quarters. I was surprised that there was no apparent response or discussion, not even to dispute the accuracy of the figures. I was present at a discussion of the figures by the group of cardiac anaesthetists in 1994. I do not know how much they did or did not contribute to the decision of the group, in October 1994, not to continue anaesthetising for switch operations.'[167]

The October article in 'Private Eye'

134 On 9 October 1992 *'Private Eye'* published the following:

> 'The sorry state of paediatric cardiac surgery at the United Bristol Healthcare Trust has been confirmed by an internal audit over the last two years' operations. The results of procedures to correct two congenital heart abnormalities (Tetralogy of Fallot and transposition of the arteries) were especially poor.
>
> 'James Wisheart, chairman of the hospital management committee and medical advisor to the trust board, is required to maintain standards of medical practice at UBHT. Curiously he has not felt it necessary to inform the trust board or the trust's purchasers of these findings. Could it be because he is also associate director of cardiac surgery?'[168]

135 Dr Hammond gave evidence about this article during an exchange with Counsel to the Inquiry on a further article in *'Private Eye'* he had written in 1995 based on earlier information.

136 He agreed that the figures quoted in 1995 were those which he had quoted earlier in 1992. He said that he had not followed up the story after 1992 because he had been assured that the DoH and the RCSE : '… had been made aware of the problem and we were looking into it, and … I mistakenly trusted that they would act'.[169] He said that he had been given this assurance either by Dr Bolsin or his other source: he was unsure which of them.

137 The sources of information which Dr Hammond quoted in his 1995 article were, he said, those whom he had relied upon in 1992. He described how the points in his later article had been based upon the earlier material, as well as information by which

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[167] WIT 0326 0015 – 0017 Dr Black; see Chapter 3 for an explanation of these clinical terms

[168] SLD 0002 0006 ; *'Private Eye'*, 9 October 1992

[169] T64 p. 112 Dr Hammond

> 'Through … cabarets[170] and … letters sent to *"Private Eye"* and various things … I managed to ascertain that around the country other units were doing better…'[171]

138 Dr Hammond referred to anonymous circulars that he was receiving, to the effect that parents at Bristol were being told that they were in the best hands and in the best unit. He said that he had therefore asked his sources what precisely the parents were being told:

> 'I was always very interested about what are the parents being told. If a unit is not as good as another unit, it does not necessarily matter provided the parents are being told "We do not have particularly good figures here but we are trying to improve our numbers, to get them up". I wanted to know what the parents were told … .'[172]

139 Dr Hammond agreed that the information he had received from what he described in the later article as 'an expert opinion from the sources within the Trust' was second-hand, anecdotal, and that he had chosen to rely upon it. He noted further that Dr Bolsin had told him that he should attempt to alter the referral pattern of GPs.

140 In his May 1995 article Dr Hammond had written that persons working within the Unit 'probably would not send their own children for heart surgery in Bristol'. This led to the following exchange:

> 'Q. How many people working in Bristol told you that?
>
> 'A. It was a report of a discussion that one of my sources was having with various doctors of the unit. I believe that it was fairly well known that there were problems.
>
> 'Q. So the answer is, no doctor at Bristol told you that?
>
> 'A. I would have asked Dr Bolsin, certainly, whether he would have considered sending his own children there. He very clearly said "No". But I was told that the discussion that happened around the Unit was that was the conclusion that was reached … I have to say actually on that point, some of the junior staff I spoke to would have reached that conclusion as well, I think.'

141 A number of witnesses who gave evidence about what had appeared in '*Private Eye'* told the Inquiry that they regarded it as a satirical magazine, not to be taken seriously.

142 Dr Trevor Thomas, Chairman of the District Audit Committee, thought '*Private Eye'* was 'invariably scurrilous' and had '… no currency in proper information for much of

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[170] Dr Hammond appeared on television programmes and in theatres as a stand-up comedian

[171] T64 p. 115 Dr Hammond

[172] T64 p. 115 Dr Hammond

the time'.[173] He said that the articles about paediatric cardiac surgery at Bristol were not discussed at any Audit Committee meetings.[174]

143 Miss Catherine Hawkins, Regional General Manager of the SWRHA from August 1984 to December 1992, commented that *'Private Eye'* was 'not known for its accuracy'.[175] Dr Joffe said that *'Private Eye'* was 'the last paper around that should be believed in terms of its data'.[176]

144 Dr Roylance said that, when he read the articles, some of the information contained within them occurred to him as being obviously incorrect. For that reason, he said, he thought the remainder of the information was likely to be incorrect.[177] He also said that *'Private Eye'* was recognised as representing a sustained attempt to denigrate and undermine newly created NHS trusts by a series of satirical articles.[178]

145 Mrs Helen Vegoda, Counsellor in Paediatric Cardiology at UBH/T from January 1988 to September 1996, told the Inquiry that it was her impression at the time that the *'Private Eye'* articles wrongly discredited the paediatric cardiac surgery Unit rather than raising a legitimate concern that results were unacceptable.[179] She was not able to tell the Inquiry specifically who gave her that impression save to say that it was a 'general impression'.[180]

146 Mr Alan Bryan, a Senior Lecturer in Cardiac Surgery at the University of Bristol, and consultant cardiac surgeon at the BRI since July 1993, on the other hand, thought that *'Private Eye'* did not publish information unless there was some element of truth to it.[181]

147 Dr Jordan recalled Mr Wisheart's drawing his attention to the articles in *'Private Eye'*. Mr Wisheart, according to Dr Jordan, was concerned that there had been a leak of information,[182] but seemed more upset by the fact that there was a criticism of the Unit. Dr Jordan said his impression was that Mr Wisheart felt it was a resurgence of the 'Welsh nonsense from a few years ago', although he said that he did not sense that Mr Wisheart displayed an undue intolerance to criticism.[183]

148 Professor Jeremy Berry, Professor of Paediatric Pathology at the University of Bristol, and a consultant paediatric pathologist at BRHSC since November 1983, said that the medical staff were advised by Dr Roylance at a meeting of the Hospital Medical Committee to ignore the allegations in *'Private Eye'*.[184] He said that Dr Roylance said

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[173] T62 p. 136 Dr Thomas
[174] T62 p. 136 Dr Thomas
[175] T56 p. 112 Miss Hawkins
[176] T90 p. 106 Dr Joffe
[177] T88 p. 126 Dr Roylance
[178] WIT 0108 0124 Dr Roylance
[179] T47 p. 167 Mrs Vegoda
[180] T47 p. 168 Mrs Vegoda
[181] T63 p. 44 Mr Bryan
[182] T79 p. 100 Dr Jordan
[183] T79 p. 102 Dr Jordan
[184] T55 p. 143 Professor Berry

that the allegations were nothing to worry about.[185] Professor Berry was not able to recall the date of this meeting.

149 Professor Gordon Stirrat, Professor of Obstetrics and Gynaecology at the University of Bristol, gave evidence that one of the *'Private Eye'* articles had been raised at a meeting and that those attending were reassured by Dr Roylance and Mr Wisheart that audit was being carried out and that steps were being taken to rectify problems. Professor Stirrat said that he could not recollect at which meeting this had taken place or when.[186]

150 While a number of witnesses expressed the view that the 1992 articles as a whole were widely discussed within the UBHT, and that 'everyone knew' about the adverse publicity,[187] there was a lack of specificity as to the dates or the content of the discussions.[188]

151 Mr Peter Durie, the first Chairman of the UBHT, stated in his written evidence to the Inquiry that some informal discussion took place at Trust Board level:

> 'I remember talking informally with other Board members about the articles. We concluded that as the authors were believed to be one or more junior doctors working at the BRI, it was understandable that their articles were more than likely to be about Bristol than about hospitals further afield. As we the Board had not received any adverse comment from the Department of Health or from the Royal Colleges or from the UBHT Medical Audit Committee, or any other source, we saw no reason to call for an investigation.'[189]

152 Sir Michael Carlisle was surprised when he was shown the *'Private Eye'* articles in the course of his oral evidence to the Inquiry. He said:

> 'A. Forgive me, but it is very interesting and I have only seen this now, an eminent cardiac surgeon in Southampton says "everyone knows about Bristol".
>
> 'Q. And you did not?
>
> 'A. Absolutely not.'[190]

153 Mr Alan Angilley, Administrative Secretary to the SRSAG from early 1987 until January 1992, said that he held the view that *'Private Eye'* in general was not to be believed.[191]

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[185] T55 p. 143 Professor Berry

[186] T69 p. 39 Professor Stirrat

[187] Dr Thomas T62 p. 136; Professor Vann Jones T69 p. 146; Dr Thorne T35 p. 116

[188] WIT 0086 0036 Mr Durie; T81 p. 87 Dr Bolsin; T47 p. 168 Mrs Vegoda; T46 p. 126 Miss Stratton; T79 p. 99 Dr Jordan; WIT 0169 0032 Mr Downes; T55 p. 142 Professor Berry; T69 p. 38 Professor Stirrat

[189] WIT 0086 0036 – 0037 Mr Durie

[190] T15 p. 77 Sir Michael Carlisle

[191] T11 p. 51 Mr Angilley

154 In relation to the allegation in the May 1992 article that the DoH was aware of Bristol's 'problems' and yet did nothing, Sir Graham Hart, Permanent Secretary at the DoH between March 1992 and November 1997, said:

> 'I have absolutely no knowledge of that. In so far as I understand what "cover-up" means, I think it is a pretty scandalous allegation and I would be very surprised if it was true.'[192]

155 Dr Roger Moore, a Branch Head in the NHS Executive, stated in his written evidence to the Inquiry that he understood from the Librarian at the DoH that records showed that the Department first took out a subscription to *'Private Eye'* from 1 October 1993. He stated there was no record of a subscription before that date.[193]

156 Dr Moore stated that the reaction of Ministers and officials to any journalism was: '… dependent on its authority and accuracy and the influence which it might be expected to have in presenting or influencing public opinion.'[194]

157 Miss Hawkins indicated that Dr Alastair Mason, the Regional Medical Officer, had shown her the July article. Miss Hawkins told the Inquiry that, until she saw that article, she had not heard of the alleged problems at Bristol and that Alastair Mason had said that he had not known either.[195]

158 Miss Hawkins said the follow-up action that was taken was that '… the RMO was, I believe, going to investigate … and visit the Unit and talk to the department [of Health].'[196]

159 Dr Mason told the Inquiry that he saw the *'Private Eye'* articles in May and July 1992. He confirmed that he brought the latter to the attention of Miss Hawkins. He explained:

> 'Having no formal role in relation to this service, I made discreet inquiries of colleagues … to ascertain whether there was any truth in the allegations. I was reassured by those to whom I spoke that they were not aware that the clinical performance of this service was poor and reported back accordingly to [Miss Hawkins].'[197]

160 Dr Moore added that in his view '*Private Eye*' was '… not an automatic choice for authoritative journalism on NHS or clinical audit.'[198]

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[192] T52 p. 66 Sir Graham Hart
[193] WIT 0482 0002 Dr Moore
[194] WIT 0482 0002 Dr Moore
[195] T56 p. 112 Miss Hawkins
[196] T56 p. 57 Miss Hawkins
[197] WIT 0399 0004 Dr Mason
[198] WIT 0482 0002 Dr Moore

161 Sir Terence told the Inquiry that before the contact from Dr Zorab, neither he nor the RCSE had known about the adverse publicity in *'Private Eye'* (or elsewhere) concerning the UBHT. He said:

> '… the cardiac surgeons … are a small specialty within the whole discipline of surgery, and I do not know that anybody would have picked up the *"Private Eye"* piece at all, other than some cardiac surgeons may have noticed and mentioned it to others. … I had no such inkling [that there may have been problems at Bristol] until I received Dr Zorab's letter.'[199]

162 Sir Terence added:

> 'The *"Private Eye"* piece meant nothing to me. The letter from Dr Zorab did. *"Private Eye"* had run a campaign against perhaps the most distinguished cardiac surgeon of my generation, Sir Donald Ross, some years earlier and, quite honestly, I do not think anybody paid a lot of attention … But I did pay attention to Dr Zorab's letter.'[200]

163 Sir Donald Irvine, President of the General Medical Council (GMC), gave evidence that the GMC only acts in its disciplinary capacity on the basis of a complaint.[201] He said the GMC does scan the press but 'did not scan *"Private Eye"*'.[202]

164 Dr Christopher Monk, a consultant anaesthetist at the BRI, and Clinical Director of Anaesthesia from January 1993 to December 1995, told the Inquiry that in his opinion *'Private Eye'* was an inappropriate vehicle through which to bring to light serious concerns about performance.[203] Dr Hammond agreed that it was 'not ideal' for confidential audit details to be published in *'Private Eye'*. He stated that he did so at the time because he felt so strongly about the issue that he was '… willing to risk a charge of breach of confidentiality from the General Medical Council'.[204] Professor Stirrat told the Inquiry that the articles were 'prime examples of lack of confidentiality'.[205]

165 Dr Hammond reported that he had subsequently changed his approach in responding to confidential audit information sent to *'Private Eye'*. He stated:

> 'I now fax it back immediately to the chief executive of the Trust, the President of the relevant Royal College and the chief executive of the General Medical Council. I ask for the matter to be looked into urgently, ask to see the results of any inquiry and reserve the right to investigate and publish if I do not believe action has been

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[199] T18 p. 136–7 Sir Terence English

[200] T18 p. 137 Sir Terence English

[201] T48 p. 114 Sir Donald Irvine

[202] T48 p. 132 Sir Donald Irvine

[203] T73 p. 57 Dr Monk

[204] WIT 0283 0003 Dr Hammond

[205] WIT 0245 0006 – 0007 Professor Stirrat

> taken to protect patients. Inquiries using external assessors into the quality of surgical care in two UK trusts are currently underway because of this approach.'[206]

Concerns of the theatre nurses

166 Mrs Mona Herborn, a sister in cardiac theatres at the BRI from 1988 to 1998, stated in her written evidence to the Inquiry:

> '… for me personally, I began to have a real problem with the arterial switch operation around this time, about 1992. This was because the poor outcomes were too frequent. By this time I was also much more aware of Dr Bolsin's activities, and we often talked about them. We discussed the length of operations and complications during operations. I cannot say that I knew every detail, but he told me he had expressed his concerns at very high levels, and also that he had Professor Angelini as an ally. When these operations continued in spite of this, I felt quite helpless.'[207]

167 In her written evidence to the Inquiry Kay Armstrong, cardiac theatre sister, stated:

> '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. … My "concern" at that stage was a sense of regret that these children did not survive.'[208]

168 Ms Armstrong went on:

> 'Sometime 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.'[209]

169 She continued:

> '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.'[210]

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[206] WIT 0283 0010 Dr Hammond
[207] WIT 0255 0014 Mrs Herborn
[208] WIT 0132 0055 Ms Armstrong
[209] WIT 0132 0055 – 0056 Ms Armstrong
[210] WIT 0132 0057 Ms Armstrong

Further events in 1992

170 Shortly after the appointment of Professor Gianni Angelini, as Professor of Cardiac Surgery, in October 1992, Dr Black and Dr Bolsin presented him with the results of their collection and analysis of data.[211]

171 On 19 November 1992 the Regional Adviser of the Royal College of Physicians, KR Hunter, wrote a report: *'Regional Adviser's Visit'* to the BRI. The report stated:

> 'There are major problems due to the great increase in work load in emergency medicine without commensurate increase in resources. When a full complement of staff is present, the system is just able to cope, but if anyone is on leave those remaining can be stretched to the limit and the level of cover is inadequate to ensure proper training. It seems probable that, at times, the quality of patient care may fall below safe levels. In my discussions with Managers, it was clear that they are aware of these difficulties …'[212]

172 Professor Jarman asked Dr Roylance about the report:

> 'Q. … their comment is that it seems probable at times the quality of patient care may fall below safe standards?
>
> 'A. Yes, well, that would have been taken very seriously and addressed. There is always a tension, I have to say, between professionals who want to do as much as possible for as many people as possible, and of sustaining safe standards. There are times when some would feel that poor care was better than no care. I do not expect you to share that view and I do not share that view, but that was a tension. This was a very helpful and I believe successful monitoring programme. If every report said "things are perfect", then everybody would have been wasting their time. They actually did pick up matters that were difficult. I believe that they are referring probably to a time when junior staff were working excess hours and it was becoming recognised that this was unacceptable and of course a major initiative was undertaken to correct that.'[213]

173 In December 1992 Mr Dhasmana visited Birmingham with Dr Masey in order to observe Mr William Brawn, a consultant paediatric cardiac surgeon at the Children's Hospital, Birmingham, at work. The operation which they observed was recorded on video and Mr Dhasmana was given a copy. Mr Dhasmana stated:

> 'I was particularly impressed with the organisation. As a result of this I arranged for theatre nurses and other perfusionists to visit and learn the workings of the

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[211] WIT 0080 0114 Dr Bolsin

[212] WIT 0032 0259 *'Regional Adviser's Visit'*

[213] T26 p. 7–8 Dr Roylance

> Birmingham set-up … I believe that the whole team received further training as a result of these visits.'[214]

174 Given Dr Hammond's view, expressed in articles in *'Private Eye'* in 1992, that concern about the performance of the paediatric cardiac service at Bristol was widespread in the area, even if only to the extent of rumour, the Inquiry wrote to referring paediatricians. Their evidence is set out fully in Chapter 11. The Inquiry heard from six paediatricians in Bath.[215] Dr Lenton, a referring paediatrician, who was in Bath throughout the period of the Inquiry's Terms of Reference, stated:

> 'I was only aware that there might be a problem with the cardiac services offered in Bristol due to indirect feedback via SHOs [Senior House Officers] and Specialist Registrars who had previously worked in UBHT.'

175 Dr Lenton did not suggest that he had any direct evidence of poor standards at Bristol and stated that he 'had assumed that the … service … was about average'.

176 The only other concerns expressed were by Professor Osborne, who was in Bath throughout the period, and Dr Tyrrell who was in Bath from 1992. Both stated that they were aware that Bristol had a split site.[216]

The Unit's own report of its performance in 1992

177 No Annual Report was produced by the Unit for 1992. There was no return to the UK Cardiac Surgical Register in 1992. The period over which data was collected for the UK Cardiac Surgical Register had changed from the chronological to the financial year, and the next figures were to be supplied in 1993, showing the results from April 1992 to the end of March 1993. These are set out at the end of Chapter 28.

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[214] WIT 0084 0112 – 0113 Mr Dhasmana

[215] Dr T Hutchinson (REF 0001 0016), Dr S Lenton (REF 0001 0017 – 0018), Dr A R R Cain (REF 0001 0019), Professor J P Osborne (REF 0001 0020 – 0021), Dr P T Rudd (REF 0001 0023 – 0024) and Dr J Tyrell (REF 0001 0025 – 0026)

[216] This evidence is difficult to place in the chronology of events, because no specific time period was indicated when the views expressed were held. All Bath paediatricians continued to refer children to Bristol during the rest of the period of the Inquiry's Terms of Reference

Chapter 28 – Concerns 1993

Concerns

The data produced by Dr Bolsin and Dr Black

1 Dr Bolsin stated that the results of his data collection were available in early 1993. Dr Bolsin's evidence was:

> '… [Dr Black] subjected the data to simple statistical analysis. The numbers were small but gave an indication of potentially significant differences between the results of Bristol and the national average comparative data. The indications were that for two operations (Tetralogy of Fallot and A-V canal) the mortality in Bristol was higher than the rest of the country. The initial data also indicated incorrectly that there was a higher mortality for VSD procedures in Bristol than in the rest of the country. When the error in the VSD data was pointed out to Dr Black and myself we withdrew the comparison. The Fontan procedure mortality was the same in Bristol as the rest of the country.'[1]

2 Dr Bolsin continued to collect data on the Arterial Switch programme and showed the initial results to Professor Prys-Roberts, Professor of Anaesthesia at the University of Bristol. Dr Bolsin also went to see Professor John Farndon. Dr Black also showed the data to Dr Sally Masey, consultant anaesthetist.[2]

3 Professor Farndon was appointed as Professor and Head of the Division of Surgery at the University of Bristol in 1988. He indicated in his written evidence to the Inquiry that he was not an expert in cardiac surgery:

> 'My understanding of cardiac surgical procedures in general and their associated morbidity/mortality and, in particular paediatric cardiac surgery, was and is very limited. I would not have known the benchmarks that the cardiac surgeons should have been achieving. Few other surgical sub-specialties have mortality and morbidity to match that of cardiac surgery, … I knew that the cardiac surgeons were submitting data to a national audit where comparisons with other units would be made. The process should have identified problems and corrections to allow closure of the audit loop. When reporting to the Medical Audit Committee I informed them that cardiac surgery were submitting externally. I felt that this national arena was the most appropriate way of dealing with cardiac surgery and provided a secure mechanism.'[3]

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[1] WIT 0080 0113 Dr Bolsin. See Chapter 3 for an explanation of these clinical terms

[2] WIT 0080 0113 Dr Bolsin

[3] WIT 0087 0003 – 0004 Professor Farndon

4 Professor Farndon was asked in oral evidence about his knowledge of paediatric cardiac surgery in Bristol in the early 1990s and whether he had heard anything about Bristol's performance. He replied:

> 'It is a very difficult question to answer, because I suppose in hospital settings, one gets a buzz or a ring and some departments are totally quiet and one hears of no reputation or repute, and in others one hears of some anxieties, general anxieties. I cannot honestly recall when I first became aware of others' concern in that area.'[4]

5 Professor Farndon became aware of concerns about the Bristol service early in 1993 when Dr Bolsin came to see him:

> 'In the early part of 1993, Dr Bolsin came to see me to express concern about the results of the treatment of children with congenital heart disease. His main concern focused on mortality rates. I cannot recall clearly now, but I believe that Dr Bolsin declared at that meeting that he had compiled some data. I cannot remember the exact details of the conversation but I would say that the data would need to be validated, shared and owned by all doctors involved in the process of the care of children and a joint decision made as to its validity. I cannot recall whether I saw the data at that time.'[5]

6 Dr Bolsin stated in his written evidence to the Inquiry that he left hard copies of the data with Professor Farndon and that he remembered Professor Farndon saying he would look into the matter.[6]

7 On the data itself, Professor Farndon told the Inquiry:

> 'I find it very difficult to remember exactly what the nature is, and contrary to his [Dr Bolsin's] statement with regard to my own, I do not have and do not remember receiving a folder of data.'[7]

8 Professor Farndon described his meeting with Dr Bolsin in the following exchange:

> 'Q. When I asked you why Dr Bolsin came to you, whether you thought he was coming for general advice or whether he was bringing you particular problems with particular surgeons in particular operations, you said you presumed he was coming for two reasons: (1) that you would be the audit co-ordinator for surgery, and hence I assume would be in a position to give some general advice about the carrying out of audit; and (2) that he had some idea that your stance might be one of equity, and might be one of providing some help in a situation that he found difficult.

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[4] T69 p. 88–9 Professor Farndon

[5] WIT 0087 0006 – 0007 Professor Farndon

[6] WIT 0087 0032 Dr Bolsin

[7] T69 p. 94 Professor Farndon

> ‘What “help” were you referring to?
>
> ‘A. The advice that he needed to be sure that everyone could agree his data, and then to benchmark and see whether there was a problem.
>
> ‘Q. So the help you provided was to tell him, give him general advice about benchmarking his audit?
>
> ‘A. About the process – advice about audit in general.
>
> ‘Q. And then telling him to discuss it with the other people involved in the care of children?
>
> ‘A. Absolutely.
>
> ‘Q. Which bit of that was the situation, as you put it, that Dr Bolsin found difficult?
>
> ‘A. I do not know.’[8]

9 Professor Farndon told the Inquiry that he was not competent to comment on the data itself:

> ‘… I had nothing with which to benchmark. The concept of some of the operations, the complexity, the outcome measures, are totally unknown to me in my own practice. It does not come across to me in any professional reading or continued education. I have no idea where to benchmark any such data.’[9]

10 Professor Farndon said that his advice to Dr Bolsin at the time would have been:

> ‘… that this data has to be owned and shared and you need to look at what is the mechanism of any problem, if there is a problem, if you are able to benchmark, is there a problem? What are the likely contributory factors?’[10]

11 Professor Farndon took the view that the data should be shared with the surgeons and:

> ‘Not only that; that everyone, before the data gathering had begun, was aware that this was a process of audit and knew that they were contributing to the data and its analysis, so that the data is gathered with everyone knowing, looking at the risk management of patients so that the data can be meaningful.’[11]

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[8] T69 p. 105–6 Professor Farndon

[9] T69 p. 95 Professor Farndon

[10] T69 p. 96 Professor Farndon

[11] T69 p. 101 Professor Farndon

12 Once Dr Bolsin had raised his concerns, Professor Farndon stated in his written evidence to the Inquiry that he then heard of concerns that other consultants had:

> 'Once Dr Bolsin had come to see me I remember speaking with colleagues (in passing) about the concerns he had raised. I cannot remember the dates or exactly to whom I spoke. I certainly spoke to Professor Angelini, perhaps two to three times, and these were informal "corridor conversations".
>
> 'Other colleagues approached me with concerns about paediatric cardiac surgery. Mr Bryan, Dr Monk, Professor Prys-Roberts and Dr Willatts talked to me.[12] These are the only names I can now recall. I cannot remember the exact details of their conversations. My stance then, as now, was to advise them to produce agreed audit data that everyone could own. This should have allowed discussion on whether there were "problems" or not.'[13]

13 Dr Bolsin told the Inquiry that:

> '… I showed people the data and said "this is the data that Andy Black and I have collected, what do you think of this?"'[14]

14 Dr Bolsin indicated that Dr Masey was the first of the paediatric cardiac anaesthetists to see the data:

> '… because Andy [Dr Black] had literally got it hot off the printer and Sally [Dr Masey] was in the department and he asked her for her comment on it, unsolicited, which I think gives a measure of the openness with which we were doing it in that Andy got the data. His first contact was not "Steve, do you think you ought to show this to your colleagues?" it was "Sally, what do you think of this?" '[15]

15 Dr Bolsin said that he thought that this occurred in 'the spring of 1993'.[16]

16 In her written statement to the Inquiry, Dr Masey confirmed this account:

> 'In the spring of 1993, I discovered by chance about the "confidential audit" being conducted by Dr Bolsin when I was shown, in passing, by Dr Andrew Black, some preliminary results of analysis of mortality in paediatric cardiac surgery. I immediately felt that if this information was being collected that it needed to be accurate. I felt concerned that if it was being collected "confidentially", that this could lead to collection of inaccurate data. I do not recall the exact years to which

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[12] Mr Alan Bryan, Senior Lecturer in Cardiac Surgery, University of Bristol and consultant cardiac surgeon, BRI; Dr Christopher Monk, consultant anaesthetist and Clinical Director of Anaesthesia from January 1993–December 1995; Professor Cedric Prys-Roberts, Professor of Anaesthesia, University of Bristol and Honorary consultant Anaesthetist, UBHT; Dr Sheila Willatts, consultant in anaesthesia and intensive care medicine, BRI, and consultant in charge of ICU, BRI

[13] WIT 0087 0007 Professor Farndon

[14] T82 p. 123 Dr Bolsin

[15] T82 p. 121 Dr Bolsin

[16] T82 p. 122 Dr Bolsin

> the figures Dr Black showed me referred, but do recall that they included some data on Tetralogy of Fallot that included the 1990 figures. This was the year that I knew that the results had been unexpectedly, and unusually, high. There were also data on closure of ventricular septal defects, but I did not study these closely.
>
> 'Dr Bolsin arrived in my office while I was discussing these results with Dr Black and I again asked Dr Bolsin, if he had concerns, why he was not involving his cardiac anaesthetic colleagues, as I had done in 1990 after he had written to Dr Roylance. I expressed the opinion to him that it would be advisable to involve us, his cardiac anaesthetic colleagues. I suggested it would be easier to make sure that information was accurate if all of the cardiac anaesthetists were involved, and also the paediatric cardiac surgeons, and that if genuine concerns were highlighted it would be easier to address these as a group rather than as an individual. The only reason I recall that Dr Bolsin gave me that day as to why he was reluctant to approach the paediatric cardiac surgeons was that he thought that if they knew he was collecting this information they might prevent his access to information. I stated strongly to him that I considered it was inappropriate to collect this information in secret. However, Dr Bolsin continued to say that he felt this was the only way he could get information, as he felt that the paediatric cardiac surgeons did not produce these results themselves, or, if they did, they did not show them to anyone else. I commented to him that I had always been shown the results, but did agree that I could not recall having seen recent results. I said to Dr Bolsin that I had no doubt that if I asked Mr Dhasmana for the recent figures that he would give them to me immediately. Dr Bolsin showed some doubt as to whether the figures would be forthcoming. To test my hypothesis, I approached Mr Dhasmana the following day, and without explaining why I wanted them, I asked to see the most recent surgical results. He apologised that I had not received them earlier, and explained that the reporting date had been changed from the year-end to the end of March, and this had led to a delay in their preparation. He then went on to say that he had just completed the figures, and, as I had predicted, he showed them to me immediately. However, he did ask me not to show them to Dr Bolsin.
>
> 'As far as I am aware, apart from seeing the initial data in early 1993, I was never formally shown the results of Dr Bolsin's "confidential audit", although I did ask Dr Bolsin on a number of occasions to inform us, his cardiac anaesthetic colleagues, as to what he was doing, again for the reasons given above.'[17]

17 Mr Dhasmana indicated in a written response that he did not recall this conversation with Dr Masey.[18]

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[17] WIT 0270 0014 – 0015 Dr Masey

[18] WIT 0270 0028 – 0029 Mr Dhasmana

18 Dr Sheila Willatts, consultant in charge of the Intensive Care Unit (ICU) at the BRI since 1985, stated:

> 'I had prolonged discussions with Dr Stephen Bolsin in 1993 regarding the potentially adverse outcomes and the course of action he might reasonably take. I advised as follows … "the issue was principally an audit one, namely that the results needed to be scrutinised, validated and agreed. During 1993 and 1994 I spoke to Professor Prys-Roberts, Professor Farndon and Chris Monk expressing my concerns that the data needed to be verified. I hoped that the results could be examined by a joint meeting of the surgeons and anaesthetists. It was my hope that the surgeons would bring their results to the meeting and the results should be discussed in an open forum. Professor Farndon volunteered his services as a potential chairman for such a meeting as he was not a cardiac surgeon".'[19]

19 In relation to the collection of data by Dr Bolsin and Dr Black, Dr Willatts stated:

> 'I believe that the surgical procedures reviewed and the sources of information were appropriate. If this audit could have been conducted openly with agreement between surgeons and anaesthetists it would have been a much stronger audit as the data would have been openly agreed. However, I do believe that it was impossible to obtain the necessary conditions for such a joint discussion to take place at that time as the strong personalities in cardiac surgery did not agree that this was necessary.'[20]

20 Mr Wisheart was asked about what he knew of the collection of data:

> 'Q. … did you at any time see any data or figures or analyses, however one describes them, which were produced by Dr Bolsin in respect of paediatric cardiac surgery, at any rate before April 1995?
>
> 'A. Not before April 1995.'[21]

21 Dr Stephen Jordan retired in May 1993. He stated: 'I was unaware of Dr Bolsin's audit of cardiac surgery until sometime after my retirement.'[22] In his oral evidence to the Inquiry he said:

> 'A. I saw no data at all. I was unaware at the time, up to the time of my retirement, that he had actually ever produced any data.

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[19] WIT 0343 0002 Dr Willatts

[20] WIT 0343 0002 Dr Willatts

[21] T 94 p. 132–3 Mr Wisheart

[22] WIT 0099 0027 Dr Jordan

> 'Q. And you do not recall anyone mentioning such data existing to you during your time in post?
>
> 'A. As I have put in my statement, the only possible connection with this is the fact that I think it was Dr Bolsin introduced Dr Black to me and said he understood that I had some information on a computer at the Children's Hospital; could Dr Black have a look at it. I think I took Dr Black up and showed him what the information was. I am not aware of Dr Black ever having used this. That is the only possible connection that I can recall between myself and Dr Bolsin in terms of collecting data and auditing data.'[23]

22 Dr Jordan agreed, however, in the following exchange that he was aware of 'some problems' in Bristol:

> 'Q. (the Chairman): Just one question from me, Dr Jordan. If an observer having heard your evidence formed a picture that you were someone who, recognising that there were some problems in Bristol, fought within Bristol to effect change while outside quietly suggested or warned people off; would that observer have any right to hold that view?
>
> 'A. There is some truth in it. I will perhaps give you an example: shortly before I retired I had discussions with cardiologists in South Wales, I think this has sort of been obliquely referred to. Basically they were obviously considering whether they should continue to send patients to Bristol and take on a new cardiologist from Bristol, there was going to be a change anyway and they were being offered, in fact being encouraged to use the service in Cardiff instead. The thing I said to all of them, and I used very similar words but not necessarily identical ones were "You have asked my advice and what you are asking is really what is best for our patients. If I thought that the centre in Bristol was absolutely the best centre in the UK and there was no way that anyone else was going to produce comparable or better results, I would say to you, 'Do not try an untried unit in Cardiff'. Frankly, I do not think I am in a position to say that to you and therefore you will have to make up your mind whether you want to try a new unit or stick with Bristol." I think that is the sort of, if you like, comment I made which indicated that I was not going to go around blindly saying "Bristol is wonderful, keep on sending your patients there".'[24]

23 Dr Susan Underwood, consultant anaesthetist at the UBHT from 1991, stated in her written evidence to the Inquiry:

> 'I was aware that Steve Bolsin was undertaking an audit of the paediatric surgical work because he told me. He did not discuss details with me or show me the results.

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[23] T79 p. 95–6 Dr Jordan

[24] T79 p. 188–9 Dr Jordan

> 'I recall an evening meeting in winter, possibly 1993, where I think all cardiac anaesthetists were present and Steve Bolsin expressed his concern over the paediatric cardiac surgery mortality. The group asked him to produce some data to substantiate it. He did not bring any data to future meetings.'[25]

24 Mr Roger Baird, consultant general surgeon, and Clinical Director for Surgery at UBHT from April 1991 to November 1993, told the Inquiry:

> 'I was aware that Dr Bolsin had some funding from the Department of Health to enable him to develop audit techniques in cardiac surgery from the anaesthetics point of view. I thought that was a good thing. I did not associate this with anything other than an academic interest in developing audit, at that time. I was not aware of the nature or purpose of the "confidential audit".'[26]

25 Dr Joffe stated that he and Dr Bolsin 'never discussed paediatric cardiac surgical outcomes or services, nor was I privy to his secret audit. Indeed my first sight of his figures was in the *'Daily Telegraph'* and BBC West television, in April 1995.'[27]

26 Dr Roylance was asked when he first knew about the audit:

> 'Q. When did you first become aware that Dr Bolsin had been collecting, let us call it, "figures" or "data"?
>
> 'A. After the visit of Marc de Leval and Stewart Hunter.
>
> 'Q. Not before?
>
> 'A. No.'[28]

27 Dr Roylance was asked by Counsel to the Inquiry specifically about 1993:

> 'Q. Did any whisper reach you do you think in 1993 that Dr Bolsin was not only collecting data but analysing it?
>
> 'A. No, I did not know about Dr Bolsin's activities until after the external inquiry by Marc De Leval and Stewart Hunter. That is when it emerged and I did not know of his activities before that date.'[29]

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[25] WIT 0318 0011 Dr Underwood

[26] WIT 0075 0035 Mr Baird

[27] WIT 0097 0169 Dr Joffe

[28] T88 p. 24 Dr Roylance

[29] T88 p. 138 Dr Roylance

28 Professor Gordon Stirrat, Dean of the Faculty of Medicine, University of Bristol 1991–1993, told the Inquiry that no one made him aware of the collection of data and that:

> 'I would most certainly have expected Prys-Roberts to have done so … Andrew Black and I have worked together closely for a long time … I would have hoped that he might have felt able to tell me. But his direct line of responsibility was through Prys-Roberts.'[30]

29 Dr Bolsin, in his written evidence to the Inquiry, stated that Dr Black had told him that Professor Prys-Roberts had telephoned Dr Roylance 'and informed him that there was a real and demonstrable problem in the Department of Paediatric Cardiac Surgery'.[31]

30 Professor Prys-Roberts was asked about this in the following exchange:

> 'Q. … Do you recollect having any further information from Dr Bolsin or Dr Black about the process they had been engaged in since the summer 1992?
>
> 'A. I recollect having a meeting with them during which Steve had to leave and go off and left me to look at the data with Dr Black. I cannot recall the date. I know it would have been mid-1993 but probably not earlier and Dr Black showed me the results in tabulated form from a minute-type analysis that he had done. I do not recall doing anything about it at that stage because my recollection is that Andy Black went away and discussed it subsequently with Dr Bolsin, but they did not ask me to take any specific action at that stage.
>
> 'Q. If we go down the page, I think you have already referred to this, we can see that Dr Bolsin there informs us [the Inquiry] of something Dr Black is said to have told him, that you immediately telephoned Dr Roylance; that is not something, I think you have already told us, that you remember doing?
>
> 'A. I do not remember doing it. I have discussed it with Dr Black and he does not remember me doing it in his presence.
>
> 'Q. You say that Dr Black and Dr Bolsin did not ask you to do anything specific?
>
> 'A. No.
>
> 'Q. What was your reaction to the data they had given to you?
>
> 'A. My reaction was that the data – which were still not what I could call finalised figures, but they were figures which were much more reasonable, I did not look at them in real detail at the time – that these were simply confirming the conclusions we had come to before, that there was a serious cause for concern.

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[30] T69 p. 32 Professor Stirrat

[31] WIT 0080 0113 Dr Bolsin

> 'Q. If there was a serious cause for concern, why not ring either Dr Roylance or possibly Mr Wisheart?
>
> 'A. With hindsight I do not know why not. As I have said, at that stage I was not spending a great deal of time in Bristol. I was not involved in the overall process, I knew that others were involved and becoming more involved certainly on the cardiac anaesthesia side and that they were concerned with Dr Roylance.
>
> 'I cannot recollect why at that particular stage I did not take it any further.'[32]

31 Dr Christopher Monk, Clinical Director of Anaesthesia from January 1993 to December 1995, said that he first became aware of the audit: 'I believe in September 1993.'[33] He explained that he found out 'because I went into the perfusionists' room … where their data was recorded and one of them, or one of two people, said to me: "Do you know that Steve is looking at the data and trawling through the patients' notes?" or some similar phrase.'[34]

32 Dr Monk described the audit as 'clandestine' because: 'it did not involve the process of speaking to the consultant anaesthetists providing the anaesthesia or the consultant surgeons who were performing the operations in providing the information'.[35]

33 Dr Monk told the Inquiry that had he known about Dr Bolsin's exercise beforehand:

> 'I think I would have been sympathetic to his intentions, but I think it should have been open as opposed to private in the way that he did it, because, having got the data, it then becomes difficult to disseminate it.'[36]

34 Putting it in the context of the time, Dr Monk said:

> '… you have to look at it in terms of 1992, when audit nationally was only just being introduced. The impressions were that the people who did the work owned the audit.'[37]

35 In his written evidence to the Inquiry, Dr Ian Davies, consultant anaesthetist at the BRI from 1993, stated:

> 'When I worked at St George's as a Senior Registrar and was applying to Bristol, Mr John Parker led me to believe that the Bristol Cardiac Unit was under threat because of the quality of the services provided at that Unit. As I recall, he told me

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[32] T94 p. 57–8 Professor Prys-Roberts
[33] T73 p. 110 Dr Monk
[34] T73 p. 110 Dr Monk
[35] T73 p. 111 Dr Monk
[36] T73 p. 114 Dr Monk
[37] T73 p. 111–12 Dr Monk

> that if I had been interested in a career in paediatric cardiac anaesthesia, he would advise me not to go there.'[38]

36 Dr Davies referred to a conversation which he had had with Dr Bolsin prior to his joining the BRI in April 1993:

> 'In the course of my conversation with him, he told me that the Paediatric Cardiac Surgical Programme was unsatisfactory, and that he was particularly concerned about the switch programme.'[39]

37 Dr Davies went on:

> 'After I started at BRI, Dr Bolsin spoke to me on a number of occasions about his concerns.'[40]

38 At a meeting of the UBHT Management Board on 7 December 1992 it was noted in the minutes that:

> 'Dr Roylance advised that Julian Le Vay, a member of a Regional working group set up to look at cardiac services in the Region would recommend to Bristol & District the creation of a second site for cardiac services at Derriford. Dissatisfaction had been expressed about the quality and cost of services offered in Bristol. He would discuss this with Mr Wisheart.'[41]

Concerns about the Arterial Switch procedure

39 On an occasion in 1993, Mrs Mona Herborn, Sister in Cardiac Theatres at the BRI from 1988 to 1998:

> '… expressed to Dr Masey, Consultant Anaesthetist, my view that Mr Dhasmana was not capable of performing the switch operation. She then explained to me that none of the switch operations had been straightforward, that many unexpected implications [*sic*] had only been found when the patient was "opened up", which made it very difficult for the surgeon. From this and other conversations with the medical staff, I had to concede that I could not substantiate my concerns with hard facts. I just knew that I no longer wished to be taking part in switch operations. I tried to avoid other paediatric cardiac surgery where I could, but as it was a part of my job, I was not always able to do so.'[42]

40 Mr Dhasmana had some initial success in carrying out the Arterial Switch operation on neonates on his return to Bristol following his visit to Birmingham in December 1992. His first two patients survived. The third died. The third patient had an abnormal

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[38] WIT 0455 0006 – 0007 Dr Davies

[39] WIT 0455 0001 Dr Davies

[40] WIT 0455 0002 Dr Davies

[41] UBHT 0058 0031; meeting of the UBHT Management Board; 7 December 1992

[42] WIT 0255 0016 Mrs Herborn

coronary arterial pattern that was undiagnosed prior to surgery. Two further patients then died. This prompted Mr Dhasmana to revisit Birmingham for further retraining. He was asked what made him go back to Birmingham in July 1993:

> 'I lost two patients in succession and both of these patients had normal coronary arteries, so in a way, that raised doubt again in my mind that here I was, I did two successful operations, the third did not make it, but it was a highly abnormal coronary artery and probably could be explained in any centre. But the next one survived so I am still happy, I have got, you know, out of four, three survivals. And the next two did not, although of course, with one of them we did have evidence of myocardial infarction, but nevertheless, these two did not and they had a normal coronary artery.
>
> '… During this period, between 1992 and this time, July 1993, I had operated on about 7 or 8 older Switches and they all survived. So that is why, really, I was very concerned that something is probably a little different in neonates which I have not still been able to transfer. That is what was quite worrying me.
>
> 'I told Dr Joffe that, "I am very sorry, it appears that I will not do anymore neonatal Switches" … He said, "Well, it so happens that I was going to get in touch with you". I said "What for?" He said "I have got another patient admitted with a similar problem".
>
> 'Then I narrated again what happened during the day in theatre and he I think tried to probably comfort me, saying "Let us just wait for the post mortem examination and then we can really — ". I said, "Well, I am not taking that next case on".
>
> 'He said "Well, what should we do?" I said "I tell you what. We talk to Birmingham". He said "Well, why do you not do that?" So the next day, I ring Birmingham, I ask for Mr Brawn. It so happened he was nearby … he said "No problem, you know, bring the patient and I will operate here, and I tell you, I have got another patient here, so you will see two patients operated on the same day".'[43]

41 Mr Dhasmana stated:

> 'I re-visited Birmingham in July 1993 accompanied by Dr Undewood [*sic*] and a patient from Bristol that Mr Brawn had agreed to operate on. We had further discussion on the problem being experienced in the unit. We returned to Bristol, re-assured and prepared to re-start the programme. The next neonatal patient survived followed by a further fatality and the programme was ended.'[44]

42 Dr Underwood said that, due to the changes Dr Masey had put in place on her return from Birmingham in 1992, she did not see anything that was really different between the practice in Birmingham and in Bristol in relation to anaesthesia. She said:

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[43] T85 p. 48–9 Mr Dhasmana

[44] WIT 0084 0113 Mr Dhasmana

> '… when I went in the middle of 1993, it was to observe them doing that same thing which Dr Masey had described to me, and I do not remember adding anything different or extra after that particular visit.'[45]

43 Mr Dhasmana was asked what he expected to discover from a second visit to Birmingham:

> 'What I noticed over these cases is that somehow, from outside and even when I have gone back in, the coronary artery looked in the right place. There was no obvious kink from outside. So I started asking myself whether what I called at that time the "lie", the way they are lying over the heart, have I got the angulation right, and maybe, technically anastomosis fine, and when you are looking at the post mortem, it looks fine, no problem, but the heart did not work. One of the things with anastomosis I think is the coronary artery, which I think is very important.'[46]

Further concerns expressed at Bristol

44 Mr Alan Bryan, consultant cardiac surgeon specialising in adult cardiac surgery, took up his post as Senior Lecturer in Cardiac Surgery at the University of Bristol on 1 July 1993.

45 He stated in his written evidence to the Inquiry that:

> 'Prior to taking up my senior lecturer appointment, I had formed the general opinion that paediatric cardiac surgery in Bristol may not meet contemporary standards. This opinion was based on general professional knowledge within the field of cardiothoracic surgery and my own perceptions dating from the time of my senior house officer post in Bristol. I was aware that attempts had been made to recruit Mr Martin Elliott … to a Chair in Bristol which had failed. I had also seen disturbing articles in the magazine "Private Eye", I had briefly discussed this question with Professor Angelini [British Heart Foundation Professor of Cardiac Surgery, University of Bristol] prior to taking up my appointment.'[47]

46 Mr Bryan went on:

> 'Having taken up my appointment in July 1993, some time in autumn 1993, Dr Stephen Bolsin presented to me outcome statistics in relation to specific diagnoses in paediatric cardiac surgical practice, namely Tetralogy of Fallot and Ventricular Septal Defect. I found these results disturbing since the data suggested that the operative mortality of one of the surgeons, Mr Wisheart, in relation to certain operations was well above the national average from the UK cardiac surgical register and was significantly higher than that of his colleague, Mr Dhasmana. At the time, I had no immediate way of clarifying whether the

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[45] T75 p. 99 Dr Underwood

[46] T85 p. 50–1 Mr Dhasmana. See Chapter 3 for an explanation of clinical terms

[47] WIT 0081 0023 Mr Bryan

> results presented to me were accurate or not since I had only just taken up my appointment. I was also aware at the time that there was considerable concern being expressed by a number of senior colleagues including Professor Angelini, Professor Prys-Roberts, Professor Farndon and Dr Monk. I have subsequently learned from Mr Wisheart that some of this data, in particular that relating to VSD, was incorrect.'[48]

47 Dr Bolsin said that, in September 1993, he spoke to Professor Angelini regarding the data which had been collected. Dr Bolsin said that he did this because:

> '… I discussed it with Andy Black and we both felt that the peculiar sensitivity of the surgeons may have been related to the fact that there is, as you may or may not know in medicine, rivalry between specialist groups. There is a particular rivalry between surgery and anaesthesia because probably they work so closely together. Surgeons do not like to be told what to do by anaesthetists and anaesthetists do not like to be told what to do by surgeons and it is legendary and it exists.'[49]

48 In his written evidence to the Inquiry, Dr Monk stated that:

> 'After a number of personal requests, SB [Dr Bolsin] brought his data to me in the Department of Anaesthesia, I believe in October 1993.'[50]

In his oral evidence, Dr Monk put the number of requests at three or four.[51]

49 Dr Monk said that he did not take the data to either Mr Wisheart or Mr Dhasmana because 'the audit I got was not verified',[52] but said that he: 'spoke to them both about my concerns'.

50 Dr Monk went on:

> 'I did not feel that it [the audit data] was strong enough, robust enough, that I could take it directly to Mr Wisheart and say: "Here you are", because I think that he would have raised points that I could not answer about: "How did the audit take place? How was it performed? What were your criteria for selecting these epochs?" Therefore, very quickly I would be unable to make the point I wished to make.
>
> '… What I wanted was to produce a forum where initially the cardiac anaesthetists spoke about the data, and I asked Steve, and we discussed the need to present the data to the cardiac anaesthetists, and he appeared to agree with me, but we did not achieve it. We had meetings and Dr Bolsin did not come …'[53]

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[48] WIT 0081 0023 – 0024 Mr Bryan

[49] T82 p. 132 Dr Bolsin

[50] WIT 0105 0020 Dr Monk

[51] T73 p. 115 Dr Monk

[52] T73 p. 119 Dr Monk

[53] T73 p. 120–1 Dr Monk

51 Dr Bolsin was asked in the following exchange about presenting his data to colleagues:

> ‘Q. … did he [Dr Monk] or did he not suggest to you that it would be appropriate to present your data to a meeting of the anaesthetists?
>
> ‘A. I do not think so because if he had said that I would have prepared overheads and I would have been prepared to go to a meeting that anybody arranged.
>
> ‘Q. He has suggested that there were meetings and you did not come.
>
> ‘A. What sort of meetings has he suggested they were?
>
> ‘Q. He is talking about meetings of the anaesthetists, as I understand his evidence. I have read you out the passage and you will have to rely on that.
>
> ‘A. Yes, I mean they were not formal meetings. Certainly I never received a request to present this data to the paediatric cardiac anaesthetists.’[54]

52 Dr Bolsin was asked:

> ‘Q. Do we leave it like this; you had data in a form which could have been appropriately discussed at a meeting. That, as it happens, you did not take any initiative to go to a meeting of anaesthetists to discuss it?
>
> ‘A. Yes, I think that is a fair summary.’[55]

53 Professor Angelini told the Inquiry that in November 1993 he had talked to Mr Jaroslav Stark, Consultant Cardiothoracic Surgeon at Great Ormond Street Hospital, (amongst others) about the data which Dr Bolsin had given him:

> ‘Q. … Did you compare the data that Dr Bolsin had given you with the returns to the cardiothoracic register?
>
> ‘A. No. I cannot remember if I did. Probably I did not.
>
> ‘Q. Could you have done so?
>
> ‘A. Yes, I could, but I did something even better than that.

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[54] T82 p. 128 Dr Bolsin

[55] T82 p. 131 Dr Bolsin

‘Q. Which was what?

‘A. I went to see Mr Stark at Great Ormond Street because I was aware of the fact that Mr Stark had information on what the performance of various units in the country were, and this was for two reasons: (1) because somehow he had been part of some government panel; (2) because he had recently given a speech at the European Association of Cardiothoracic Surgeons. He was the honorary guest of the President, where he had presented data, albeit anonymous, on cardiac surgery in the United Kingdom and he had specifically pointed out how centres which were not doing enough cases had worse performance and so forth. So he really was the person, in my view, who knew everything of what was going on in the UK in paediatric cardiac surgery.

‘Q. So you went to see Mr Stark at Great Ormond Street?

‘A. Yes.

‘Q. I think you said at the GMC that that was in November 1993?

‘A. Yes, that is correct, 17th November, something like that.

‘Q. Did you actually physically show him the data Dr Bolsin had shown you?

‘A. No, I did not.

‘Q. Why not?

‘A. First of all because I did not think it was fair to take stuff which in a way had been given to me in a sort of confidential matter, and also because I knew that Mr Stark was fully informed of what was going on. He had pictures of information of all the United Kingdom data.

‘Q. You said that this data had been given to you in a confidential matter?

‘A. Yes. I mean, “confidential”; “do not take it out of your own institution and show it to everybody”. … Incidentally, even at a later stage I was accused of having done this.

‘Q. How did you know how confidential the data was that Dr Bolsin gave you?

‘A. I mean, I guess it was relatively confidential because if it had been given to 5 or 6 people, I do not know, how can you describe “confidential”? But I thought that it was really not appropriate at that stage to take it out of what was our institution. I had gone to see Mr Stark to ask advice from a senior paediatric cardiac surgeon who was well informed of what was going on nationally on how I should act, if anything, in trying to resolve this problem.

‘Q. Did you discuss with Dr Bolsin how secret this data was?

‘A. No.

‘Q. Did you tell Dr Bolsin you were going to see Mr Stark?

‘A. I do not think I did until I came back. When I came back, I told Dr Bolsin and I told Professor Farndon, and my senior lecturer, Mr Bryan.

‘Q. What did Mr Stark say?

‘A. The conversation took place in his office and effectively I said to him that I have come to him for some advice as a senior person, since he was a very senior person in the business. I said that there had been data suggesting that the mortality was high. Also, my perception, after having spent a year in Bristol by that time, was that mortality and morbidity was a much different story to what I was accustomed to. He said that he was aware of those problems. Indeed, he showed me some of the slides which he had presented at the European meeting, saying “You are not telling me anything new because I have done an analysis” and demonstrated that centres which do not do a great volume of work, like Bristol, will have worse results than specialised centres which do a lot more operations. We discussed these aspects, after which I said to him, “What would you advise? You are a senior man, what would you advise me to do?” He said he thought the best way would have been for me to go back to Bristol, to my head of department —

‘Q. Who was?

‘A. – the Professor of Surgery, Professor Farndon, and in a way present him with the problem, telling him I had discussed things with Mr Stark, and he said, “I am sure you can resolve this matter in-house. Failing that, you may have to ask for some external help.” There were some other issues discussed —

‘Q. Just pause there a minute. What did you understand by “external help”?

‘A. I mean somebody senior like Mr Stark coming in and having a look at what we were doing.

‘Q. Did he mention anything about sending patients from Bristol to Great Ormond Street in the meantime?

‘A. No. What he said, I think, it was that if we have a problem with a patient that needed urgent treatment, certainly this could have been done at the GOS.

> ‘Q. Did he mention the ability of clinicians in Bristol to go with those patients to GOS?
>
> ‘A. I think he said that, also because in the case of Mr Dhasmana, he had already worked for a year at the GOS.’[56]

54 Mr Stark, in a written comment on Professor Angelini’s written evidence, stated:

> ‘I do remeber [*sic*] meeting with Prof Angelini. He came to see me at GOS to discuss Congenital Heart Surgery at Bristol. I do not recall the exact date
>
> ‘It is correct, that I did not offer formal retraining for the Bristol team. Retraining as such was not organised by the Colleges nor by the Sociaty [*sic*] of Cardiothoracic Surgery at that time. Although today there is much talk about retraining, the practical aspects of retraining have not been worked out yet.
>
> ‘I do recall that I have suggested that my coleagues [*sic*] and myself would be happy to operate [on] children with the diagnoses, with which the Bristol team was experiencing problems. I have mentioned, that if they decided to send some patients to us, the surgeons or any other member of the team would be most welcome to come with the patient to see the way how we handled such problems at GOS.’[57]

55 Professor Angelini responded to Mr Stark’s comment in the following exchange:

> ‘A. … What he did not mention – I am sorry, what we did not discuss – I have not seen this yet, I am seeing it now. What we did not discuss, which was highlighted at the GMC trial, was the fact that he never offered to retrain people and I stand to what I said: there was never any offer from him to retrain people. What he said is correct —
>
> ‘Q. Have a look at the previous paragraph, Professor, that may help.
>
> ‘A. “It is correct that I did not offer formal retraining”, yes, that is right, I am glad he said that.
>
> ‘Q. So are you and Mr Stark on the same wavelength?
>
> ‘A. I think so, yes. I do not have any problem with this.

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[56] T61 p. 73–7 Professor Angelini

[57] WIT 0073 0111 Mr Stark

‘Q. The suggestion that patients and clinicians might go to Great Ormond Street, that Mr Stark made to you, to whom did you communicate that offer in Bristol?

‘A. To Professor Farndon, but if you read this through, this does not mean the surgeons go there and they do the operation. The surgeon and their staff go there and see what the people in the GOS do, which to a certain extent is the same that happened when Mr Dhasmana and some other member of the surgical team went to Birmingham.

‘Q. All right, take it slowly. To whom did you communicate this suggestion?

‘A. I think to Professor Farndon, but quite honestly, I do not know if I did.

‘Q. You did not do it in writing, did you?

‘A. No.

‘Q. You did not communicate it to Mr Wisheart?

‘A. No.

‘Q. Mr Dhasmana?

‘A. No.

‘Q. Dr Roylance?

‘A. No. I did not see any point in sending patients to the GOS with everybody going in and observing. Quite honestly, I do not think that would have helped Bristol in any way whatsoever.

‘Q. But is it not the case that going to observe a centre that is a recognised centre of excellence can assist a surgeon to –

‘A. Yes, that is correct.

‘Q. – to retrain. For example Mr de Leval and the “Cluster of failures” and the Arterial Switch operation?

‘A. Yes, but also what we say in surgery is “Watch, do it and teach it”. Watching on its own is not a solution to the problem. You can take your registrar and ask him to help you on a million cases. The first time he does it, there will not be much difference if he helps you on a million cases or 100,000 cases. Therefore, what I am reading in this letter is that although they were prepared to take this patient in the interests of the children, they were not going to do anything to really retrain the people because they could not retrain the people.

‘Q. So you had no faith in the ability of Great Ormond Street or anyone else to retrain the Bristol surgeons?

‘A. No, I did not say that. To retrain people, you have to take these people, not just to watch. Training means you are standing on the side of the assistants and the trainee does the operation. That to me is training. Otherwise just watching by itself is not what I regard as training. That is part of the training, but it cannot be the whole training, if you are not allowed to do things at the first operating surgeon.

‘Q. You took it upon yourself to sweep Mr Stark’s offer under the carpet?

‘A. I do not know what you mean.

‘Q. You did not tell anybody about it?

‘A. Fine. I made a mistake.

‘Q. You accept that was a mistake?

‘A. Absolutely.

‘Q. Because did you consider Great Ormond Street to be a better centre than Bristol for paediatric cardiac surgery?

‘A. Yes, absolutely, but I also considered that Birmingham was a much better centre, particularly for the Switch, than the GOS.

‘Q. Later on we will see that you were suggesting, at the time of the Loveday operation, that if it was truly urgent, the case might be sent to Mr Brawn in Birmingham, for example?

‘A. That is correct.

‘Q. Is that right?

‘A. Yes.

‘Q. Might there not have been patients between your visit to Mr Stark in November 1993 and Joshua Loveday’s operation in January 1995, who, in your opinion, would have benefited from being operated on elsewhere?

‘A. Absolutely.

‘Q. And Mr Stark’s offer would have provided for that?

‘A. Yes.

> 'Q. Would it not?
>
> 'A. Yes. Why did not I refer the offer? Very simple: because my main concern was to stop the surgery from taking place in Bristol, because in Bristol we were no good at this kind of surgery; therefore it should not have been carried out. I do not think that I was in any position to influence anybody's decision for these children to be sent to another institution because in fact, as demonstrated, even in the last Switch case, nobody gave a toss about what I was saying. Therefore, they were not listening.
>
> 'I accept with you that I should have related this particular information that Mr Stark had given to me to the surgeon and to the cardiologists, and it was a mistake on my part not having done so.
>
> 'Q. This is not a case of not listening, this is a case of not hearing because you were not telling them?
>
> 'A. In this case, that is correct.'[58]

56 On 16 November 1993 Dr Bolsin went, by appointment, to see Professor Vann Jones who had become the first Clinical Director of the newly created Directorate of Cardiac Services in the preceding month.[59] Professor Vann Jones described his meeting with Dr Bolsin as follows:

> 'Dr Bolsin came to my office on 16th November 1993 … He showed me results from four different types of operations carried out on children [in the BRI]. They were four specific operations and the point that he was trying to make was that the performance [at the BRI] was well below the national average for these conditions. One of these conditions was ventricular septal defect which is a relatively simple congenital defect and, because of my background ten years earlier in paediatric cardiology, I could tell that the data for that particular operation must have been flawed. A very high mortality was reported for a very low risk procedure and it just could not have been possible that these data were true. I expressed my concern about this to Dr Bolsin and asked him to go away and check his figures. Obviously, this led me to doubt the validity of the data on the other three operations. Dr Bolsin did not seem to me to be particularly concerned and the data were presented in a very matter of fact way. However, because I was convinced, at least, one set of data was flawed I expected him to go away, check the figures and to return. He never did return.'[60]

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[58] T61 p. 78–82 Professor Angelini

[59] WIT 0115 0002; Professor Vann Jones stated that he regarded himself as responsible for an adult, rather than a paediatric, service

[60] WIT 0115 0019 Professor Vann Jones. See Chapter 3 for an explanation of clinical terms

57 Professor Vann Jones was asked about his reaction to the results:

> 'We have to envisage the situation in which I found myself. At that stage I had 12 years of very good service from Mr Wisheart, and from Mr Dhasmana, although not so many years. For many years these chaps operated on some extremely sick patients of mine, and the patients survived, the patients did well and were very grateful, and so was I. In front of me was a set of figures which said three operations were worse than the national average, one was not significantly different, and one I could see was blatantly flawed, so I actually wanted some further clarification of this information … .'[61]

58 Professor Vann Jones was asked further about the meeting with Dr Bolsin in the following exchange:

> 'A. It was a totally amicable meeting. It is absolutely right that people should express concerns about the management of cases. That is what they are all there for. Our job is to look after patients in the best possible way. So it was a perfectly amicable meeting. I was somewhat worried about the Tetralogy of Fallot figures. I was hoping he was a bit worried about the VSD figures, but I have to say, it was only four operations, one was not significantly different. Three were and one set of results was obviously quite wrong. I most definitely mentioned that to him, but just how strongly or what message he got from it, I do not know. I think if you are taking sets of figures around and someone actually questions the validity, and it is a very, very important issue you are raising – I mean, we all know how important it is now – I think the least you should do is go and make sure you have your facts right. And I did expect him to come back and he did not.
>
> 'Q. What did Dr Bolsin ask you to do, if anything?
>
> 'A. He asked me to do absolutely nothing. He purely and simply said "Look at these tables, John. I think this is worrying." That was it.
>
> 'Q. Did he suggest that any particular action needed to be taken on those figures?
>
> 'A. No.
>
> 'Q. Because again, his account is that he explained to you that this was as thorough and as complete an audit as he could carry out, and that he believed that there needed to be a full investigation into the paediatric cardiac surgery service on the basis of the figures that you were given?
>
> 'A. Well, I have no recall of him being anything like as positive as that.

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[61] T59 p. 107 Professor Vann Jones

> ‘Q. What was his manner to you, as you recollect it?
>
> ‘A. As I have already indicated, it was a very bland, no sense of urgency type meeting that we had that morning. He presented those very sheets of A4, we talked around them for an hour, but there was no question of “This is a national tragedy brewing, John”, absolutely nothing of that. There was a concern about some of these operations and it was expressed at that sort of level, no emotions involved, no tears, such as has happened subsequently.
>
> ‘Q. Does it need emotions or tears to translate the sort of figures that you are being given into the proposition that children’s lives were being unnecessarily endangered?
>
> ‘A. No, it does not, but you have to remember that if you are talking about 4 per cent of the paediatric cardiac programme, and we are talking about a very small percentage of the cases, then I would want to have seen the whole picture. If the whole picture was one of uniform, you know, worse performance, then that obviously would have been a very, very major cause for concern, but I have not the slightest doubt that had people taken my angioplasty results for 1985, let us say, and compared them with elsewhere, I may well have looked worse than Southampton and I may well have been worse for two vessel disease than for single vessel disease. We all have runs of procedures where we get to the stage where we think we cannot do them any more, and have bad runs. In paediatric cardiology, in particular, the investigations are very complicated.’[62]

59 Dr Bolsin in his written evidence to the Inquiry described the meeting as follows:

> ‘Professor Vann Jones did not ask me to return having checked the figures. I explained that this was as thorough and complete an audit as we could carry out and that I believed there needed to be a full investigation into the paediatric cardiac surgery service on the basis of the figures I gave to him that morning.’[63]

60 Dr Bolsin stated that he had approached Professor Vann Jones in his capacity as Director of Cardiac Services:

> ‘I approached Prof Vann Jones as the new Director of Cardiac Services. I assumed that he had some control over the events in the Associate Directorate of cardiac surgery.’[64]

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[62] T59 p. 115–18 Professor Vann Jones. See Chapter 3 for an explanation of clinical terms

[63] WIT 0115 0025 Dr Bolsin

[64] WIT 0115 0025 Dr Bolsin

61 Professor Vann Jones stated:

> 'It was obvious from my conversation with Dr Bolsin … that he had shown these figures to a number of other more relevant people.'[65]

62 When asked why, in his view, Dr Bolsin came to see him, Professor Vann Jones said that he:

> '… would have expected to have been well down the pecking order of people that [Dr Bolsin] should have been reporting his concerns to … That may well have been erroneous … but why he should elect to come to an adult cardiologist who had been Clinical Director of a non-existent directorate for three weeks and regard me as an important player in this … .'[66]

63 He went on that he:

> 'Would have expected [Dr Bolsin] to at least have gone to his Chairman of Division of Anaesthesia.'[67]

64 Professor Vann Jones said that it was his understanding that Dr Bolsin had not approached the surgeons concerned, Mr Wisheart and Mr Dhasmana, with his data:

> 'I think [Dr Bolsin] owed the two surgeons a courtesy to say he had concerns about their performance. … I think you are obliged to go and discuss with people how they were performing … I would have thought if one consultant was really concerned with the performance of another two consultants, that he should go and say "I have serious concerns about this and I must go and raise the subject with the relevant parties". I think it would have been courtesy. Then we would not have people running about with different sets of figures and we could perhaps have sat down and got the whole thing clarified.'[68]

65 In his written evidence to the Inquiry, Professor Vann Jones stated that a day or two after Dr Bolsin went to see him, Mr Wisheart also came to visit him:

> 'He had quite a different set of figures and certainly as far as ventricular septal defects were concerned the figures he presented were much more what I would have expected.'[69]

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[65] WIT 0115 0019 Professor Vann Jones

[66] T59 p. 119 Professor Vann Jones

[67] T59 p. 122 Professor Vann Jones

[68] T59 p. 122–3 Professor Vann Jones

[69] WIT 0115 0020 Professor Vann Jones

66 Mr Wisheart set out the reasons for his visit to Professor Vann Jones:

> 'A short time prior to my visit to Prof. Vann Jones, Prof. Dieppe[70] had come to see me in my office. Dr Bolsin had just been to see him and had expressed concerns about paediatric cardiac surgery which he [Professor Dieppe] came to discuss with me. I do not remember whether or not Prof. Dieppe mentioned any specific operations. He did not have, or mention to me, any actual figures, or give me any indication that audit figures existed …
>
> 'On reflection, I considered that if Dr Bolsin was expressing concerns to people in the Trust and the University, that Prof. Vann Jones, Clinical Director of Cardiac Services in which Directorate I did most of my work, should know and have the accurate results of paediatric cardiac surgery. Therefore I went to see him. I did not know that Dr Bolsin had already been to see him.
>
> 'Prof. Vann Jones did tell me that Dr Bolsin had been to see him but did not tell me about, or show me, any figures or audit. I continued in ignorance of the existence of Dr Bolsin's audit.'[71]

67 Professor Vann Jones expressed the view, after speaking to Mr Wisheart, that:

> 'At the end of the day, something as important as this should have been a matter that the Chief Executive should have attended to. I do not mean personally, but certainly he should have set in place some form of investigation.'[72]

Discussions with the Department of Health (DoH)

68 Dr Jane Ashwell, a Senior Medical Officer (SMO) at the DoH from 1991 to 1995, described in her written evidence to the Inquiry the contact she had with clinicians at the BRI:

> 'I then met Dr Bolsin at the Royal College of Anaesthetists, in what I believe was about December, 1993, although I have no record of that date. After the College meeting, he approached me on the steps of the College and asked me if he could discuss something privately. I have no written record of what was said and what follows is to the best of my recollection.
>
> 'He was concerned about the outcomes of cardiac surgery in a number of children at the BRI. He had anaesthetised some of them and he continued to have responsibility for future cases. I understood that he was talking to me as a professional colleague and one who had practised as an anaesthetist and would understand the difficult position he felt he was in, but also might have useful advice on what practical and procedural steps he could take.

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[70] Dean, Faculty of Medicine, University of Bristol

[71] WIT 0115 0026 – 0027 Mr Wisheart

[72] T59 p. 136–7 Professor Vann Jones

> 'Such approaches are not unusual for officials in the DoH. Any approach has to be considered and a judgement made about handling. In this case, I understood Dr Bolsin's enquiry to be confidential in the sense that I would not normally divulge what he said to others without his explicit agreement.
>
> 'This was the only occasion on which he sought advice on his concerns about paediatric cardiac surgery at the BRI.
>
> 'On the basis of what he told me, and with his agreement, I raised the issue with Professor Farndon, in his capacity as a Clinical Director in the BRI. I expressed my concern that issues over the quality of cardiac surgery had been raised with me and indicated that I thought that it should be addressed locally. I expected that the matter would then be investigated further.
>
> 'I confirmed in a letter to Dr Bolsin dated 13th December 1993 that I had spoken to Professor Farndon and had raised the issue, although I had not mentioned Dr Bolsin by name. I also enclosed what relevant Departmental guidance I found.
>
> 'Dr Bolsin replied on 10th February 1994, thanking me for what I had done and indicating that he thought there would be little benefit from further Departmental intervention. He said he was convinced that I had assisted in the resolution of the matter.
>
> 'Dr Bolsin did not speak to me again on this matter.'[73]

69 Dr Bolsin in his written evidence to the Inquiry stated that in his contact with Dr Ashwell he:

> '… explained my concerns about the paediatric cardiac surgical unit at the Bristol Royal Infirmary and provided her [Dr Ashwell] with my provisional figures for the Bolsin/Black data collection and analysis. She agreed to review the data and then provide me with some advice in due course.
>
> 'I subsequently received a letter from Dr Jane Ashwell referring me to the GMC guidelines and the "three wise men" procedure. This letter confirmed that Dr Ashwell had been contacted the next day by Professor Farndon, who had expressed to her exactly the same concerns as I had expressed to her.'[74]

70 In her letter to Dr Bolsin dated 13 December 1993, Dr Ashwell wrote:

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[73] WIT 0338 0004 – 0005 Dr Ashwell

[74] WIT 0080 0116 Dr Bolsin

> ‘You spoke to me in confidence last Thursday. By complete coincidence John Farndon spoke of the same matter to me on Friday. I did not mention you. This letter includes what I expect you would receive, were you to write to the Chief Medical Officer.’[75]

71 In December 1993 Professor Farndon attended a meeting at which Dr Ashwell was also present, as an observer from the DoH. He stated:

> ‘She approached me after the meeting to see if I could spare some time to talk to her … she raised with me a concern which had been expressed to her about performance in the paediatric cardiac surgery unit. At this stage, both Dr Ashwell and I were aware that statistics were being prepared by Dr Bolsin. I cannot remember the specifics of the conversation. In general terms we discussed the concerns that some people[76] had about paediatric cardiac surgery. Something was discussed about the mechanisms by which those concerns had arisen, and about the ways forward, to either substantiate or refute the concerns.’
>
> ‘I took the meeting to be an informal one, in that we left one place and she wished to talk to me in confidence out of the venue of the previous meeting about some other concerns. I did not interpret this as an “official” Department of Health approach to me about any concerns in Bristol.’[77]

72 Professor Farndon was asked whether it was his recollection that he raised outcomes in paediatric cardiac surgery with Dr Ashwell or whether she raised the issue with him. Professor Farndon said:

> ‘My recollection was that she raised it with me and invited me to walk around to another office block of the Elephant and Castle[78] to talk to me.’[79]

73 Professor Farndon told the Inquiry:

> ‘I just found it strange and almost unreal that here was someone from the Department of Health, knowing about issues and talking to me after a meeting was complete when other business was being done, and I suppose one had to think, “Is the Department of Health knowing about this formally [or] informally? Is this a formal approach to me to do something about this? Am I still part of a process of trying to help this situation?”’[80]

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[75] UBHT 0061 0265. The paper which Dr Ashwell enclosed with the letter was HC(90)9 *‘Disciplinary Procedures for Hospital and Community Medical and Dental Staff’*, which can be found at WIT 0037 0079

[76] Professor Farndon, when asked in the oral hearings to whom he was referring in this sentence, stated: ‘People such as Professor Angelini. I am not sure, again, at what stage others spoke to me, whether people like Sheila Willatts or Cedric Prys-Roberts spoke to me around that time.’ Counsel to the Inquiry suggested that Dr Bolsin might also be included in this list. Professor Farndon agreed. T69 p. 124

[77] WIT 0087 0008 Professor Farndon

[78] Department of Health, Hannibal House, Elephant and Castle, London

[79] T69 p. 130 Professor Farndon

[80] T69 p. 126 Professor Farndon

74 He went on:

> '… if there were a clear instruction that she had a concern, it was in her domain to have responsibility for clinical performance and that she knew, for example, that there was a problem in Bristol, if she wanted me to be part of that, and a clear signal had come to me from her that this was a responsibility she wanted me to take, I would take it very seriously.
>
> 'But as I say, this was admixed with a chat about other anaesthetic colleagues that she knew and I knew.'[81]

75 Professor Farndon was asked whether he thought it was his responsibility to take the matter forward in any way:

> '… every one of us is so burdened with our own responsibilities in our own domain, one hopes that one does not have to assume responsibilities from areas where there may be no area of expertise, no professional interaction whatsoever. And I felt up to that point that I had given advice as well as I could.'[82]

76 Professor Farndon explained that he had said:

> 'To Dr Bolsin and to Professor Angelini and to others who have said to me about the situation: "Talk together. Is there a problem? Is there not a problem?"'[83]

77 Professor Farndon also stated that he did not know what Dr Ashwell's role, as an SMO at the DoH, would have been in the resolution of any problem in paediatric cardiac surgery at the BRI.[84]

Late 1993

78 On 23 December 1993 Professor Angelini and Professor Farndon went to see Mr Wisheart. Professor Angelini told the Inquiry:

> '… the focus of the meeting was about the desirability of a new appointment of a consultant paediatric cardiac surgeon?'[85]

79 Professor Angelini later in his evidence said:

> '… The purpose of the meeting was first of all to express our concern; second, the appointment of the paediatric surgeon was the resolution to the concern. It was not the other way around.'[86]

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[81] T69 p. 129 Professor Farndon
[82] T69 p. 127 Professor Farndon
[83] T69 p. 128 Professor Farndon
[84] T69 p. 128 Professor Farndon
[85] T61 p. 85 Professor Angelini
[86] T61 p. 90 Professor Angelini

80 Professor Angelini was asked by Counsel to the Inquiry:

> ‘Q. Was the data that you had seen from Dr Bolsin actually presented and discussed at that meeting?
>
> ‘A. The data was sitting on the table between myself and Professor Farndon who were on one side facing Mr Wisheart. We did not go through in detail with the data … .’[87]

81 Professor Farndon described the subject matter of the meeting as: ‘about the appointment of a paediatric cardiac surgeon.’[88] He was asked:

> ‘Q. Was there any data from Dr Bolsin, or anyone else, about the outcomes of paediatric cardiac surgery at that meeting?
>
> ‘A. Not that I remember.
>
> ‘Q. Do you remember any discussion of any data?
>
> ‘A. I do not. I remember that our meeting was amicable and proceeded well and it concerned the appointment of a paediatric cardiac surgeon.’[89]

82 In a comment on Professor Angelini’s evidence, Mr Wisheart stated:

> ‘This meeting took place on 23rd December 1993 for a short time at lunch time.
>
> ‘The point of the meeting, as I recall it, was that Prof Angelini wished to create an appointment of a consultant paediatric cardiac surgeon and to do so as a Consultant Senior Lecturer within his department. Although I too, wished to appoint a new paediatric cardiac surgeon, and we did so during the next year, I did not feel that this was the best way to go about it.
>
> ‘There was no reference to any specific figure or to Dr Bolsin’s audit; there was no presentation of any figures.’[90]

83 Professor Angelini, when asked about Mr Wisheart’s comment, indicated that he ‘stood by’ his description of the meeting. [91]

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[87] T61 p. 85 Professor Angelini
[88] T69 p. 148 Professor Farndon
[89] T69 p. 150 Professor Farndon
[90] WIT 0073 0104 Mr Wisheart
[91] T61 p. 92 Professor Angelini

84 Professor Peter Keen, Dean of the Faculty of Medicine from 1993 to 1995, in his written evidence to the Inquiry, stated:

> '… in late 1993 Professor Angelini expressed his serious concerns about the standards of paediatric cardiac surgery … we agreed that while this was a matter of concern it would not be appropriate for me as Dean to become involved and that Professor Angelini would take the matter forward.'[92]

85 Dr Sheila Willatts stated in her written evidence to the Inquiry that she had 'prolonged discussions'[93] with Dr Bolsin in 1993 and in 1994. She stated that she advised:

> 'the issue was principally an audit one, namely that the results needed to be scrutinised, validated and agreed. During 1993 and 1994 I spoke to Professor Prys-Roberts, Professor Farndon and Chris Monk expressing my concerns that the data needed to be verified … Professor Farndon volunteered his services as a potential chairman for such a meeting as he was not a cardiac surgeon.'[94]

Report of the performance of the PCS Service in 1993

86 No Annual Report or figures were produced by the Unit in 1993. The Unit's return to the UK Cardiac Surgical Register (UKCSR) showed figures for open-heart surgery:[95]

Operations – Over-1s	Operations – Under-1s
94 (3)	53 (8)

87 There was no record of the Unit having received or considered the 1992/93 figures from the UKCSR, but when the figures for 1993/94 were available (in mid to late 1994) they showed overall mortality in the under-1 group as being 10.5%, and that for the over-1s as being 5.4%.[96] The figures were available from the UKCSR for 1992/93. These record that, for the year 1992, mortality in the UK in the under-1 age group was 14%, and in the over-1 age group was 5.4%.[97]

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[92] WIT 0413 0001 Professor Keen

[93] WIT 0343 0002 Dr Willatts

[94] WIT 0343 0002 Dr Willatts

[95] Figures taken from UBHT 0055 0221; report to the UK Cardiac Surgical Register for 1992–1993; figures in parentheses are for deaths

[96] Figures taken from UBHT 0055 0377; Unit return to the UK Cardiac Surgical Register 1993

[97] Figures taken from UBHT 0055 0377; Unit return to the UK Cardiac Surgical Register 1993

Chapter 29 – Concerns 1994

Concerns

January

1 During the latter part of 1993, Dr Alison Hayes, a consultant paediatric cardiologist at Bristol Royal Hospital for Sick Children (BRHSC) from October 1993, had been asked by those in the paediatric cardiac mortality meeting to collate the figures for the Arterial Switch operation. Dr Stephen Pryn, a consultant in anaesthesia and intensive care at the BRI from August 1993, was also asked, by his Clinical Director,[1] to prepare figures on paediatric cardiac outcome data, which he did for the chronological year ending 31 December 1993.[2]

2 It was planned that Dr Alison Hayes would present the data, and that Mr Dhasmana would speak about them, at a meeting on 20 January 1994. At the meeting were a number of anaesthetists: Dr Davies, Dr Pryn, Dr Underwood, Dr Masey, Dr Bolsin and Dr Monk; surgeons: Mr Wisheart, Mr Bryan, and Mr Hutter; and cardiologists: Dr Hayes and Dr Martin.[3] The meeting was held in the seminar room of the Department of Cardiac Surgery on Level 7 of the BRI. In the event, Mr Dhasmana did not attend the meeting,[4] Dr Hayes did not produce data, Dr Pryn presented some figures and Mr Wisheart presented from memory figures for the previous year.[5]

3 Various witnesses described the meeting. Dr Monk, in his oral evidence to the Inquiry, stated that the meeting arose:

> ' … because Professor Angelini and I were discussing how we would create a forum for the issues and problems of data to be discussed … I suspect that the actual timing and venue of the meeting came from the Professor's office … that … would have been ... because Professor Angelini felt that the issues that they talked about in bringing forward the figures on the paediatric cardiac service had not achieved what he wanted, he, and I, may have said, "Then we must try a different route and we will have a meeting in Level 7 of all the cardiologists, surgeons and anaesthetists, and get the figures presented". So it may have been that the January meeting was a direct consequence of Professor Angelini's feelings that enough had not been achieved between the meeting of these three surgeons [Mr Wisheart, Professor Farndon and Professor Angelini].'[6]

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[1] Dr Monk
[2] WIT 0341 0041 Dr Pryn
[3] It is not clear whether Dr Joffe attended
[4] Mr Dhasmana was operating at the time
[5] T92 p. 6 Mr Wisheart
[6] T73 p. 127–9 Dr Monk

4 Dr Monk described the meeting further in the following exchange:

> ‘A. There was no agenda produced and, as I noted, there was no Chair of the meeting … I realise that was one of the reasons that the meeting was not as effective as it should have been. … If [Mr Dhasmana] had been there, he would have chaired the meeting … My understanding of the meeting was that it would give an opportunity for the surgeons to present their paediatric data and an opportunity for Dr Bolsin to raise his data and that afterwards we could try and find a way forward to get these two groups, or parties, together and that we could resolve the differences that occurred. … The issue that I thought was going to be addressed was the overall performance …
>
> ‘Q. So is it your view, having been at the meeting, that the cardiac surgeons had some idea as to why they were there?
>
> ‘A. I would have that view, yes.
>
> ‘Q. Why do you think Mr Wisheart thought that he was there?
>
> ‘A. I think because Mr Wisheart expected that he was going to present his data and he duly did.
>
> ‘Q. Your perception from the time, please: why would it be that he should think he was being called upon as an unusual step in this ad hoc specially convened meeting to present his data?
>
> ‘A. Because of the concerns that had been raised about the performance of the Unit. …
>
> ‘Q. … from where would [Mr Wisheart] have understood … the impetus for the meeting to have come?
>
> ‘A. I would think that because Professor Angelini had discussed the meeting; it may well have come from him that he was activating the surgical group and I was bringing in the anaesthetic group.
>
> ‘Q. So this may well be a case … of the cardiac surgeon knowing that the anaesthetists were raising concerns about the performance of cardiac surgery?
>
> ‘A. It could be an instance or circumstance, yes.’[7]

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[7] T73 p. 129–32 Dr Monk

5 Dr Monk was questioned further about the meeting in the following exchange:

> 'Q. When you spoke … to the anaesthetists to get them there … did you tell them what was on the agenda?
>
> 'A. There was no agenda. But I think we would have discussed the fact that this was an opportunity to discuss the data, or the lack of agreed data. But we were still, at that time, trying to produce an environment where people could talk about the differences of data and we could find a way forward. To do that, it had to be presented.
>
> 'Q. This would have been a perfect opportunity, one suspects, for Dr Bolsin, had he thought his data presentable, to present his data.
>
> 'A. The whole point of the meeting was for the data to be presented. It seemed to me to be a time at which it could be presented, yes.
>
> 'Q. And for Dr Pryn to present the results of the work that he had been doing at your request up until then?
>
> 'A. I think that Dr Pryn … may not have had adequate time to produce the data in a form that was useful. I think his data was lost to discussion … because it did not match the format of the data that Mr Wisheart presented on a blackboard from memory. …
>
> 'Q. And somehow Mr Wisheart begins the discussion, does he, by putting the figures on the board?
>
> 'A. Within that meeting, James Wisheart presented his data from memory, or the Unit's data from memory, on the blackboard. If I recall correctly, he had expected that Mr Dhasmana would be there because Mr Dhasmana had been collating data. So what you have are a number of threads which are all happening simultaneously, that we had hoped, or I had hoped, would come together at that meeting. … There was some discussion [about Mr Wisheart's data], but the point of the meeting was to hear another side and to look at it in a constructive way. From that point of view, the meeting did not succeed.
>
> 'Q. Why?
>
> 'A. Because there was not a Chair of the meeting and there was not an agenda. … it was done in a way which was not as clear as I would like to have done it if I did it tomorrow, then the meeting was already flawed. … Dr Bolsin … did not present his data. … Dr Bolsin played a very minor role, if any at all.

> ‘Q. Dr Pryn raised, did he, some of the figures that he had collated, and then fell into an argument as to whether he should have divided it between particular age groups?
>
> ‘A. One of the issues that is very hard to deal with when you are looking at retrospective data, particularly in this field, is that the definition of the operation, the diagnosis of the operation, what epoch or age group you define them in, varies. Indeed, it even varies from the point whether you do it from January 1st, December 31st or whether you do it for a financial year. Whereas it seemed sensible for me to do it for a calendar year, in fact the data given centrally is for a financial year. In fact Dr Pryn discovered, to the cost of his data, that the way in which he presented it did not quite accord with the way other people were thinking and therefore, rightly or wrongly, it was dismissed as being inaccurate. But that was the atmosphere at that time, which was difficult, and his data was not in the correct format and he was unable to get his message across.
>
> ‘Q. So the atmosphere was difficult?
>
> ‘A. The atmosphere, as people have discussed, is where people were aware of criticisms, so it was a difficult meeting.’[8]

6 Dr Monk continued in the following exchange:

> ‘Dr Pryn was not successful in putting forward his data.
>
> ‘Q. And Mr Wisheart’s was therefore the only data effectively presented to the meeting?
>
> ‘A. Yes.
>
> ‘Q. Did that show an acceptable picture of paediatric cardiac surgery in Bristol at the time?
>
> ‘A. The determination of “acceptable” is very difficult, because we did not have a standard to say “that is acceptable” or “that is not acceptable”. If we had a standard that was UK-wide and it said “you can accept this level of mortality or this level of morbidity” and you cross it, you can say it is unacceptable. You are talking about a judgment that is being made in the middle of the experience. So that is one of the cruxes of the whole problem.

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[8] T73 p. 132–6 Dr Monk

> ‘Q. Let me approach it this way: was there any challenge to the accuracy of the data that he produced, leave aside their interpretation?
>
> ‘A. Mr Wisheart‘s data was not challenged from the floor. … You recall from these meetings the impact and what your actions were going to be afterwards, and I had great frustration because what I had hoped to achieve was that other data was presented and then you could say “We need to go forward and have an audit that looks at our work …” When you have got that, we can sit down and talk about it and we can truly analyse the problem. We needed to try and bring everyone together.
>
> ‘Q. Do you think, looking back on it, that perhaps part of the problem was that there had been insufficient time for preparation before the meeting, for those who might have presented rival data to get their tackle in order to present it?
>
> ‘A. There are many things that should have been in place before that meeting, one of which was a joint opinion of the cardiac anaesthetists so we could say “This is what we as a group say”. It would have been helpful if we had put an agenda on the table with a Chair to run the meeting, but we had not done it. The meeting happened in a very Latin way, as it were, in that Professor Angelini and I still recognised there was a problem and we had an idea, and we thought “Let us go and do it”. It developed an impetus of its own. Yes, looking back, I should have, somebody should have, been more structured in the meeting, and because it was not structured the point you are making was not achieved.[9]

7 Dr Pryn, in his written evidence to the Inquiry, described the meeting as a regular audit meeting. He stated:

> ‘In early 1994 I attended a regular audit meeting where Mr Wisheart presented the paediatric cardiac outcome data for the year (I believe ending March 1993). I clearly remember being most impressed by the fluency of his presentation, which was done without reference to notes. I have never seen a hard copy of the data that Mr Wisheart presented on that occasion. As he was presenting this data, I was trying to compare his figures with my data, particularly in relation to the outcome for AV canals. In part this was complicated by the fact that my data was compiled from January to December 1993 rather than for the financial year ending March 1993. I also had not appreciated the importance of distinguishing between children aged over 12 months and those under 12 months. I felt, at the conclusion of this meeting that one did need surgical expertise in order to categorise the data properly. I also thought that as the surgeons were collecting the data anyway, and they were in a better position to interpret it, my efforts were unlikely to be helpful. Although I had undertaken this study at Dr Chris Monk’s request, he did not ask me about it again, and following this audit meeting, it did not appear to have any great

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[9] T73 p. 139–41 Dr Monk

> relevance. I assumed, as I believe my colleagues did, that in due course the cardiac surgeons would present the figures for the year ending March 1994.'[10]

8 Later, Dr Pryn told the Inquiry that:

> '… it probably was not a regular meeting, because Sally Masey[11] would not have been there if it was a regular audit meeting.'[12]

9 Dr Pryn described further his understanding and recollection of the meeting in the following exchange:

> 'A. I thought we were going to talk about the recent results.
>
> 'Q. Dr Bolsin's data was not presented to that meeting?
>
> 'A. No. … It would have been a good opportunity to present it. It would have been a good opportunity to present my data, but I did not know the meeting was called for that purpose and my data was not ready. If I had been told a few days before, I might have been able to get it ready.
>
> 'Q. So what warning did you have of the meeting?
>
> 'A. It cannot have been that much, otherwise I would have made a big attempt to complete my data. …
>
> 'Q. You do say your data was not comparable because it covered a calendar year, whereas the other one, Mr Wisheart's, was covering a financial year?
>
> 'A. His would not have been as up-to-date as mine, because basically I had cases on my list who were still in the intensive care ward; they had only just been operated on, so there were some outcomes we did not know yet.'[13]

10 Dr Pryn's oral evidence to the Inquiry included this:

> 'Q. He [Dr Monk][14] says at the meeting there was no effective Chair. What is your comment on that?
>
> 'A. I think that is true. I think somebody at the back said "James, can you present your data?" and he got up and presented it, but nobody was questioning him on that data and nobody was chairing the meeting to bring in other people's comments and discussions.'[15]

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[10] WIT 0341 0041 Dr Pryn. See Chapter 3 for an explanation of clinical terms

[11] Consultant anaesthetist

[12] T72 p. 144 Dr Pryn

[13] T72 p. 145–6 Dr Pryn

[14] WIT 0105 0022 Dr Monk

[15] T72 p. 146–7 Dr Pryn

11 Dr Pryn expressed the following view about Mr Dhasmana's absence from the meeting:

> 'I would have thought it was really important for him to play a part …'[16]

12 The pattern of the meeting, as seen by Dr Pryn, emerged from the following exchange:

> 'Q. It says here that the main data presented was presented by Mr Wisheart on a blackboard, or a whiteboard, and then it suggests there was something from you: some of the most recent data available on the 1993 operations. Does that overstate the nature of your contribution?
>
> 'A. I think it does, a little bit. Whilst Mr Wisheart was presenting his data, I was looking down through my very rough workings and was trying to count in my mind. I particularly chose the AV canals, because I think Mr Wisheart had said, "Here are the realities for the AV canals; they are not good but they are tolerable", and I wanted to cross-check that with my data. So I was counting the AV canals and I got a little confused between children who were aged over 1 and under 1, and at the end I made some comment about, I do not know, mortality in children with an AV canal over 1, and both Mr Wisheart and Alison Hayes, the cardiologist, actually said to me, "Your data must be rubbish because we do not do AV canals in the over 1s". So that was it. So I sat down again: basically, I had not prepared for a presentation. I was not in a state to do it. So I got what was coming [to] me.
>
> 'Q. Can you remember whether Mr Wisheart's figures covered the range of operations and procedures within the BRI, or whether it was related to one or two procedures only?
>
> 'A. No, I believe that he covered the entire range, which is what impressed me, because it all came off from memory and he could write down all these figures, even for tiny groups. He must have known the figures particularly well to do that.
>
> 'Q. If we go on back to [Dr Monk's] statement: "The meeting resolved little as there was not a frank discussion on outcome, and I believe it did more to consolidate difficulties and differences than start a process to address the problems". What do you have to say about that commentary?
>
> 'A. I think there you come down to the problem that I think Mr Bryan highlighted, where difficulties were often explained away by poor cases such that when Mr Wisheart presented his data, it was all in small subsets of procedures or diagnoses, and it was difficult to see the overall picture of the Unit performing poorly for small children. So the conclusion that Mr Wisheart drew and that we all came away from the meeting with was that "Bristol is not brilliant, but some things

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[16] T72 p. 147 Dr Pryn

are quite good; other things are okay; some things are pretty poor, but you know, that is the way all units are and we are no worse than any other unit".

'Q. Which things were pretty poor?

'A. I cannot remember the specifics, but I would have imagined he may well have drawn AV canals, saying they are not good, because that is why I was looking through AV canals.

'Q. Would the Switch operation have featured in discussion?

'A. It may well have done, but I am not sure whether he presented it as a Switch or just mixed the Switches up with Atrial Switches and just had them in diagnostic categories as opposed to operative categories. I cannot remember how he presented his data. In fact, there was no hard copy for us to take away from that meeting.'[17]

13 Dr Bolsin gave his account of the meeting in the following exchange:

'Q. … At that meeting, Mr Dhasmana is supposed to present the results of the Unit but he is operating so he does not?

'A. Yes.

'Q. And the meeting is there. Everyone goes to Level 7. That is unusual, is it?

'A. Yes.

'Q. So there was particular interest in the results?

'A. Yes.

'Q. Particular interest by you, because you had been carrying out your work with Dr Black and you had shown that to some of your anaesthetic colleagues?

'A. Yes. …

'Q. So here was Mr Wisheart coming forward, presenting the results of [the] Fontan operation?

'A. Yes. … I can remember a few figures being put up on what I think was a whiteboard, but I am not sure there was an enormous amount of discussion.

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[17] T72 p. 147–50 Dr Pryn. See Chapter 3 for an explanation of clinical terms

‘Q. And open to you, had you wished, to say, “Look, we, the anaesthetists, have a bit of concern about the overall outcomes. Can we have a fuller review? We were going to review the figures here today. We have not had them because Mr Dhasmana is elsewhere, can we be circulated because we are concerned from individual experiences that something may need to be improved”?

‘A. Yes. … I specifically did not have any concerns about the Fontan procedure, because we had audited the Fontan procedure.

‘Q. But the purpose of the meeting would be to look at the results generally?

‘A. Yes.

‘Q. If you had a general concern, which you say you did … why not raise it at that meeting in some appropriate terms?

‘A. I think I was still expecting concerns about results to be raised directly with the surgeons by those people who were empowered to do so, and that was really the Clinical Director and possibly Professor Angelini. …

‘Q. … is it right that you understood at the time of this meeting, 20th January 1994, that Chris Monk was calling you and your activities “trouble”?

‘A. I think probably for me to say that definitely at this time that had been said may not be true, but certainly, I was aware of a groundswell within the department or possibly the organisation that this was seen as troublesome activity. …

‘Q. … if you had felt free in 1991 to raise the issue, after the 1990 events, to raise the vigilance of the anaesthetists and drawing attention to the mortality figures and so on, put your head above the parapet, as it were, then why did you not do it at this meeting here in January? …

‘A. … There were also two very different meetings. I think the meeting in 1991, at which I had been prepared to say that the “vigilance of the anaesthetists” was something sitting in an armchair, much more informal. I think in a formal meeting, such as the one on Level 7, I was much less prepared to raise formal criticisms of the paediatric cardiac surgery mortality … Saying this indicated the vigilance of the anaesthetists in keeping their morbidity and mortality data is not the same as raising a service problem of mortality in that unit in a formal setting. …

‘Q. So you had a feeling, at this stage, that if you had pushed the issue — let us suppose that you had said something at the meeting of 20th January 1994 … to the effect, “This data is disturbing, we must do something about it and I propose X and Y”? …

‘A. I am not sure I would not have had support. I would have been worried about the consequences from other people.

‘Q. Both Dr Pryn and Dr Monk seem to recollect that at this meeting, 20th January 1994, it was not just the Fontan results which were presented, that in fact the results for the Unit were presented, even though they might not have been presented as Mr Dhasmana might have wished. Are they right or are they wrong about that?

‘A. As I remember the Fontan results, I do not remember the whole results of the Unit.

‘Q. Might they have been presented?

‘A. It is possible, but I just remember Mr Wisheart standing and writing figures down, and I think it would have been almost impossible for him to have written down all the results of the Unit.

‘Q. Had you wished, and had you not felt vulnerable as a result of the influences you told us of, you could, I take it, have presented the data?

‘A. Yes, I could if I had wished.

‘Q. And if you had done, you would have urged the meeting to carry out a full and thorough review?

‘A. Yes. I think my hope was that this meeting was going to be the full and thorough review that we had been aiming at for a long time, so to a certain extent, although it had taken a long time and we had had our data for about two years, my hope was that by going around the various routes that we had gone to, we had actually now achieved the full and open review that certainly I, and I think Andy [Black] working with me, had always wanted. So I expected at this meeting on 20th January, it was actually the goal, the destination that our data was the signpost towards.

‘Q. Did you contribute to the meeting at all?

‘A. No, I was very disappointed that we were not at this destination.

‘Q. So you have a very disappointing meeting on 20th January?

‘A. Yes, in terms of data, yes.’[18]

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[18] T82 p. 158–72 Dr Bolsin. See Chapter 3 for an explanation of clinical terms

14 Mr Dhasmana gave his view of the meeting in the following exchange:

> 'Q. … it had been intended that you would present the results, the annual results?
>
> 'A. No, that is wrong. That [meeting of 20 January 1994] was an extraordinary meeting, a paediatric cardiac club meeting, not an audit meeting of the department, because I had already presented my yearly audit figure in December 1993, but this was called because I had stopped my neonatal Switch in October 1993. Dr Alison Hayes was asked to have the data prepared …'[19]

15 Mr Dhasmana's evidence also included this:

> 'Q. … The meeting … was a meeting for you to present results, particularly in relation to Switch, you say?
>
> 'A. It was not just for me, really. It was for Dr Alison Hayes to present her figures on Arterial Switches and of course, I would be there in a way to present whatever I could really say on my behalf, but I was told "You are too much involved with this thing, let somebody else do the audit and you be there to answer whatever questions are there". So that is how it was. …
>
> 'Q. As it happens, you were not able to go because you had commitments elsewhere?
>
> 'A. Well, I was operating. I got held up so I started getting worried and I made enquiries, what is going to happen? I was quite shocked to find out Dr Alison Hayes had already presented that data during the first week of January in the Children's Hospital, one of these Monday morning meetings, and I was at that time on holiday to India. I returned only 15th/16th January, and she had presented just after the Christmas break. So that was already presented.
>
> 'Q. That would be to the cardiologists, would it?
>
> 'A. That would be the cardiologists, the cardiac surgeons, and I was told Dr Masey and Dr Underwood also …
>
> 'Q. Were you worried about the Arterial Switch?
>
> 'A. I stopped. That is why I stopped the neonatal Switch programme. …
>
> 'Q. So you had made your decision about that, so that was it?
>
> 'A. In a way I was not going to, but Dr Joffe said "Let Alison Hayes analyse this and find out if we learn anything more". She came back to almost the same type of

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[19] T86 p. 145 Mr Dhasmana

> answer which I already knew, that there was a higher percentage of coronary abnormality in the series and of course, you know — I think that is what I remember. I think she may have mentioned one or two other things, I am not sure.
>
> ‘Q. But in any event, nothing in that to make you reconsider your decision?
>
> ‘A. No …
>
> ‘Q. … knowing that Alison Hayes had presented data to the cardiologists and surgeons earlier in January, knowing that Mr Wisheart had presented data to the meeting of 20th January … what need did you see to present any further data to the Unit?
>
> ‘A. I did not.’[20]

16 Mr Dhasmana told the Inquiry that he had subsequently learned that:

> ‘A. … Mr Wisheart presented what he had on last year’s figures, and because he saw me preparing, I always thought that he knows and by that time, I would have thought that he also had a copy of my Unit’s figures which I had already sent to the register [UKCSR[21]]. So he would have had the data for 1992/93, but I was quite surprised why he should be doing that, because I have already presented that, but this was a different forum. … I asked him what did they talk about, Arterial Switches and various things? Then he said that “The Arterial Switches were already discussed before as you know, but it was mentioned again in the meeting, and I presented what I could remember from your figure”.’[22]

17 The overall effect of the meeting was explored by the Inquiry Chairman with Dr Pryn:

> ‘Q. (The Chairman): … this is a meeting called by your Clinical Director. He said here in front of us that he believed it did more to consolidate difficulties than to start a process. I was just wondering about your reflection on whether that is particularly surprising. If you did not know about the meeting until just before it was called, you were not in a position to present proper data, not everybody who should have been there could have been there, and so on and so forth, no one is in the chair. If this is a meeting called to address what is deemed by some to be a serious matter, what was your view, did the meeting as it proceeded achieve anything like the objectives claimed for it?
>
> ‘A. I did not know the objectives at the time, but in retrospect, it did not address the issue of whether there was a serious problem going on in Bristol at the time.

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[20] T86 p. 149–53 Mr Dhasmana

[21] UK Cardiac Surgical Register

[22] T86 p. 150–1 Mr Dhasmana

> ‘Q. (The Chairman): What does that tell you about organising meetings?
>
> ‘A. Organising meetings with clinicians is phenomenally difficult, because we all have other commitments. It is very difficult during working hours. We often end up organising meetings in our free time in the evenings. That is just about the only way we can all get together. …’[23]

18 Dr Pryn went on in the following exchange with Counsel to the Inquiry:

> ‘Q. So did anyone suggest that the results were not good enough, or needed dramatic or substantial improvement?
>
> ‘A. I cannot recall it, unless Chris Monk spoke from the back and said “Mr Wisheart, there have been some concerns, can you tell us the most recent data that you have?”. He may have done it like that.
>
> ‘Q. But once Mr Wisheart presented the data, there was no comeback and argument with that, or conclusions?
>
> ‘A. I think there might have been a discussion about some of the diagnostic groups, for instance, the Fallots, who had had some particularly poor outcomes in the years preceding, but I think the surgeons had changed their operative techniques and the results were a lot better. So there may have been some discussion about that sort of improvement, but not as a Unit as a whole.
>
> ‘Q. Dr Monk talks about consolidation of difficulties and differences. What was the overall “temper” of the meeting?
>
> ‘A. It is hard to tell that because I did not know what the objectives were at the time. It was amiable and professional. I felt somewhat humiliated because I had not prepared properly. It was a professional meeting.
>
> ‘Q. Did Dr Bolsin speak at any point?
>
> ‘A. Not that I recall.
>
> ‘Q. If we go back to your statement, page 41,[24] you say there that after this meeting your audit was effectively abandoned?
>
> ‘A. Yes, I put it to one side. I did not think it would be that useful, because I thought it would be very difficult to actually categorise the children and I realised that the surgeons were actually collecting this data anyway and were in a much better

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[23] T72 p. 150–1 Dr Pryn

[24] WIT 0341 0041 Dr Pryn. See Chapter 3 for an explanation of clinical terms

> position to do it, and I thought they were also presenting it regularly. So I did not think that my efforts would be particularly useful.'[25]

19 When asked by Counsel to the Inquiry about the approach that Dr Bolsin might have adopted, Dr Pryn said:

> 'I think he [Dr Bolsin] should, first of all, have presented it [his audit] to us, to the cardiac anaesthetists at a cardiac anaesthetic meeting, and we would all then have got an appreciation of its strengths and its weaknesses, and its meaning, and then, depending on the relative balance of strengths and weaknesses, I think we should have presented it at a joint audit meeting, and the one in January 1994 would have been a prime example when he could have done that.'[26]

February

20 Dr Bolsin replied to Dr Ashwell's, Senior Medical Officer, DoH, letter of 13 December 1993 on 10 February 1994.[27] He wrote:

> 'Thank you very much indeed for the letter you sent me immediately after the Audit Meeting at the Royal College of Anaesthetists last year. Professor Farndon, Professor Angelini and myself have made considerable progress with the matters of concern that we discussed. There is now in place a programme for the appointment of a new paediatric cardiac surgeon and a commitment from the highest levels of the Trust to improve and maintain performance. There would seem to be little benefit from any further investigation from your end at this stage although this should not be ruled out if words are not converted speedily into actions.
>
> 'I am most grateful to you for your intervention in this matter and I am convinced that you have significantly helped in the resolution of what was an unacceptable clinical practice.'[28]

21 Professor Angelini told the Inquiry that he began to raise concerns with Dr Roylance at about that time:

> 'Q. How many meetings did you have with Dr Roylance?
>
> 'A. I cannot recollect, but I guess at least two from the end of 1993 to March 1994 — at least two.

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[25] T72 p. 151–2 Dr Pryn

[26] T72 p. 125 Dr Pryn

[27] See Chapter 28

[28] UBHT 0061 0270; letter dated 10 February 1994

> ‘Q. Who was present at those?
>
> ‘A. At the first one there was nobody except myself and Dr Roylance. At the second one there was Dr Monk and after that, there were several other meetings, but with many other people present, like all the cardiac surgeons; or another one, we had a meeting towards the August of 1994 with Mr McKinlay[29] in his office, Professor Farndon and myself, and Mr McKinlay called Dr Roylance in. So there were several meetings, but always with lots of other people involved.
>
> ‘Q. Let us look at the period in the early months of 1994, shall we, before the letter that you and Professor Farndon wrote to Mr Durie?[30] Can we confine ourselves to the meeting between —
>
> ‘A. I think there were definitely two meetings, one on my own and one in the presence of Dr Monk.
>
> ‘Q. I think you told the GMC [General Medical Council] that you had at least two meetings on your own?
>
> ‘A. I cannot remember. It may have been one or two. I do not have any evidence to support one or the other.
>
> ‘Q. There is no written material evidencing what was discussed at any of these meetings; is that right?
>
> ‘A. Correct.
>
> ‘Q. No contemporaneous correspondence either from you or Dr Roylance?
>
> ‘A. No… In fact the first letter I wrote on this matter was when Peter Durie asked me. Then I became very [aware] of the need to write a letter and I wished I had written twice as many.’[31]

March

22 On 3 March 1994 Dr Peter Wilde, a consultant cardiac radiologist at the BRI from 1982, distributed a discussion document, *‘Echocardiography on The Cardiac Unit’*,[32] to Professor Angelini, Mr Wisheart, Mr Dhasmana, Mr Bryan, Mr Hutter, Dr Murphy, Dr Jones, Dr Monk and Dr Martin. In a covering letter he said:

> ‘The system is certainly unsatisfactory at present and could potentially be very much better if we had an organised strategy. I feel sure that a high

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[29] Chairman, UBHT from July 1994 to November 1996

[30] Mr Peter Durie was Chairman of the UBHT from April 1991–June 1994

[31] T61 p. 97–8 Professor Angelini

[32] UBHT 0146 0051 *‘Echocardiography on The Cardiac Unit’*

> quality supporting echo service would undoubtedly lead to improvements in cardiac outcomes.'[33]

23 In March 1994 Professor Angelini and Dr Monk had a meeting with Dr Roylance. Professor Angelini described the meeting in the following exchange:

> 'Q. Did you yourself ever actually tell Dr Roylance what data was available?
>
> 'A. Yes. He knew that Dr Bolsin had done this data collection.
>
> 'Q. Did you yourself —
>
> 'A. I said that. I am sure I said that.
>
> 'Q. Did you yourself ever tell Dr Roylance that there was data floating about from Dr Bolsin, or did you simply assume that he must have seen it?
>
> 'A. I honestly cannot say. If I say yes, I may be lying; if I say no, I may be lying too. I cannot recollect it.
>
> 'Q. You cannot confirm that you told Dr Roylance about this data from Dr Bolsin?
>
> 'A. No, I cannot, although the data was in my hands in Dr Roylance's office. I cannot remember the specific terms of the conversation.
>
> 'Q. So this was another meeting where the data was actually there?
>
> 'A. No, this was the meeting with Dr Monk. We both had the data.
>
> 'Q. But it was not shown specifically to Mr Roylance?
>
> 'A. No.
>
> 'Q. A bit like the meeting with Mr Wisheart earlier?
>
> 'A. Yes.'[34]

April

24 On 5 April 1994 Dr Monk, Mr Wisheart, Dr Bolsin and Professor Angelini went to dinner at Bistro 21, a restaurant in Bristol.

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[33] UBHT 0146 0050; letter from Dr Wilde dated 3 March 1994

[34] T61 p. 108 Professor Angelini

25 Dr Monk in his written evidence to the Inquiry explained the background to the Bistro 21 dinner:

> ‘In an attempt to depersonalise the continued differences in opinion over the P.C.S. [paediatric cardiac surgery] outcomes I spoke individually with JDW, SB [James Wisheart, Stephen Bolsin] and Professor G. Angelini (GA), I chose these colleagues because it was JDW under criticism, SB had performed the audit and GA supported both SB and the need for change. I spoke with each to explain that the aim was for an informal discussion on the different opinions and that I had arranged a meal at a restaurant (13.4.94) to obtain a non-confrontational atmosphere. Although I directly asked the question whether there were any concerns regarding P.C.S. neither SB nor GA replied. In conversation shortly after with JDW I formed the impression from him that if the concerns were not worthy of discussion at the meal then the concerns could not be major.’[35]

26 Dr Bolsin set out his view of the meeting in his written evidence to the Inquiry:

> ‘In 1993 [*sic*] Professor Angelini, Dr Monk, Mr Wisheart and myself attended a meeting that was arranged in a restaurant near the hospital, Bistro 21. We were booked in the upstairs room, which was deserted. The meeting proceeded over supper with peripheral discussion of the performance of the unit. There were no direct requests for figures from Mr Wisheart, which led me to believe that he was aware of the results that Andy and I had produced. Certainly my information from both Gianni and Chris Monk was that they had shown the results to the surgeons involved. It was also my understanding that the Chief Executive had been informed of the results and must have discussed them with his Medical Director. It came as no surprise to me that a request for data was not forthcoming at this meeting because as far as I was concerned everybody at the meeting had the results that I, and others, had generated. There was little consequence to the meeting but the issue of poor performance had been raised and I expected a full and open review to ensue as the Medical director of the Trust was aware of the concerns of:–
>
> ‘1) A Clinical Director of the Trust [*sic*]
>
> ‘2) The Professor of Cardiac Surgery
>
> ‘3) An adult cardiac surgery auditor of National Reputation.’[36]

27 Mr Wisheart responded to Dr Bolsin’s statement to the Inquiry:

> ‘I had become aware that Dr Bolsin, with Professor Angelini, were expressing criticisms about paediatric cardiac surgery. Why they were doing this and on what basis was unknown to me. As rumours continued and progressed I expressed the view to Dr Monk that the only satisfactory course was to speak directly with

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[35] WIT 0105 0023 Dr Monk

[36] WIT 0080 0118 Dr Bolsin

Dr Bolsin and ask him what his concerns were. He agreed and the dinner was set up by Dr Monk and myself for this purpose. I asked the question to Dr Bolsin and Professor Angelini "What are your concerns?" but I did not receive an answer at the dinner party or subsequently.

'Dr Bolsin says that there was no request for figures and of course that is true because I did not know that figures existed. Dr Bolsin, therefore, was mistaken to conclude that I was aware of the figures.

'Neither Professor Angelini or Dr Monk showed me the results, or told me that an audit had been carried out, or that figures existed.'[37]

28 Dr Bolsin discussed the meeting further in the following exchange with Counsel to the Inquiry:

'Q. What was the purpose of going to the meeting? …

'A. I think Chris Monk invited me to attend the meeting. I think it was at relatively short notice, and my understanding was that we were going to address some of the issues in cardiac surgery and probably paediatric cardiac surgery.

'Q. Why the four of you?

'A. To be quite honest with you, I have not thought about that. I assume it was because we all had an interest in paediatric cardiac surgery.

'Q. Was it perhaps because Dr Monk is the Director of Anaesthesia, Mr Wisheart is the Medical Director and has obviously an input into cardiac surgery, was, had been the Associate Director of Cardiac Surgery?

'A. Yes.

'Q. Professor Angelini had been a surgeon whom you had talked to about your concerns and because you were known to be expressing or promoting concerns?

'A. It is certainly possible that those are the reasons, yes.

'Q. If that is possible, did you know, at this stage, whether Mr Wisheart had seen your data?

'A. No. I assumed he had, because when I had given it to Dr Monk, he had said, "Right, I will take this on", and Professor Angelini had said, "I will show the appropriate people this data".

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[37] WIT 0080 0332 Mr Wisheart

‘Q. So your understanding was, “Mr Wisheart has a copy of my data and knows it has come from me”?

‘A. Yes. He may well have known that it came from myself and Andy Black, yes.

‘Q. So there you are, at the meeting, at the dinner: called to discuss your data and the conclusions to be drawn? The way forward? What?

‘A. I am not sure. I think it was paediatric cardiac surgery and adult cardiac surgery.

‘Q. Did you in fact discuss it?

‘A. It was a very unusual meeting because if the agenda or the purpose of the meeting was as you suggest it, the first two courses were spent in small-talk, talking about nothing really to do with cardiac surgery at the BRI, and only latterly did we get into any conversation about cardiac surgery at the BRI at all.

‘Q. Is that a reflection of awkwardness in grappling with the subject, bearing in mind that there may be different perspectives on it?

‘A. Yes, I think it was the taboo nature of the subject.

‘Q. So there you are circling around the issue in the first two courses?

‘A. Yes.

‘Q. Talk being whatever it was, Manchester United [Football Club] and so on. When did you get to grips with the subject? Did you ever?

‘A. I did not want to raise it, and I do not think I did raise the subject.

‘Q. Why not?

‘A. Because I felt very uncomfortable raising this subject with that company. I would raise it with —

‘Q. That is what you were there for, was it not?

‘A. I was not sure that the purpose of the meeting was for me to raise the subject in front of that company. I had already raised the subject with Dr Monk and I had already raised the subject with Professor Angelini, and I would have been happy to contribute to a debate if they raised the subject and it impacted on the data that I had collected or the views that I held.

‘Q. So you thought you were there to contribute to a discussion, but not to begin it?

‘A. Yes, very much so. I was not prepared to initiate a discussion on the basis of what had happened up until this meeting.

‘Q. So if someone had said, “Do you have any concerns about paediatric cardiac surgery?” looking at you or Professor Angelini, you might have responded to it?

‘A. If the issue of concerns about paediatric cardiac surgery would have been raised, I would have expected either Professor Angelini or Dr Monk to have taken the lead and said, “Well, actually now you come to mention it, we do have a problem and I do not know, Steve, whether you would like to come in on this one and tell us about your data collection?”

‘Q. What Dr Monk has suggested to us he said – because he told us you were getting frustrated that by the end of the evening nobody had grappled with the subject which he had arranged the meeting for –

‘A. It was a very difficult subject to grapple with.

‘Q. His recollection is that although he does not recall the exact words, he said words to the effect of: “Do you have any difficulties with the paediatric cardiac services?” May I tell you that in comments he has given us, Mr Wisheart says he said words to the same effect, “Do you have a problem with paediatric cardiac services?” Did one, or the other, or both say that to you and Professor Angelini, or you or Professor Angelini?

‘A. I think the question, if it arose, would have arisen to the table, so that one person would have been speaking to three others, and I would not have responded to that; I would have contributed to it, but I would not have responded to that —

‘Q. Can I take it in stages. Was the question asked?

‘A. Possibly.

‘Q. If it was asked, why did you not respond?

‘A. I would have contributed. I did not want to raise the issue of me being the prime mover in concerns about paediatric cardiac surgery. That was why I was going through every other route possible to press alarm bells to get somebody to come and deal with the issue of paediatric cardiac surgery.

‘Q. So Professor Angelini, someone you were on friendly terms with, shared your concerns?

‘A. Yes.

‘Q. After the dinner, did you say to him, “Gianni, for goodness sake, why did you not respond to that question? It was not for me, I am a junior consultant, but you are a Professor, why did you not say something?”?

‘A. Yes.

‘Q. Did you say that to him?

‘A. No, I thought in a sense the question in my mind was redundant, in that, at that stage, I believed that both Chris Monk and Professor Angelini had raised the issue with Mr Wisheart so that the issue of concerns was one that was current within this group, within that group; it was not really a question of saying, “Is there a problem?”, it is a question of what we are going to do about the problem.

‘Q. … The meeting, you are going to tell me, I know, ended without any discussion actually taking place?

‘A. Yes.

‘Q. If a question were asked, as it is suggested to us and you cannot deny was asked, like “Are there any difficulties?” and so on, “What is the problem?”, why did it not lead to a discussion there and then?

‘A. I am not sure, because Dr Monk was aware of my concerns and Professor Angelini was aware of my concerns. I was aware of my concerns. I thought that Mr Wisheart was aware of the data, and I would have expected a meeting like this to have been dealing much more with solutions than with whether or not there was a problem. As far as I could see, the data coming from the Unit already recognised that there was a problem. My data confirmed the data that recognised that there was already a problem. We should not have been talking about whether there was a problem, “Do you have any concerns?”; we should have been talking about, “What are the solutions to the problems we know exist within this Unit?” and the director should have been very much aware of that.

‘Q. The solution you had in mind was the need for an immediate, thorough investigation and review?

‘A. Which we had been promised in January when Mr Dhasmana was due to present the data and he did not …

‘Q. Would not this meeting have been an ideal opportunity, bearing in mind your concern for little children in the Unit, to press the case for just such a review?

‘A. Yes.’[38]

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[38] T82 p. 178–85 Dr Bolsin

29 At a later stage in his evidence to the Inquiry, Dr Bolsin had the following exchange with Counsel to the Inquiry:

> ‘A. Could I add one other thing about the Bistro 21 dinner. … The other possibility and I think this was a very real possibility, was that this was a sort of “bonding” exercise in the Trust, and I think that given the sort of management culture that was overtaking the NHS at this time, those kinds of exercises were seen as quite useful, and I think it is quite possible that I believed that I was going to a bonding, you know, touchy-feely-fuzzy-warm meeting at which we were going to get together, rather than necessarily a meeting at which we were going to address a specific issue of paediatric cardiac surgical mortality. I do not know if that helps?
>
> ‘Q. I am not sure it does. For what reason do you think, looking back on it, the Bistro 21 meeting may have been a touchy-feely-fuzzy-warm bonding session, as opposed to a dinner intended to sort out differences, if there were differences, as to the performance of cardiac surgery and the interpretation of any figures there were?
>
> ‘A. I think firstly the venue, holding a meeting in a restaurant, is not a venue for where you will sort something out; it is more a venue where you will have a warm convivial meeting, and I think if we were going to sort out paediatric cardiac surgery, it would have been better to have done it in an office in the University department, or something.
>
> ‘Q. Yesterday you were telling us that – these are your words “I think Chris Monk invited me to attend the meeting. I think it was at relatively short notice”?
>
> ‘A. Yes.
>
> ‘Q. “My understanding was that we were going to address some of the issues of cardiac surgery, and probably paediatric cardiac surgery.”
>
> ‘A. Yes, but I think it could have been in a “How can we move this forward together?” kind of atmosphere.
>
> ‘Q. Again, to try and get what you are saying right, are you saying that you go along to address the issues, not with the object of being confrontational, but with the object of producing a resolution?
>
> ‘A. Yes.
>
> ‘Q. So what you would have been looking to achieve from your own point of view from the meeting, was a consensus that matters needed to be moved forward and a plan of action?
>
> ‘A. That kind of thing, yes.

> ‘Q. And as it happened, as we know, nothing transpired?
>
> ‘A. I think if we had been intending to do that in a Bistro 21 atmosphere, it would have been formal and not informal, and the formality was not there.’[39]

30 Professor Angelini gave his view of the Bistro 21 meeting in the following exchange:

> ‘A. That dinner was organised by Dr Monk and the idea of that dinner was to have Mr Wisheart and [Dr] Bolsin together to try to reconcile some of their differences. I was invited, I guess, I do not know, as a sort of honest broker, or outside — I do not know what to call it, but the dinner was organised by Dr Monk.
>
> ‘Q. Was the dinner the place where Mr Wisheart asked Dr Bolsin and yourself if you would share your concerns with him and Dr Monk about the paediatric cardiac surgery?
>
> ‘A. No.
>
> ‘Q. It is right, is it not, that Dr Bolsin did not take any data to that dinner?
>
> ‘A. Correct.
>
> ‘Q. You did not take any data?
>
> ‘A. No, I was just the guest at a meeting organised by somebody else.
>
> ‘Q. No data was produced, if I can put it like this, from Mr Wisheart’s side?
>
> ‘A. No.
>
> ‘Q. So it must follow that presumably if Dr Monk did not bring any data there was no data discussed at the dinner?
>
> ‘A. Again, the purpose of this meeting, everybody seems to emphasise the need to have these pieces of paper in front of you with the data. The fact of the matter was that we were at a stage where we were trying to get across the message that some of us in the Unit were not happy with what was going on in paediatric cardiac surgery. On the other side, there were people like Mr Wisheart who were not prepared to accept that there was a problem. So effectively, any conversation was almost dead before it started, because we could only agree to disagree. Therefore, there was never the opportunity to expand and go into details of “Let us look at the VSD, whether a mistake has been made; let us look at the AV canal”[40], because there were two opposite views. One view was what was going on was acceptable surgical practice; the other view was that what was going on was not acceptable

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[39] T83 p. 52–4 Dr Bolsin

[40] T61 p. 114–22 Professor Angelini. See Chapter 3 for an explanation of clinical terms

surgical practice. These two things were impossible to reconcile. As a result of this, there was never any proper conversation which could try to analyse the problem or, if so, how to resolve it.[41]

‘Q. Dr Monk had accompanied you to the meeting with Dr Roylance?

‘A. Yes, just a few days or weeks before.

‘Q. He was also at this dinner with you and Dr Bolsin and Mr Wisheart?

‘A. Yes.

‘Q. Did he try to bridge the gap between Mr Wisheart on the one side and Dr Bolsin on the other?

‘A. I think Dr Monk was concerned about all of this because of his position, and also because he was genuinely concerned, but again, as it had happened for other people, it was very difficult for him to get the message across.

‘Q. Across to whom?

‘A. To Mr Wisheart. I mean, everybody, even the Professor of Surgery who was in a much more senior position, was always finding himself almost embarrassed in having to say to a colleague, a friend, somebody very senior, that his results were not up to scratch. It was always the sort of psychological barrier, if you want to call it, where people could not just get the message across. One reason was that there was apprehension, because as I said, Mr Wisheart was a very influential individual within the Trust. But there was also —

‘Q. So does that mean that there was the fear that there would be repercussions?

‘A. I do not know if “fear” is the right word, but let us say apprehension.

‘Q. Apprehension of what?

‘A. Yes, even apprehension of what it would be, your future career.

‘Q. What was going to happen?

‘A. I do not know. Perhaps your career, internal promotion, would have been curtailed down, really.

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[41] See Chapter 3 for an explanation of clinical terms

‘Q. How would that come about?

‘A. How would that happen? At the end of the day the people who were running the hospital can have a profound effect in the way your practice or your individual practice is run. They may not be so sympathetic when you go and ask for something like, you know, you want to go and improve something in the service, or even on personal grounds.

‘Q. Was Mr Wisheart, so far as you are concerned in the spring of 1994, one of the people who was, as you put it, running the hospital?

‘A. More or less, yes. I do not know if he was running the hospital, but as the Medical Director he was [on] the Trust Board. Maybe he was not the Chairman of the Hospital Medical Committee at that stage. Before that stage he had been Chairman of everything that moved in [the] hospital, the Division of Surgery, cardiac surgery, everything. We had an Associate Director of Cardiac Surgery, Mr Dhasmana, who could never take a decision. He never ever took a decision because whatever decision he took was going to be turned down or changed by Mr Wisheart.

‘Q. So were you scared of Mr Wisheart?

‘A. Not particularly, no.

‘Q. Not particularly?

‘A. No.

‘Q. A little bit?

‘A. No. And I can tell you why.

‘Q. So not at all?

‘A. I would say not at all, yes, but despite of the fact I was not scared, I was feeling very uncomfortable all the time, because it is not very pleasant to confront a colleague who happened to be senior to – I mean, Mr Wisheart could have been – he is the same age of the person who trained me. He could have been my trainer. And now I was there, confronting him, trying to tell him, “Look, your results are not good”. This is very uncomfortable.

‘Q. But you did not confront him, because paediatric cardiac surgery was never mentioned at the dinner?

‘A. But many times before. That dinner was not organised by me, I was simply there as an observer. I did not organise the meeting, I was not responsible for the talking of anything. I had spoken to Mr Wisheart about the results of paediatric cardiac surgery in a very polite fashion many, many times.

‘Q. I think you said, possibly at the GMC, that you discussed the arts, you discussed Manchester United?

‘A. Everything. Football, Italy, all sorts of things. One of the difficulties people have to talk to Mr Wisheart, not only because he is a very senior person and is a very authoritative person, but also, he is very fluent. You start a conversation on a subject, you end up with something totally different, you do not know how you got there. He has a very good ability of discussing in the fashion he wishes, and therefore wriggles out if he does not like the kind of conversation that is taking place.

‘Q. If that is the perception that you had of Mr Wisheart, does that not make it all the more odd that you should not have made full use of the meeting that you had with Dr Roylance in March when Dr Monk was with you, when there was a chance, with somebody who was higher up the management tree even than Mr Wisheart, indeed, at the top, and you and Dr Monk pulled your punches with Dr Roylance?

‘A. I think you British say “You need two to tango”. If the other one is not prepared to listen, as I said, short of pinning him down on a chair, I do not know what else I could have done, and so with Dr Monk. Dr Roylance was not interested whatsoever in this kind of conversation. It was like listening to a tape-recorder: “This is not a matter for me. This is a matter for the clinician.” This was the message over and over and over. Even when I went to see Dr Roylance, before I spoke to him, before and after the last operation, even after the last operation, this was the same recorded message.

‘Q. But it was a matter for the clinicians, was it not?

‘A. You are asking me?

‘Q. The Chief Executive cannot force people to talk about a subject over dinner if they do not want to talk about it?

‘A. No, but the Chief Executive can call all the involved parties in a room around the table, which should have happened, and said, “Right, concern has been expressed in the hospital by various sides. I would like first of all to see, if I have not seen it, the data of Dr Bolsin that everybody is talking about”; second, I would have instructed the two surgeons, Mr Wisheart and Mr Dhasmana, to produce their data to be confronted with the one of Mr Wisheart [*sic*] and then, once the facts were concerned, all the people, not just the surgeons, the anaesthetists and everybody else, discuss this matter, then we decide if we have a problem. If we have a problem, we decide how we are going to solve it. If we do not have a problem, the people who said we had a problem will have to apologise. This never took place.'

31 Dr Monk gave his view of the dinner at Bistro 21 in the following exchange:

'A. The venue was chosen because I had recently organised a large meal there. I had asked the restaurateur to use the upstairs room, which would be private and quiet. It would enable me to produce an environment outside the hospital and to be non-confrontational. I had James Wisheart, who was aware of the concerns but did not have any details. I had Dr Bolsin, who had produced an audit and was asking me to act upon it but was not willing to present this audit to people who could help me form a corpus of opinion and take it forward. And I had Professor Angelini, who was aware of Dr Bolsin's audit and was willing to support it. I therefore produced an environment in which I thought we could, with the least amount of conflict possible, bring together these divergent opinions. To get Dr Bolsin and Mr Wisheart to sit around a table, I would have had to go through a number of conversations in order for them to understand why we are going there. I do not think that Dr Bolsin and Mr Wisheart would just wish to go for a meal to chat about football.

'Q. In fact, did you end up talking about football?

'A. We did indeed. I am a keen Manchester United supporter, having lived there for many years. Professor Angelini had helped me organise a holiday in Italy. Therefore much of the meal was spent, as these meetings are, I presume, talking about generalities before we start to get down to the meat of the conversation.

'Q. What you have said already suggests that you had spoken to Mr Wisheart because – you arranged the meeting, you had spoken to Mr Wisheart, Professor Angelini and Dr Bolsin?

'A. Correct.

'Q. And your purpose was to get them talking?

'A. That is correct.

'Q. Did each of them know that that was your purpose?

'A. I believe so, yes.

‘Q. … What was he [Mr Wisheart] given by you to understand he should expect to deal with at the meeting?

‘A. I believe he knew Steve Bolsin had raised criticisms and he would want to know from Steve Bolsin what those criticisms were.

‘Q. What would Dr Bolsin have understood from you?

‘A. He and I had numerous conversations about the form of his audit: that, in my opinion, it had been performed in a clandestine manner and therefore its value was lost because it was not owned by people, it was not open; it had not been verified and therefore could be criticised; and that it would be appropriate in this non-threatening environment, supported by me as the Clinical Director and also Professor Angelini, to put forward his data. The danger that I had in having this data and putting it forward to James is that I may not be able to support it from criticism, because my knowledge of it is literally what you have in front of you.

‘Q. So at this stage Mr Wisheart would have understood your role to be effectively that of the United Nations, trying to bring peace between the rival views?

‘A. I think that is a little excessive in a description. What we had were people with different views upon outcome, and the views were that it was —

‘Q. What I am asking is whether he appreciated the role that you sought to fulfil?

‘A. Who appreciated?

‘Q. Mr Wisheart?

‘A. I believe so. I may be mistaken about that, but I would have thought that he understood it.

‘Q. Was the meeting, the meal, relatively amicable or not?

‘A. It was a difficult meeting because people were there with an agenda, and therefore it is difficult to be amicable in those terms where you were there just for a social meal for the pleasure of your colleagues.

‘Q. … At any stage, did the conversation at the meal turn to the issue that had brought everyone together?

‘A. It was raised in a very peripheral way on a number of occasions. I felt it was important that we did discuss the issue. Towards the very end, my personal frustrations in not succeeding led me to ask a direct question. I cannot recall the exact words that I used, but I did say, "Do you have any difficulties with the paediatric cardiac service?"

'Q. You were addressing whom?

'A. I was looking across the table at Dr Bolsin and next to him was sat Gianni Angelini. It was a table for four, obviously. There was no reply. There was no denial; there was no assertion that there was; there was no answer. At that point my frustration rose to a very high level because I realised that my intent in bringing these people together to discuss the issue … had failed.

'Q. Did you consider going further and saying, "Look, Steve, you have raised concerns with me. Do you now want to raise them with James?", or anything to that effect?

'A. After asking the direct question and receiving no response my frustration was such that I did not ask those questions. To my recollection, the meal, the meeting, whatever, just disintegrated and we all left.

'Q. And no attempt was made by Professor Angelini on the one hand, Dr Bolsin on the other, or for that matter Mr Wisheart, to raise and grapple with the issue which had in fact brought them to Bistro 21?

'A. All four of us failed to achieve that. An option would have been for me to have put the data on the table and say, "What about that?". I did not do that.

'Q. Did anyone have the data with them?

'A. I certainly did not. James could not because he had not got the data. Whether Professor Angelini or Dr Bolsin had the data, I do not know.

'Q. Did James Wisheart know something of the nature of what had been going on, that there had been a collection of data which showed paediatric cardiac services in a bad light?

'A. I cannot answer for his knowledge base at that time —

'Q. Had he been told in front of you, in your hearing?

'A. I did not tell him that I had in my possession an audit of this form ...

'Q. There may have been suggestions in other forums — you did not give evidence at the GMC, did you?

'A. I was not asked to give evidence by any of the people involved.

> ‘Q. But there may have been a suggestion that there were two camps at this restaurant: you and Mr Wisheart on the one side and Professor Angelini and Dr Bolsin on the other. Would there be any truth in that or not?
>
> ‘A. I did not see my role as being in any “camp”. I was the Clinical Director of Anaesthesia, and therefore I had a management role, but I had worked closely with Dr Bolsin for many years, and I had discussed our concerns. He and I had spoken beforehand, and I had taken it to a non-threatening environment. Had we had this meeting in the Medical Director’s office, within the Trust headquarters, then I think that could be a reasonable supposition. But it was not, it was held outside of the Trust.
>
> ‘Q. You had had the view before this meeting that the concerns which Dr Bolsin had, which you tended to share because you tended to be towards his wing, as it were, of the spectrum of anaesthetist opinion, were major concerns?
>
> ‘A. They were concerns — I had such concerns that I was willing to work hard to try and resolve the issue.
>
> ‘Q. After this meal — can we look at your statement[42] that describes Mr Wisheart’s reaction to the meal. He was effectively saying to you, “Well, if you are not prepared to raise it to my face”, or something along those lines, “then there cannot be much in it”. Was that the flavour of it or not?
>
> ‘A. I think it was an impression that I gained from him that if we had gone to the effort to sit at the table, it was an opportunity that was of such low impact as regards to the Trust management situation, because he was probably the Medical Director at this stage, if they cannot raise it then, when he is at his most open, then what were these concerns? I do not know what JDW actually thought at that time, but I felt – maybe it represents also some of my frustrations – that that was a reasonable summary.[43]

32 Dr Monk was asked by Counsel to the Inquiry about his view of Mr Wisheart’s capacity to listen to criticism:

> ‘Q. You valued your relationship with Mr Wisheart, did you?
>
> ‘A. I value all my relationships with my colleagues. It is an important way of working.

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[42] ‘In conversation shortly after with JDW I formed the impression from him that if the concerns were not worthy of discussion at the meal then the concerns could not be major’; WIT 0105 0023 Dr Monk

[43] T73 p. 148–54 Dr Monk

> ‘Q. You had been prepared to suggest and, as it were, host a meeting of Bistro 21 at one stage in order to reconcile what you saw as opposing views?
>
> ‘A. At that stage the Bolsin data, the audit, had not been presented to Mr Wisheart. There were concerns raised by Dr Bolsin and these had been discussed between many people.
>
> ‘Q. The point I am driving at is, was it your view throughout the 1990s that Mr Wisheart was someone who was amenable to conciliation, someone who regularly took the bigger picture and would not necessarily hold it too strongly against someone that he was the object of their criticism?
>
> ‘A. I think everyone finds personal criticism difficult to accept, particularly when you are a senior person, but we would not have got Mr Wisheart to the dining table with Dr Bolsin unless Mr Wisheart was willing to listen to the criticisms.
>
> ‘Q. So it is your view that he was someone who was willing to listen to criticisms, even though they were personal?
>
> ‘A. The function of that meal was to achieve that.
>
> ‘Q. No, I am asking for your view of Mr Wisheart and the extent to which he would be prepared to listen to and accept eventually criticisms which were to an extent personal?
>
> ‘A. I think Mr Wisheart was very proud of his performance. He was towards the end of his career. To criticise his performance would be very difficult for him to accept, but we did discuss on occasions the concerns over the paediatric service, and he accepted that, with the appointment of a new surgeon, he would give up paediatric practice. He had looked to appoint a paediatric professor of cardiac surgery, and, therefore, he obviously realised that the service would improve by bringing in new blood. So in a way he accepted the criticisms that the service was not as good as it may well have been.’[44]

33 Mr Dhasmana was asked about his views of the Bistro 21 meeting in the following exchange:

> ‘Q. … Mr Wisheart, Dr Monk, Professor Angelini and Dr Bolsin went out for an evening to a restaurant, Bistro 21 in Bristol. You know that now.
>
> ‘A. I did not know that until really the GMC proceeding, that they went to some dinner or something like that. And the reason, and purpose that I heard, I felt were quite ...

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[44] T73 p. 36–8 Dr Monk

‘Q. Part of the reasoning appears to have been a view that they all four shared that there was a need to discuss matters of concern, if they were of concern, so as to, I suppose, create a harmonious way forward. Did you have any sense, in early 1994, that those with whom you worked were unhappy with any aspect of the Unit’s performance?

‘A. No.

‘Q. (The Chairman): Mr Dhasmana … when you were talking about the dinner, you said “and the reason for it and the purpose, I felt were quite...”, and you did not finish the sentence. I was intrigued to discover what you felt?

‘A. I do not know what would have come out in the flow at that time, but I felt no real — I mean that, to my mind, was not the way to discuss the problem in a dinner meeting at the Bistro club.

‘Q. (Counsel): What would have been the way to discuss the problem?

‘A. Well, if the problem is in the paediatric cardiac surgery, if there is a concern, whether it was relating to me or not, I would have thought that being 1993 [*sic*] must have related to my neonatal Switch, why did not any of those gentlemen talk to me and I could have also gone to same dinner and probably would have raised the question, or there should have been a meeting of all concerned parties, and an open airing; it should have been aired openly.

‘Q. Did you still share an office with Mr Wisheart?

‘A. No, I did not. I moved out from the office I think in 1992.

‘Q. Did you still see him regularly?

‘A. Yes.

‘Q. Did you discuss matters of interest to the Unit in 1994?

‘A. I had almost a monthly consultants’ meeting arranged during part of my Associate Director job, or post, or appointment, and of course Mr Wisheart I would be meeting quite often in the ITU and other areas, yes.

‘Q. Mr Wisheart never mentioned, did he, the fact that he went to a dinner meeting with a view to whatever it was, ironing out concerns that there might be?

‘A. Not until after, you know, when it was known to almost everybody else.

> ‘Q. Did you have the sense later on then that you were almost the last to know?
>
> ‘A. That is a difficult question to answer. I cannot answer that.
>
> ‘Q. (The Chairman): If we can just press on that question a little bit more, you were, after all, doing the surgery. Did you think it was odd that you were not there at the meeting?
>
> ‘A. I think that was the word I was really looking for at that time, “odd” to have gone to that dinner meeting. So odd, yes.
>
> ‘Q. Not odd that others would go, but odd that you were not invited, was what my question was.
>
> ‘A. Odd that I was not even told.’[45]

34 Dr Joffe told the Inquiry of Mr Wisheart’s account to him of the Bistro 21 dinner:

> ‘A. He [Mr Wisheart] mentioned that they had had this dinner together and that he was anticipating that this would give Professor Angelini and Dr Bolsin an opportunity to comment, if they had criticisms which appeared to be the case, so he said, for them to state those criticisms and raise the whole question of data or what they felt was amiss with the performance of cardiac surgery – in this case paediatric cardiac surgery – but somehow the evening went by and this did not happen. … That is the sum total of my information that I gleaned from that discussion.’[46]

35 Mr Wisheart described to the Inquiry a number of approaches to him, including the Bistro 21 dinner, over doubts about performance figures as indirect and ‘incomplete’:

> ‘Q. The indirect approach you had had in respect of doubts over performance figures … ?
>
> ‘A. That would have been the matter of Professor Dieppe [Dean, Faculty of Medicine], talking with me, which we have discussed, the subsequent discussion which I initiated with Professor Vann Jones [Clinical Director of Cardiac Services], and those of course were the main issues that led up to the Bistro 21 dinner when I made inquiries. So those were the approaches which were indirect and in retrospect quite incomplete approaches, yes.’[47]

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[45] T86 p. 153–6 Mr Dhasmana

[46] T91 p. 156–8 Dr Joffe

[47] T94 p. 136–7 Mr Wisheart

36 Mr Wisheart told the Inquiry that he had not pursued matters raised by Dr Bolsin after the Bistro 21 dinner:

> ‘Q. You regret as well, in your statements, not having pursued Dr Bolsin in early 1994, when you appreciated that he was said to have concerns but had not discovered what those concerns were?
>
> ‘A. Well, I had discovered that he was expressing the viewpoint. I am not sure if you are using the word “concern” in the manner defined by this Inquiry. If you are, then I did not know that. I knew that he was expressing criticisms to other people, for a variety of reasons, and I did ask him to tell me what those concerns were in April 1994.
>
> ‘Q. But you say in your statement – I assume it is right – that you regretted not pursuing him?
>
> ‘A. After that.
>
> ‘Q. And you give us the reason why you did not?
>
> ‘A. Yes. I allowed myself to be deflected.’[48]

37 Three days after the Bistro 21 dinner, a report on the activities of the Cardiac Surgery Department was presented by Mr Wisheart, as Medical Director, to the Trust Board. It included the following:

> ‘The work of the department has been of a high standard and includes a larger proportion of high risk cases than in some other centres … In recent years the results of the work with children has [*sic*] been excellent, and in infants similar to that reported elsewhere …’[49]

38 On 18 April 1994 Dr Bolsin went, by appointment, to see Janet Maher, then General Manager of the Directorate of Surgery at the UBHT. Mrs Maher stated that she was unsure why Dr Bolsin, a consultant from another directorate, wanted to see her:

> ‘Dr Bolsin told me that he had been doing some work which had produced data, which he had collected in the form of an audit. I do not recall a time period that this information related to, but it concerned the outcomes following paediatric cardiac surgery. I remember that early on in our conversation Dr Bolsin made reference to the Department of Health. My understanding was that he was on a committee or working party at the Department of Health in relation to other issues. His position on this committee had, however, placed him in a position where he had access to data, and this data was the source of concern which had brought him to me on 18 April 1994. Dr Bolsin said that he had data from other paediatric

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[48] T92 p. 24–5 Mr Wisheart

[49] UBHT 0020 0015. The results reported in Bristol and elsewhere in respect of 1993 are summarised at the end of this chapter

cardiac surgery centres and the comparisons made with BRI data showed that the results of the Bristol Paediatric Cardiac Unit were not as good, in comparison with other units.'[50]

39 Mrs Maher stated further:

> 'Dr Bolsin repeatedly referred to the data upon which he based his concerns. At no stage during that meeting did Dr Bolsin explain what that data was, or show me the data.'[51]

40 Mrs Maher continued:

> 'The potential seriousness of what Dr Bolsin was saying made me feel extremely uncomfortable. I asked Dr Bolsin if he had shared this information with paediatric cardiac surgeons, or if he had shared the information with anybody else. I could not get a clear response from Dr Bolsin on this point. He intimated that he had talked to colleagues in his own anaesthetic department, although he did not identify who they were. He implied having spoken to other cardiac surgeons, but again did not say who they were. He had already by this stage made reference to the Department of Health and discussing it with someone there, although again this person was unnamed. Dr Bolsin's response was extremely unclear and he left me feeling increasingly uncomfortable that he had not actually spoken to the clinicians involved in the work. He appeared to have spoken to some people, but they did not seem to be the people who were directly concerned with paediatric cardiac surgery. I was very concerned that if he did have data, that it ought to be shared and on the table for everybody to have a look at. I remained unsure as to what the data was. I got the distinct impression that he had not discussed his concerns openly with the clinicians in question and I felt this was wrong.
>
> 'I said to Dr Bolsin that I felt he should go through the appropriate channels. I told him that I did not know what data he was referring to and that it was inappropriate for me to get involved. I advised him to talk to his Clinical Director, who at that time was Dr Chris Monk. I also advised him to go back and talk to the paediatric cardiac surgeons, Mr Wisheart and Mr Dhasmana. I felt that that was the correct way forward. From our conversation, given that Dr Bolsin had referred to other conversations he had had with other people (again not named), I was not sure just how widely he had discussed it with anybody and I felt that the people directly involved needed to know. I also suggested to Dr Bolsin that he ought to discuss his concerns and whatever data he had available to him in an open audit between the surgeons, cardiologists and the anaesthetists involved in paediatric cardiac surgery.

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[50] WIT 0153 0019 Mrs Maher

[51] WIT 0153 0020 Mrs Maher

> 'I was extremely concerned that Dr Bolsin should deal with his concerns in an appropriate way, talking to the right people. He was implying that Bristol results were not as good as elsewhere and I had no idea what the data was, whether it was accurate and whether this was a real basis for concern. In terms of raising it as an issue, given what Dr Bolsin had told me, it could not just be "left" because it could involve serious accusations concerning patient safety and the competence of the paediatric cardiac surgeons. Any comment that Bristol was not doing as well as elsewhere would have concerned me, but particularly where the person telling me appeared not to have talked it through with colleagues who were involved. I was not sure what Dr Bolsin expected me to do in response to his approach in April 1994 and the somewhat vague information he had given me. He did not ask me to do anything in particular.'[52]

41 Mrs Maher stated that she was concerned as to the action she should take:

> 'Following the meeting with Dr Bolsin I felt it was inappropriate to simply react to Dr Bolsin's concerns by making wide-reaching enquiries. Because Dr Bolsin had been extremely vague about who he had spoken to, I had no idea whether the matter had already been discussed and addressed elsewhere. For all I knew, if it had been, it may well have been resolved already. I felt it prudent to "sound out" key personnel to see if they were aware of Dr Bolsin's concerns. I felt that the three key people I needed to contact were Dr Chris Monk as Dr Bolsin's Clinical Director, Dr John Roylance as Chief Executive of the Trust, and Mr James Wisheart. Within approximately 1 week of Dr Bolsin meeting me, I had spoken to all three. I do not now recall in which order I spoke to Dr Monk and Dr Roylance. I do specifically remember that I spoke to Mr James Wisheart last of the three, given the possible seriousness of Dr Bolsin's allegations for him personally.
>
> 'I spoke with Dr Chris Monk and repeated to him what Dr Bolsin had said to me. I told Dr Monk that it seemed to be about an audit, but that I was unaware of the issues involved. I told him I felt I was not qualified to comment upon what these issues might be. When I spoke to Dr Monk, I recall from my GMC evidence that I was aware at the time that Dr Monk probably knew something of Dr Bolsin's concerns, but that he had not seen any information or data. I do not now recall the details of Dr Monk's response to what I told him, although I believe he was keen to bring whatever Dr Bolsin's data and concerns were out into the open in order that open discussions could take place. I left the meeting believing that Dr Monk would make every effort to open up this discussion and bring whatever issues Dr Bolsin had into an open forum so that they could be resolved.
>
> 'In the same week that I spoke with Dr Monk I also spoke with Dr John Roylance, the Chief Executive, in his office. I do not recall which of the two I spoke to first. I repeated what Dr Bolsin had said to me. I got the impression that Dr Roylance may have been in a similar position to Dr Monk, that is someone who was starting

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[52] WIT 0153 0020 – 0021 Mrs Maher

> to get to know that there was something being raised as a concern, but that the detail of that concern was still very unclear. I would not have expected Dr Roylance to indicate to me how he planned to deal with this information and, quite rightly, I believed he needed time to assess the best approach. My understanding was that Dr Roylance intended to take time and talk to the key people involved, probably including Dr Chris Monk and also Mr James Wisheart. I did not know if he would go directly to Dr Bolsin or not. I cannot remember any other details of my meeting with Dr Roylance.
>
> 'Having spoken to Dr Roylance and Dr Monk, I also spoke to James Wisheart. To put this in context, my position as General Manager for the Directorate of Surgery was such that I regularly liaised with all three colleagues, particularly in relation to the proposed move of paediatric cardiac services to the Children's Hospital, on an almost weekly basis. A combination of my level of concern, and the regularity with which I saw these three individuals meant that within about a week of Dr Bolsin's meeting with me I had raised the matter with each of them.
>
> 'When I met with James Wisheart, I repeated the substance of my meeting with Dr Bolsin in the same way that I had explained to Dr Monk and Dr Roylance. Mr Wisheart was very concerned, both in terms of not understanding which data Dr Bolsin was referring to, and also that nobody had directly raised any concern with James Wisheart himself. The lasting impression I have about these discussions was that there was a lack of clarity about which data was the basis for the concern, and that it certainly did not seem to have been imparted to the cardiac surgeons involved. When James Wisheart expressed his concern about the basis for Dr Bolsin's comments, I told him that I thought the best person to talk to was Dr Bolsin himself and also to Dr Chris Monk. I remember that Mr Wisheart's main concern was that he did not have access to whatever this data was, or that there was some other data around that he had not seen. I am reminded by my GMC transcript that at the time I gave evidence to the effect that Mr Wisheart had found Dr Bolsin's comments about data confusing, as it did not tie in with Mr Wisheart's own data. I could not recall his exact words at that time and I certainly am unable to recall them now.'[53]

42 Dr Monk described his response to Dr Bolsin's meeting with Mrs Maher in the following exchange:

> 'Q. In any event, very shortly after that meeting I think Dr Bolsin reports that he went to speak to Janet Maher, and that the following day, he suggests, you came to him and said in effect that it was the wrong approach to go to the manager of the surgical department in order to take his concerns further. What do you say about that?
>
> 'A. Yes, I believe I did tell him that.

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[53] WIT 0153 0023 – 0025 Mrs Maher

> ‘Q. So the way in which it worked was, what? Janet Maher had had a word with you and said one of your anaesthetists had come to [her] with this concern, and you then went to Steve Bolsin and said that is not quite the way to do it?
>
> ‘A. The culture of the Trust at that stage was that the managers at that level had very little input into clinical management and decision-taking.
>
> ‘Q. I do not want to press you on that, as to why you said it, but just the fact that you did?
>
> ‘A. I just felt that an explanation of why I said it would be quite appropriate. The person that Dr Bolsin needed to give his data to were the surgeons or the cardiac anaesthetists, not a manager who had no obvious way in which she could influence that problem.’[54]

43 Professor Vann Jones was asked by Lesley Salmon, General Manager of Cardiac Services from October 1993 to October 1994, to convene a meeting of the non-medical staff: the perfusionists, the physiotherapists and the nurses. The meeting, held in April 1994, was, according to Professor Vann Jones, ‘to inform or to reassure the departmental staff in a situation where there were many rumours flying around.’[55]

44 Professor Vann Jones said that he:

> ‘… told them at that meeting that I still had reservations about some of the data because [Dr Bolsin] had not come back about the information on VSDs. I was not certain by any means about the statistics and that the matter was being looked into. I said “in the meantime, we have to carry on business as usual”.’[56]

45 He went on:

> ‘I told the non-medical staff of the meeting on November 16th [with Dr Bolsin when] I had been presented with some data that had caused some concern and I had been presented with some that was basically wrong, I thought incorrect, and we waited for their [Dr Bolsin’s and Dr Black’s] clarification of that.
>
> ‘Q. The reference to the data that was wrong and incorrect was meant to be a reference to Dr Bolsin’s figures on VSD, was it?
>
> ‘A. That is right.

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[54] T73 p. 154–5 Dr Monk

[55] T59 p. 155 Professor Vann Jones

[56] T59 p. 148 Professor Vann Jones. See Chapter 3 for an explanation of clinical terms

> ‘Q. Was it fair to characterise what you said to the meeting as “an attempt to discredit the Bolsin/Black data”?
>
> ‘A. Absolutely not. The whole point of the meeting, as I recall, was to try and keep our team figure [*sic*] — inform people as to what might be happening, and as I say, there were moves afoot to appoint a new surgeon and move to the Children’s Hospital, so it was an information-providing meeting. There was absolutely no way I was attempting to discredit Steve Bolsin and Andrew Black.
>
> ‘Q. After that, Dr Bolsin goes on to say[57] you received a letter from Dr Black asking you to retract your criticism of the Dr Black/Dr Bolsin data, which you did by letter. Do you have any recollection of that account of events?
>
> ‘A. That is also inaccurate. What actually happened was that within about half an hour of the end of that meeting – and it was a very efficient grapevine – within half an hour of the end of that meeting Andy Black was in my office, all fire and brimstone, and not very pleasant. However, I told him to calm down and tell me what the problem was. He accused me of casting aspersions on his statistics, his statistical ability. That is quite a bit different to the data. So we agreed that we had actually not disagreed at the end of the day and there was no, as far as I recall, exchange of letters, but it was certainly a very entertaining half-hour with Andy Black in my office.’[58]

May

46 In May 1994 Professor Angelini was visited by Mr Durie, Chairman, UBHT, and Mrs Maisey, Director of Operations and Nurse Advisor. Professor Angelini told the Inquiry about the meeting in the following exchange:

> ‘ … at short notice, my secretary said that Mr Durie’s secretary had phoned and he wanted to see me to discuss the expansion plan for the Academic Department on Level 7. I said, “Fine, tell him to come along”. He came along, to my surprise, with Margaret Maisey. Quite honestly, I do not know what she was there for in terms of discussing the academic plans.
>
> ‘Q. Who was Margaret Maisey?
>
> ‘A. I think she was Head of Nursing, I do not know how you call it within the UBHT. She was an executive member of the UBHT and Director of Nursing.

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[57] At WIT 0132 0072 Dr Bolsin says ‘Professor Vann Jones received a letter from Dr Black asking him to retract his criticism of our data which Professor Vann Jones did by letter’

[58] T59 p. 158–9 Professor Vann Jones

> ‘Q. She worked closely with Dr Roylance?
>
> ‘A. I have no idea. It probably was the first time I met the woman. … They came into my office. I did not organise the meeting. They came to me. The conversation on the academic department expansion lasted about 30 seconds. I must say, I was not expecting him to raise the issue of paediatric. What he said was that he was very concerned about what he had heard and he had an impression or an opinion or whatever you want to call it that the paediatric service was sub-standard.
>
> ‘Q. What did he say he had heard and from whom?
>
> ‘A. I think he just said “The service is not good”. I cannot recollect the precise words, but the message or gist of it was “I am very unhappy at what I have heard that the paediatric service is not up to scratch”. What his exact words were, I do not know. I cannot recollect.
>
> ‘Q. What did you say?
>
> ‘A. I said then, I share his sympathy in full. He asked me whether I had any solution and I said then in my view, the solution was to try to appoint a new paediatric cardiac surgeon.
>
> ‘Q. What did he say to that?
>
> ‘A. He said would I be kind enough to put this in writing and could I be kind enough to go and see Professor Vann Jones to discuss this with him, and make sure that he was in agreement with this concept and send him a letter, and he would have done something if he could.
>
> ‘Q. Why did he tell you to go and see Professor Vann Jones do you think?
>
> ‘A. Because Professor Vann Jones was the Director of Cardiac Services. Presumably he was trying to suggest to me to go through the established channel of command.’[59]

47 Professor Vann Jones stated in his written evidence to the Inquiry that, after talking to Professor Angelini independently of the meeting between Mr Durie and Professor Angelini:

> ‘Together we wrote to Mr Drury [Durie], Chairman of the Trust, hoping to fund the appointment of a new paediatric cardiac surgeon. This letter was sent in April 1994 which was the earliest opportunity at which I could possibly make such an offer as it was only in April 1994 that the Directorate of Cardiac Services finally came into being with its own budget.’[60]

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[59] T61 p. 127–9 Professor Angelini

[60] WIT 0115 0021 Professor Vann Jones

48 The letter, dated 12 May 1994, stated:

> 'Gianni has come up with the novel idea of appointing a senior lecturer under his auspices for two years and for then the NHS to take over this chap assuming he has done what we would want him to do and that is turn the service around. I am strongly in favour of this and I think the time has come to make a decision because if we do not get ahead with it paediatric cardiac surgery in Bristol is going to fold and shortly after that paediatric cardiology will go with it.'[61]

49 Also on 12 May the Cardiac Expansion Working Party of the UBHT met. A draft of their report stated, at one point:

> 'There is a perception that the quality of paediatric cardiac services in UBHT does not match the standards of the Trust's major competitors and it is imperative that the Trust demonstrates continued commitment to improved quality in waiting times and outcomes which have an impact on mortality and morbidity in specialist areas.'

50 It went on:

> 'If the BRCH [*sic*] is to regain and build upon its reputation, the appointment of a consultant paediatric cardiac surgeon is required to undertake and oversee this service. It has proved impossible to attract a suitable candidate under the current split site arrangements.'[62]

June

51 Kay Armstrong, Sister in Cardiac Theatres at the BRI, stated that she had been reassured by the expected movement of children's services to the BRHSC and the appointment of a paediatric cardiac surgeon:

> '… the reassurance began to wain [*sic*] 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.'[63]

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[61] UBHT 0061 0246; letter dated 12 May 1994

[62] UBHT 0275 0139; draft report *'Options for Development of Adult and Paediatric Cardiac Services in UBHT'* dated May 1994

[63] WIT 0132 0057 Ms Armstrong

52 On 21 June 1994 a letter was signed by six anaesthetists at the UBHT expressing concern about the Arterial Switch programme being undertaken at the BRI. Dr Davies, consultant anaesthetist at the BRI from 1993, stated in his written evidence to the Inquiry:

> 'In mid-1994 Dr Bolsin drafted a letter addressed to Dr Monk, the Clinical Director,[64] and had asked a number of the anaesthetists to sign it. … The letter went through a number of drafts.'[65]

The first draft of the letter was addressed to Dr John Roylance.[66]

53 In the first draft of the letter, Dr Monk had been a co-signatory. In its final form, he became the addressee. Dr Monk told the Inquiry how this came about in the following exchange:

> 'If I had signed the letter, it was difficult to take forward and to discuss it, so it was felt, and supported by some of the others, that it should be addressed to me; that I should not sign it and I could then take it forward. I agreed to that. It may have been better if I had signed the letter and posted it.
>
> 'Q. What did you mean by "taking it forward"?
>
> 'A. My intent was to approach the Chief Executive with this letter and use it to explain that we, as consultant anaesthetists, had concerns about the Switch programme, and, in addition, the paediatric cardiac surgical programme. It says quite clearly that there should be a confidential review and that it should take place amongst the entire multi-factorial process and the clinicians involved to look at what the figures were.
>
> 'Q. So, having got this letter, what was it intended you should do with it?
>
> 'A. My intent was to visit the Chief Executive with the letter. Whether they had other intents for it, I am not aware.'[67]

54 Dr Masey told the Inquiry that it had initially been thought that the letter would be addressed to Dr Roylance, and would be signed by Dr Monk, in addition to others.[68]

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[64] Clinical Director of Anaesthesia from January 1993 to December 1995

[65] WIT 0455 0003 Dr Davies

[66] No copy of this draft was produced to the Inquiry

[67] T73 p. 158–9 Dr Monk

[68] T74 p. 122 Dr Masey

55 Dr Underwood told the Inquiry of her understanding of the use to which the letter would be put:

> 'I was aware only that we were sending it initially to Dr Monk, with the understanding that he would then be able to use it.'[69]

56 The letter in its final form was signed by six anaesthetists and had the approval of the person to whom it was addressed, Dr Monk. It raised concerns about the Arterial Switch programme currently being undertaken, expressed the view that mortality for that operation was apparently high, referred to the recent death of a 14-month-old child following an Arterial Switch procedure, and sought a review of the results achieved thus far. The letter referred to the Arterial Switch programme without drawing any distinction between neonates and older children, although it referred to results being particularly bad in the neonatal period.

57 The first of the drafts in which the letter was addressed to Dr Monk, rather than signed by him, began:

> 'We wish to express our [increasing] concern about the Arterial Switch programme currently being undertaken in this hospital.
>
> 'The mortality for this operation is apparently [unacceptably] high, particularly for those operations undertaken in the neonatal period, but the recent death of a 14-month-old child following the Arterial Switch procedure must now lead to an open and thorough review of the results so far. It is our belief that this review should be confidential and take place between all the cardiac anaesthetists, all the cardiac surgeons, all the paediatric cardiologists and the Director of Cardiac Services. This responsible approach to (our)[70] [what is obviously an unacceptable] clinical practice would defuse many of the criticisms of this programme in this institution expressed privately and publicly.'[71]

58 The words set out in square brackets in the letter quoted above appeared in this draft but were removed following further discussion. Four anaesthetists had been prepared to sign the letter in its original draft form.[72] Dr Masey, however, stated in her written evidence to the Inquiry:

> 'I was happy to co-sign this letter, as I felt that this was the first time that Dr Bolsin had involved his cardiac anaesthetic colleagues. I viewed this as an open and transparent approach to the voicing of concerns. I asked Dr Bolsin to make a minor change in the letter before I was willing to sign it, changing the phrase "unacceptable results" in Switch procedures to "apparently unacceptable results",

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[69] T75 p. 151 Dr Underwood

[70] The word 'our' appeared in the later drafts when the words in square brackets were removed

[71] GMC 0004 0064; letter from Dr Underwood, Dr Davies, Dr Pryn, Dr Masey, Dr Bolsin and Dr Baskett to Dr Monk dated 21 June 1994

[72] UBHT 0061 0006; letter of 21 June 1994 signed by Dr Davies, Dr Pryn, Dr Bolsin and Dr Baksett, but not by Dr Underwood or Dr Masey

> as I did not believe that at that time we had accurate enough figures for the results of this procedure in older children to make this statement.'[73]

59 In her oral evidence to the Inquiry, Dr Masey said that it was:

> '… not the word "apparently" that I wished to have added but the word "unacceptably" that I wished to have removed'.

She had been unable to agree to the emphasis of the first letter.[74]

60 Dr Underwood saw the letter as amended. The letter with the words in square brackets removed became the final version. The signatories were Dr Davies, Dr Baskett, Dr Pryn, Dr Bolsin, Dr Masey and Dr Underwood. No single copy of the letter had all six signatories, although the signatures of all six appeared on one or other copy of the final version of the letter.

61 Dr Underwood stated in her written evidence to the Inquiry that by the winter of 1993 there was growing concern amongst cardiologists, cardiac surgeons and anaesthetists over the mortality of the neonatal patients undergoing the Switch operation.[75] She told the Inquiry that she signed the letter because she believed that the mortality for the operation of neonatal Switch was 'apparently high' and:

> '… in order to get the group working as a team, to have an open review, I felt that this was a suitable letter to sign. We did refer to a thorough and open review of the results so far, and I felt that that was the key issue in this letter.'[76]

62 Dr Masey told the Inquiry that she agreed with the terms in which the letter was sent.[77] Its purpose, she said, was:

> '… to actually make this into a much more open and transparent mechanism for looking at any criticisms and trying to gain more information to see whether there was any basis in these criticisms'.[78]

63 Dr Monk told the Inquiry that the letter reflected 'the strong feeling that Drs Davies, Pryn, Bolsin and myself had already expressed about the Arterial Switch programme'.[79]

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[73] WIT 0270 0015 – 0016 Dr Masey
[74] T74 p. 120 Dr Masey
[75] WIT 0318 0011 Dr Underwood
[76] T75 p. 150 Dr Underwood
[77] T74 p. 118–19 Dr Masey
[78] T74 p. 123 Dr Masey
[79] T73 p. 157 Dr Monk

64 On 30 June, nine days after signing the letter, Dr Underwood anaesthetised a non-neonatal patient undergoing a Switch operation. She told the Inquiry:

> 'I did not think this letter prevented me from continuing with that routine work, and indeed, my experience from my own records was that the cases of older children having Switches, which I had done with Mr Dhasmana, had generally survived.'[80]

65 On 29 June 1994 Mr Dhasmana wrote to Dr Martin. In his letter he stated that he had seen a patient named Joshua Loveday along with his parents earlier that day at his clinic. Joshua was then 12 months old. He stated that:

> 'I have recommended Arterial Switch repair with coronary transfer and patch repair for VSD. The nature and risk of this operation has been explained to his parents to which they have agreed. I hope to operate on him within the next four to six months.'[81]

July

66 Dr Monk stated in his written evidence to the Inquiry that he spoke to Dr Roylance on a one-to-one basis, and gave two dates in July 1994 when he might have done so in relation to the letter signed by the anaesthetists: 1 July and 12 July. He stated that he informed Dr Roylance that there was a problem in paediatric cardiac surgery regarding outcomes, which he was unable to solve as Clinical Director of Anaesthesia. He went on:

> '… his response remained unchanging in his assertion that he was the Chief Executive and therefore a manager, that the difficulty lay within clinical practice and therefore it was for the clinicians and clinical directors to solve. He did not accept that the flat management structure of the Trust had failed because it was the Medical Director and the Clinical Director of Cardiac Surgery being criticised. He did not accept the role as a final arbitrator and continued to refer the problem back to the clinicians. … In spite of discussing the letter's content, the reason for requesting an audit and my concerns JR [John Roylance] again used the logic that, if there was a problem, it was in the clinical area and it was the clinician's responsibility to address. He declined to organise a formal audit, did not accept the existence of a problem and refused a copy of the letter as it was addressed to me and did not require his action. I did not subsequently take the letter to JDW [Mr Wisheart] but assumed that JR would speak to the Medical Director [Mr Wisheart] regarding the content of the letter.'[82]

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[80] T75 p. 152 Dr Underwood. This was the last such Switch before the operation on Joshua Loveday on 12 January 1995, which is described in Chapter 30

[81] MR 0164 0033 Joshua Loveday's medical records. See Chapter 3 for an explanation of clinical terms

[82] WIT 0105 0028 – 0029 Dr Monk

67 Dr Monk added in his oral evidence to the Inquiry:

> 'I think he was saying "no" to the fact that it was him that should implement the review; that it was a clinician's problem to go and deal with. But I was saying that I could not deal with that problem and I had come to him as one of his Clinical Directors.' [83]

68 Dr Roylance stated in his written evidence to the Inquiry:

> '… I am certain that Dr Monk did not show me the letter. It would be an unusual letter for me to see and I do not believe it is possible that I could have forgotten it. … I do not believe that Dr Monk discussed with me the existence of this letter or its contents and I am sure that he did not ask me to become involved in organising a review of any paediatric cardiac surgery.'[84]

69 In his oral evidence to the Inquiry, Dr Roylance said that if he had been shown the letter he would have been astonished and would have reacted very quickly and very strongly.[85] He said that a letter such as this was unique and that he found it 'astonishing', and the fact that it was signed demonstrated that there was an 'astonishing degree of concern being felt by the signatories which they thought was not being addressed one way or another'.[86]

70 The following exchange took place between Counsel to the Inquiry and Dr Roylance:

> 'Q. How often did you see Dr Monk?
>
> 'A. Once a week, twice a week, sometimes more.
>
> 'Q. He told us that he took the letter to you?
>
> 'A. I am surprised he said that. This is not the sort of letter that I could conceivably forget.
>
> 'Q. He maintained, although pressed on the point, that he gave the letter to you?[87]
>
> 'A. No.

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[83] T73 p. 164 Dr Monk

[84] WIT 0108 0128 Dr Roylance

[85] T88 p. 148 Dr Roylance

[86] T88 p. 149 Dr Roylance

[87] In fact, Dr Monk's evidence was that he offered Dr Roylance a copy of the letter but that Dr Roylance refused to accept it; T73 p. 165–6 and WIT 0105 0029

> ‘Q. And you pointed out, as is the case, that it was not addressed to you and therefore handed it back to him?
>
> ‘A. That is nonsense, all he had to do was write on the bottom “copy to Dr Roylance” and I was stuck with it; I do not find that remotely feasible, I am sorry.
>
> ‘Q. He tells us that when he took the letter to you, as he says he did, he told you about the concerns in it and that he supported them?
>
> ‘A. He is mistaken. I do not think I ought to speculate as to how that mistake comes about but I have absolutely no doubt that I did not see this letter until after I had retired.
>
> ‘Q. I asked him “What was the response when you (that is Dr Monk) showed him (that is you, Dr Roylance) the letter?”. His answer was “The response was that it remained a clinical problem, but he was the Chief Executive of the Trust and it was for the clinicians to solve”.
>
> ‘A. If you believe that, you would believe anything. I mean, the suggestion — please, the suggestion that I would see a letter like this, astonishing as it is, inexplicable as it is and say “I do not want it, nothing to do with me” I find offensive.’[88]

71 Dr Underwood, when asked about the effect that the letter had, said:

> ‘A. I do not think that it led to an open and thorough review of the results. In that sense it was disappointing.
>
> ‘Q. Did you ever discuss it with Mr Dhasmana?
>
> ‘A. … I do not remember doing so.
>
> ‘Q. Or why no open or thorough review had been taking place in response to it?
>
> ‘A. No. I do not think I did.’[89]

72 Dr Masey told the Inquiry that she could not recall ever asking Dr Monk: ‘Look here Chris. What has happened to the open and thorough review we asked for?’.[90] Dr Monk told the Inquiry that he was:

> ‘… greatly frustrated by my [his] failure to achieve the goals, and there were a number of issues or actions that I thought I could take. It would have been appropriate to write to him and give him a copy of that letter. I did not believe it

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[88] T88 p. 152–3 Dr Roylance

[89] T75 p. 151–2 Dr Underwood

[90] T74 p. 125 Dr Masey

> would make any difference at all in the process that we were now in and I did not do so.'[91]

73 In July 1994 the anaesthetists' concerns about the Arterial Switch programme were brought to Mr Dhasmana's attention. Mr Dhasmana told the Inquiry:

> ' … Dr Monk told me that that is what the anaesthetists have decided: that in a way if you are really arranging any more Switch operations, you must discuss with us.'[92]

74 Mr Dhasmana explained that for him this meant:

> ' … the neonatal Switch was stopped and for older Switches I agreed with them that if I arranged any I would talk to them [the anaesthetists].'[93]

75 On 19 July 1994 Dr Peter Doyle, a Senior Medical Officer at the Department of Health (DoH), attended a meeting in Bristol concerning the audit system of the Association of Cardiothoracic Anaesthetists of Great Britain and Ireland (ACTA). In his written evidence to the Inquiry Dr Doyle stated:

> 'Once the formal business was completed, Dr Bolsin asked if he could accompany me back to the station. During the trip he explained that he was very concerned about the results of an audit he had conducted into neonatal and infant cardiac surgery at Bristol Royal Infirmary. His primary concern at that time was to seek my advice about how to get those responsible in the Trust to address his concerns.'[94]

76 In his written evidence to the Inquiry, Dr Bolsin stated:

> 'During this meeting Professor Angelini mentioned the problems of paediatric cardiac surgery at the Bristol Royal Infirmary. Due to pressure of time it was not possible for me to discuss in detail these problems with Mr [*sic*] Doyle but in the taxi on the way to Temple Mead station I provided the background information and the figures that were available to me at that time. These included the results of the Bolsin/Black data analysis/collection; the Arterial Switch mortality rates (provisional); the recent AV canal data for Mr Wisheart. The discussion on the journey centred on the most appropriate way to deal with [the] problem.'[95]

77 Dr Bolsin told the Inquiry his reason for accompanying Dr Doyle to the station:

> ' … I had already been to Dr Ashwell at the Department of Health and been referred to the GMC guidelines which had been deemed inappropriate and I was still concerned about the continued activity in some paediatric cardiac surgical

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[91] T73 p. 165 Dr Monk

[92] T87 p. 38–9 Mr Dhasmana

[93] T87 p. 40 Mr Dhasmana

[94] WIT 0337 0002 Dr Doyle

[95] WIT 0080 0119 Dr Bolsin. See Chapter 3 for an explanation of these clinical terms

> operations in Bristol which I believed were exposing children to risk and I thought that I was now justified in involving another senior medical officer at the Department of Health to try and find out if there was a problem and whether we should be doing something about it.'[96]

78 In the course of his oral evidence, Dr Doyle said:

> ' … He [Dr Bolsin] actually handed me an envelope which he said contained the audit results. He did not go on to be particularly specific about what those results showed or when the audit was conducted. He just said, "I have done an audit".'[97]

79 When asked what advice he gave to Dr Bolsin, Dr Doyle stated:

> 'I explained if there were questions … it was a matter for the Trust and there were well recognised mechanisms. He said he had tried to bring the results to the attention of people in the Trust, so far without success, so I went on to explain in greater detail about HC(90)9 … .'[98]

80 Dr Doyle went on:

> '… the argument over those figures, over the significance of those figures, is an inter-professional dispute. Ipso facto, if the two sides cannot agree as to the meaning of those figures and the importance of those figures, then management has on its hands an inter-professional dispute. That inter-professional dispute requires to be resolved. You cannot allow clinicians in the departments to carry on disputes for many years. It damages the effectiveness of the unit. So management has a requirement to bring in outside independent people who have the skills to look at that, to peer review in effect what is going on and to make recommendations.'[99]

81 Dr Doyle explained why he directed Dr Bolsin to HC(90)9:

> ' … One thing I was clear about is that he was one side of an inter-professional disagreement or dispute of some sort. Whether right was on his side at that stage, I had no way of judging adequately.
>
> 'There was clearly a mechanism laid out, one which I was fairly familiar with, for resolving these disputes, so the first initial concern on my part was to make sure

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[96] T83 p. 98 Dr Bolsin

[97] T67 p. 26 Dr Doyle

[98] T67 p. 27 Dr Doyle. DoH Health Circular HC(90)9 set out the terms and conditions of service for hospital medical and dental staff and doctors in community medicine and community health service. It was introduced on 18 April 1990 and set out two new procedures: one for disciplinary action short of dismissal; and the other for review of the conduct of consultants alleged to have failed repeatedly to honour their contractual commitments

[99] T67 p. 56 Dr Doyle

> that the appropriate mechanism was used, was expedited to get on with resolving this dispute.
>
> 'The question was, I have asked myself this many times, whether I could nudge the process forward and ensure that the Trust took action fairly speedily to resolve the dispute and to get to the bottom of the argument as to whether there was or was not a case to answer.'[100]

82 Dr Bolsin told the Inquiry that he discussed three options with Dr Doyle.[101] The first and second options (which were, respectively, to go to the Secretary of State, or to the Royal Colleges) were discounted. They would, in all likelihood, mean the cessation of all operations within the Unit and Dr Bolsin said that he felt that there were still beneficial operations taking place within the Unit.[102] Dr Bolsin went on:

> 'The third course of action was that Mr [*sic*] Doyle would write to Professor Angelini who was aware of the problems and I had reported to Mr [*sic*] Doyle that Gianni was aware of the problems and he would then report back to Peter Doyle with the authority of having been contacted by the Department of Health about a perceived problem. It was the third course of action we agreed upon because that preserved operating within the Unit, it would lead to the open review, it would reduce the high-risk operations and the solution would be found, we hoped.'[103]

83 Dr Doyle explained that, because there was an appropriate mechanism for dealing with disputes of the nature Dr Bolsin had outlined to him, he at no time looked at the contents of the envelope that Dr Bolsin had given him.[104] On his return to the DoH Dr Doyle filed the envelope in his personal filing cabinet with the other papers which he had collected whilst at Bristol.[105]

84 On 21 July 1994 Dr Doyle wrote to Professor Angelini. In his letter, Dr Doyle stated that concerns over mortality rates in neonatal and infant cardiac surgery at the BRI had been brought to his attention. Dr Doyle wrote:

> 'I am sure you agree that this is a matter for very great concern. If the position proves to be as reported to me, the excess deaths are in themselves a tragedy. If the problem has been recognised and adequate remedial steps have not been taken, it becomes an unacceptable tragedy.'[106]

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[100] T67 p. 34 Dr Doyle

[101] T83 p. 99 Dr Bolsin

[102] T83 p. 99–100 Dr Bolsin

[103] T83 p. 100 Dr Bolsin

[104] T67 p. 36 Dr Doyle

[105] T67 p. 40 Dr Doyle

[106] UBHT 0052 0287 Dr Doyle; letter dated 21 July 1994

85 Dr Doyle added:

> 'If there is a problem and, for any reason, you are not able to reassure me that it has been resolved, the circumstances are such that I would be obliged to seek the help of colleagues in the Performance Management Directorate who would doubtless raise the matter formally with the Trust. It is highly likely that some sort of formal enquiry would follow.'[107]

He continued:

> 'I recognise that this letter may put you in a very difficult position personally. If there is anything I can do to help, please do not hesitate to get in touch.'[108]

August

86 Professor Angelini replied to Dr Doyle's letter on 19 August 1994:

> 'Thank you for your letter of the 21st July to which I am a bit late in replying since I have been abroad.
>
> 'I appreciate your frankness and concern about some of our paediatric cardiac surgery work. I have to admit that indeed there have been audits carried out which have shown a greater mortality than perhaps could be expected in a particular surgical procedure. This has been a matter of concern for us all and we have tried very hard in the last few months to implement changes aimed at improving our results.
>
> 'In line with the expansion which is taking place in our department, we have been able to advertise a new position for a full-time consultant paediatric cardiac surgeon. I am glad to say that we have had a good response to our advert and an interview is now being held on the 20th September. I can assure you that we will do our best to appoint a suitable candidate – it is our desire to find somebody familiar with the surgical procedure for which our results have been least satisfactory. Of course, it all depends on the quality of the applicants but I can tell you that from the interest this position has generated, we will certainly have at least one, or possibly two, very experienced candidates.
>
> 'In order to achieve an excellent paediatric service, however, it is also necessary to provide a better environment in which such surgery can be conducted. The view of all the medics involved in this work, anaesthetists, surgeons and cardiologists, is that the present facilities should be moved from the Bristol Royal Infirmary into the Bristol Royal Hospital for Sick Children and it is my understanding that the Trust has been looking in this direction. The appointment of a full-time paediatric surgeon and the move [of] the activity to the "Children's Hospital" would greatly strengthen

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[107] UBHT 0052 0287 Dr Doyle; letter dated 21 July 1994

[108] UBHT 0052 0288 Dr Doyle; letter dated 21 July 1994

> our unit and address the shortcomings pointed out in your letter. I can assure you that everything will be done to appoint a suitably experienced person and I can also assure you that it is the wish of all the medics to move the paediatric surgery to the "Children's Hospital". Ultimately, however, the decision to move the unit is not in my hands but in the hands of the UBHT Trust so I am not in the position to comment any further on this particular issue.
>
> 'I am very grateful for the interest you have expressed in our unit. There is no doubt in my mind that the problem we have been experiencing is something which we can address. I am sure that in the next six months I will be able to write to you again and present you with evidence that the changes have taken place, as desired by you and indeed by everybody else concerned here in Bristol. I will keep you informed all the way along. May I thank you again for the opportunity you have given us to put our house in order.'[109]

87 Dr Doyle replied to this letter on 30 August 1994. He wrote:

> 'I am very pleased to hear that the difficulties I referred to in my last letter have been recognised and action is being taken to remedy matters. I look forward in due course to hearing that a new appointment has been made and that the results from Bristol are at least as good as those from other major centres undertaking paediatric cardiac surgery.'[110]

September

88 Following Dr Doyle's reply to Professor Angelini, Dr Roylance wrote to Dr Doyle. Dr Roylance had been made aware of the correspondence that had passed between Dr Doyle and Professor Angelini as Professor Angelini had copied Dr Roylance in to his letter to Dr Doyle.[111] Further, Mr Wisheart had written to Dr Roylance on 4 September commenting on Professor Angelini's letter of 19 August. Mr Wisheart referred in the letter to the 'limited nature of the problem'.[112]

89 In his letter to Dr Doyle dated 12 September 1994, Dr Roylance stated that:

> 'I felt I should write to confirm the Trust Board's awareness of this problem, for which reason we are seeking to appoint another full-time Consultant Paediatric

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[109] DOH 0001 0012 – 0013; letter dated 19 August 1994

[110] UBHT 0052 0284; letter dated 30 August 1994

[111] UBHT 0061 0273 – 0274; letter from Professor Angelini to Dr Doyle dated 19 August 1994

[112] UBHT 0061 0276; letter from Mr Wisheart to Dr Roylance dated 4 September 1994. In June 1996, Mr Wisheart was to report in his *'Statement to the Clinical Directors of UBHT'* that: 'Paediatric cardiac surgery had disappointing results in about 2% of its work for reasons which have not been clearly identified. However, paediatric cardiac surgery was not a disaster area and ironically in the years '92 to '95 the results were the best we had ever achieved. Audit was active, healthy and was used. True information was given to parents and consent was informed. Decisions to operate were deliberate and not cavalier.' UBHT 0054 0007

> Cardiac Surgeon, and the Appointments Committee is due to meet on the 20th September.
>
> ‘The decision has already been taken by the Trust Board, and plans are in hand, to move Paediatric Cardiac Surgery into the Children’s Hospital. I have every confidence this move, and the appointment of the new surgeon, will resolve the situation for the future.’[113]

90 Dr Roylance was asked by Counsel to the Inquiry:

> ‘Q. When you say you write to confirm the Trust Board’s awareness, did you tell the Trust Board at this time of this correspondence?
>
> ‘A. I do not know. I do not know. I may well not have done … .’[114]

91 Mrs Maisey, in her written evidence to the Inquiry, made this comment on the letter:

> ‘As an executive board member, I should like to confirm and clarify that I was not aware of such matters at that time. My recollection is supported by the Board minutes which show that the first time that concerns surrounding paediatric cardiac surgery were drawn to the attention of the Board was at a meeting on 24 February 1995, following the de Leval and Hunter visit.’[115]

92 As to the ‘problem’ referred to, there was the following exchange with Dr Roylance in the course of his giving evidence to the Inquiry:

> ‘Q. When you … write in the second paragraph that you felt you should write to confirm the Trust Board’s awareness of this problem, … you did not know what the problem was that the Department of Health had in mind?
>
> ‘A. I thought I did. I mean, I thought there was no doubt. If you read Gianni’s letter, he says there is a particular treatment with which they have had very poor results. That could only have meant, in my belief at the time, the neonatal Switch procedure, which had stopped. That is what Gianni Angelini said. There was one problem, as I remember – I cannot remember his exact words, but there was one problem of treatment, which was being addressed – something like that. I knew, because we were at that time, as it says, seeking a paediatric cardiac surgeon to reinstitute neonatal Switches.

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[113] UBHT 0061 0278; letter dated 12 September 1994

[114] T89 p. 48 Dr Roylance. No minute indicating that the Trust Board was made aware of the particular problem raised by Professor Angelini was produced to the Inquiry

[115] WIT 0337 0062 Mrs Maisey. See Chapter 30

> ‘Q. The words he used were “a greater mortality than perhaps could be expected in any particular surgical procedure”?
>
> ‘A. In “a particular surgical procedure”, yes. I knew a particular surgical procedure was neonatal Switches. It was part of the work-up to the appointment of a paediatric cardiac surgeon. So I thought I was entirely aware of what the conversation was about.
>
> ‘Q. Did you know that the neonatal Switch had in fact ceased the previous October?
>
> ‘A. Yes.
>
> ‘Q. A year before this, almost?
>
> ‘A. Yes.’[116]

93 In his letter to Dr Doyle, Dr Roylance wrote in the final paragraph:

> ‘I will continue to monitor the situation with Gianni Angelini, and I see that he has promised to keep you informed.’[117]

94 Dr Roylance was asked:

> ‘Q. … you continued to monitor the situation with Gianni Angelini. What were you monitoring?
>
> ‘A. The arrival of the new surgeon and the move up the hill. I am sorry to say the Health Service has a long track record of not achieving its firm decisions, and that was what I was monitoring.
>
> ‘Q. So we read “continue to monitor the situation” as meaning to ensure that these two promises are kept?
>
> ‘A. Yes.’[118]

95 The letter from Dr Roylance led to a reply from Dr Doyle in which he said:

> ‘I was very relieved to hear from Gianni Angelini that a change in the service had been planned. Under the circumstances I think it best to leave the Trust to effect the proposed changes as quickly as possible.’[119]

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[116] T89 p. 47–8 Dr Roylance

[117] UBHT 0061 0278; letter dated 12 September 1994

[118] T89 p. 48–9 Dr Roylance

[119] UBHT 0052 0283; letter from Dr Doyle to Dr Roylance dated 20 September 1994

96 Dr Roylance wrote back to Dr Doyle on 22 September 1994 to inform Dr Doyle that Mr Ashwinikumar Pawade had been appointed as a consultant paediatric cardiothoracic surgeon and to state that:

> ' … [UBHT] is progressing the move of paediatric cardiac surgery to the Bristol Royal Hospital for Sick Children.
>
> 'The Trust is confident that these changes will assist with the continued progress of paediatric cardiac surgery.'[120]

97 Dr Doyle replied thanking Dr Roylance for keeping him up to date.[121]

98 Professor Farndon, in his written evidence to the Inquiry, stated that it was also in September 1994 that:

> 'As the possible appointment of a new cardiac surgeon became more imminent I certainly did meet with Mr McKinlay, the then Chairman of the Trust. I may have mentioned concerns at that meeting, although I cannot remember having done so. This meeting was held between myself, Mr McKinlay and Professor Angelini. By that time it had been resolved that we would look for an appointment in paediatric cardiac surgery and we knew of the possible candidacy of Mr Ash Pawade. Professor Angelini and I wanted to ensure that there would be no administrative problems in the possible appointment of Mr Pawade associated with his move from Australia … .'[122]

99 Professor Angelini and Mr McKinlay stated that there was a discussion about the poor performance of the paediatric cardiac surgery service at this meeting.[123] Professor Farndon told the Inquiry that he could not recall this. According to Mr McKinlay, both Professor Farndon's and Professor Angelini's concern:

> '… was centred on the poor performance of the Switch operation and the controversy over the time taken by Mr Wisheart on some procedures. The Switch operation had been suspended and the position would be resolved by the appointment of a new full time paediatric cardiac surgeon.'[124]

100 Professor Farndon's recollection was that:

> ' … some smaller part of that meeting was concerned with paediatric cardiac surgical outcome and performance.'[125]

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[120] UBHT 0061 0280; letter from Dr Roylance to Dr Doyle dated 22 September 1994

[121] UBHT 0061 0281; letter from Dr Doyle to Dr Roylance dated 3 October 1994

[122] WIT 0087 0009 Professor Farndon

[123] WIT 0073 0055 Professor Angelini, WIT 0073 0016 Professor Angelini

[124] WIT 0102 0028 Mr McKinlay

[125] T69 p. 165 Professor Farndon

October

101 It was in October, according to Mr McKinlay, Chairman of the Trust Board, that he began to hear for the first time from Dr Roylance the names 'Bolsin' and 'Peter Doyle' and talked to Dr Roylance about them.[126]

November

102 Mr Alan Bryan, consultant cardiac surgeon, told the Inquiry about a consultants' meeting, attended by Mr Dhasmana, Mr Hutter, Mr Bryan and Professor Angelini,[127] immediately after the monthly audit meeting of 10 November 1994:

> 'Professor Angelini asked Mr Dhasmana whether the paediatric service could be rationalised prior to the arrival of Mr Pawade … Mr Dhasmana was very offended by the Professor's apparent interference. ... He accused the Professor of criticising the paediatric cardiac surgery service outside Bristol … Professor Angelini had sought advice and help … from [Mr Stark] … Mr Dhasmana unfortunately appeared to interpret this action as unwelcome and unfair interference from others outside the running of the service. This meeting degenerated into an unpleasant argument … the Professor asking for the rationalisation of the service and Mr Dhasmana rejecting outside interference in the service. Mr Hutter and I participated very little in the argument which ended in an acrimonious impasse.[128]
>
> ' … I can fully understand why Mr Dhasmana would view this … action as unsolicited and unfair interference by Professor Angelini …[129]
>
> 'Q. … Did Mr Dhasmana … perceive Professor Angelini as being one of the outsiders interfering with the service?
>
> 'A. Yes … I think that is specifically what I mean.'[130]

103 Mr Dhasmana told the Inquiry about the meeting:

> 'The whole meeting related to raising concerns about my surgical work outside Bristol without first discussing them with me.'[131]
>
> 'It started friendly. … It became … acrimonious … It was not — more an argument in the end, it became almost a one-sided, a Latin burst. … I was angry but I am not very good with my words so I became dumb when I heard somebody [Professor Angelini] really saying "kiss my feet". … After that I became totally dumb because I thought "if I respond now I am angry I may say something and I will regret it".

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[126] T76 p. 45 Mr McKinlay
[127] T63 p. 67 Mr Bryan
[128] WIT 0081 0026 – 0027 Mr Bryan
[129] T63 p. 74 Mr Bryan
[130] T63 p. 79 Mr Bryan
[131] WIT 0081 0039 Mr Dhasmana

> Obviously he himself felt a bit bad having uttered those words so he was trying to explain and it became … one-sided. He really said "well, I tried to save your bacon, the Department of Health was going to close the Unit and I really fought your corner, I really told them your results are very good, we do not need to stop the Unit, it is just we really need to look at a few things." But I am sorry at that time I was in no mood to reciprocate or communicate any further and I just kept listening …
>
> 'Q. … there had been concern expressed to the Department of Health about the results in paediatric cardiac surgery and that he … had suggested that the Unit was solving the problems by appointing a new cardiac surgeon so that the work would go on taking place …
>
> 'A. At that time I did not understand that that is what he was saying, but when I read further information on that I think it became more clear. I do not think it was that clearly mentioned at that time. What upset me … we were meeting almost every other day or every week in the Unit, we were working on a common purpose, to get a paediatric cardiac surgeon and he never mentioned that there was this talk with Dr Doyle or the Department of Health … I was very pleased that he was with me on this one to get [Mr Ash Pawade]. … He talked to other people, why could not he really just tell me at the same time? … If you are told by somebody "kiss my feet", would you take any further part in the conversation?
>
> 'Q. (The Chairman): Mr Dhasmana, what did you understand was meant by that? …
>
> 'A. Very humiliating.'[132]

104 Mr Dhasmana told the Inquiry about the effects of the meeting:

> 'I thought I had good relations with all the gentlemen who had been here and saying something totally different than what they said before.
>
> 'Q. And Professor Angelini?
>
> 'A. I have changed my mind after the November 1994 meeting.'[133]

105 On 17 November Professor Farndon discussed the concerns being expressed about paediatric cardiac surgery with one of the surgeons involved, Mr Wisheart:

> 'I met with James Wisheart on 17 November 1994. At that meeting I made a note … The meeting took place in James' office on Ward 5, which is the cardiac ward. I made the note on the night of the meeting but did not provide a copy to James. The fact that I made a note was a measure of the degree of importance I attached to

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[132] T87 p. 27–30 Mr Dhasmana
[133] T86 p. 160 Mr Dhasmana

> the meeting. Until that occasion the writing of notes would *never* have been something I would have done.'[134]

106 Professor Farndon told the Inquiry about his reasons for calling the meeting:

> 'I think I had heard a volume of continued disquiet, noise, and it was almost an exasperation that no resolution had occurred. It still was not within any of my remit, strictly speaking, to be concerned with the results of cardiac surgery, but people kept talking and no evidence was ever handed to me that everybody had agreed upon, identifying that there is a problem or there is not a problem. So there was a feeling of exasperation that the thing had not been resolved.'[135]

107 Professor Farndon, in his written evidence to the Inquiry, stated that:

> ' … as a friend and colleague of James, I could not tolerate hearing oblique criticisms (without objective evidence) of a colleague's work or performance. I felt a duty, first, to be sure that James was aware of these criticisms, and, secondly, to see if I could help in the resolution of any particular problems that might exist.'[136]

108 Professor Farndon went on:

> ' … James agreed that the outcomes of some paediatric cardiac procedures were not good but I do not remember discussing any specific procedures. I think I would have made a note if we had. I also remember that we discussed case complexity and risk factors and how these played upon outcome.'[137]

109 He concluded:

> ' … at the end of the meeting we had resolved the issues and we had seen a potential way forward. It was agreed that there would be a tabulation of results, and an agreement between the relevant surgeons as to their authenticity and accuracy. Then, there would be an open meeting with the cardiologists and anaesthetists to discuss that data. This was in respect of all the cases, adult and paediatric … .'[138]

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[134] WIT 0087 0009 Professor Farndon (emphasis in original)

[135] T69 p. 170 Professor Farndon

[136] WIT 0087 0010 Professor Farndon

[137] WIT 0087 0010 Professor Farndon

[138] WIT 0087 0011 Professor Farndon

110 Professor Farndon's note of the meeting recorded the outcome as follows:

> ' … *That it is resolved that*: the 5 cardiac surgeons will tabulate results, agree them as authentic and accurate and that the 5 surgeons will then meet openly with cardiologists and cardiac anaesthetists to discuss results.
>
> 'Agreed that
>
> '(i) cardiac surgeons will meet & agree figures for all cases
>
> '(ii) hold an open meeting for *all* to examine results …
>
> '(iii) that I ring Chris Monk and advise him of these things
>
> '(iv) that JW [Mr Wisheart] recognises that he gets more difficult cases … .'[139]

111 On the following day, Professor Farndon wrote to Mr Wisheart, with a copy to Dr Monk:

> 'I really do believe that the best way forward is for an internal discussion to begin initially with the five cardiac surgeons. Work should be done fairly quickly to agree the data and this should then be openly discussed with colleagues from cardiology and cardiac anaesthesiology.'[140]

112 Professor Farndon stated:

> 'I wanted the matter to be resolved quickly. I was getting impatient with colleagues talking in corridors without objective evidence. I wished to see the situation resolved. I indicated to both James and Dr Monk that if the group wished me to play any further part I would be pleased to do so. My aim was to be an objective and honest broker, or chair, if that were to be desired. I hoped that the things we had agreed would happen.[141]

113 Professor Farndon noted:

> 'No one ever returned to me to ask for my further services.'[142]

December

114 On the evening of 8 December 1994 a scheduled meeting of the Paediatric Heart Club took place at Dr Joffe's home.[143] Mr Dhasmana told the Inquiry that Dr Martin and he had discussed the proposed Switch operation on Joshua Loveday after Joshua

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[139] WIT 0087 0025 – 0026; transcript of Professor Farndon's handwritten note of the meeting on 17 November 1994 (emphasis in original)

[140] WIT 0087 0028; letter from Professor Farndon to Mr Wisheart dated 18 November 1994

[141] WIT 0087 0012 Professor Farndon

[142] WIT 0087 0012 Professor Farndon

[143] T87 p. 41 Mr Dhasmana

had been seen in Gloucester in November 1994.[144] Mr Dhasmana and Dr Martin decided, and Dr Joffe agreed, that the meeting of the Paediatric Heart Club was a suitable occasion on which to discuss the issue of Mr Dhasmana's performing non-neonatal Switch operations. After the decision had been taken to dedicate the meeting to a discussion of the non-neonatal Switch series, Mr Dhasmana told the Inquiry that he:

> '… made personal telephone calls and communicated to everybody that I would be grateful if they attended this meeting, all of them.'[145]

115 Mr Dhasmana said that he asked Dr Bolsin to attend:

> '… when I talked to him he looked in his diary, he said "Sorry, I am busy at that time somewhere else but I will see what I can do". In the end he did not turn up.'[146]

116 Mr Dhasmana was asked about the meeting in the following exchange:

> 'Q. So the meeting then took place. What discussion was there about the Joshua Loveday operation? Was it about the operation or was it about the Switch programme itself?
>
> 'A. It was about the older Switch programme. It is just I intimated to them that: "I have got a patient on my list to be operated on".
>
> 'Q. So no specific conversation about that particular patient, just about the Switch programme?
>
> 'A. Yes.
>
> 'Q. Were there any figures discussed at that meeting?
>
> 'A. I took my hand notes because I was not going to that meeting without any information with me. So in my hand I had written down all the Switches which I had done right from number 1 in 1988 – I am talking of all older Switches – until the last one.'[147]

117 Mr Wisheart, in his written evidence to the Inquiry, stated:

> '… there was a long and detailed discussion as to whether it was appropriate for Mr Dhasmana to continue to do the Arterial Switch operation in older children. For the purposes of the discussion, all sides of the debate were examined and data

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[144] T87 p. 41 Mr Dhasmana
[145] T87 p. 41 Mr Dhasmana
[146] T87 p. 41 Mr Dhasmana
[147] T87 p. 42 Mr Dhasmana

> was provided to that meeting. The meeting concluded that Mr Dhasmana should continue to do the Arterial Switch operation in older children.'[148]

118 Mr Wisheart stated that Dr Joffe, Dr Martin, Dr Hayes, Dr Masey, Dr Underwood, Dr Pryn, Dr Wilde, Mr Dhasmana and he were present at the meeting. Mr Wisheart stated that Dr Bolsin was not present.[149]

119 When Dr Masey was asked about the meeting, she said that she had 'very little recollection of the subject matter' of the meeting.[150] As regards the discussion of the non-neonatal Switch series, she said:

> 'My recollection was that the results in the older Switches were acceptable, yes, were within acceptable … were acceptable, yes.'[151]

120 Dr Pryn and Dr Underwood both had a very poor recollection of the meeting and what was said at it.[152]

121 No minutes were made of the meeting.

122 On 15 December Professor Vann Jones, having received some further data from Mr Wisheart, wrote to Mr Wisheart acknowledging receipt of the data:

> 'I looked through the figures with interest and certainly as far as I can see all the groups to which statistics could be sensibly applied equal or better the national average. As you know there are many small groups some better, some worse than the national average but where one single event totally distorts the picture. I personally feel very re-assured about the figures and would stoutly defend them if they ever become the subject of further debate.'[153]

123 Subsequently, in his oral evidence to the Inquiry, Professor Vann Jones said that he had:

> ' … made assumptions that that must be validated data. I did not know until later on, for instance, that the whole thing was anonymised and lumped together … I had no idea in those days, it was just people sending forms in and the whole thing was lumped together, so therefore any particular centre that was not performing was just lost in the overall … .'[154]

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[148] WIT 0120 0455 Mr Wisheart
[149] WIT 0120 0455 Mr Wisheart
[150] T74 p. 129 Dr Masey
[151] T74 p. 131 Dr Masey
[152] T75 p. 155 Dr Underwood; T72 p. 161 Dr Pryn
[153] JDW 0005 0180; letter from Professor Vann Jones to Mr Wisheart dated 15 December 1994
[154] T59 p. 129 Professor Vann Jones

124 Dr Bolsin stated in a report in October 1995 that at some point in December 1994 he contacted Dr Doyle at the DoH in the light of the proposed operation on Joshua Loveday:

> 'When it became apparent that the operation was very likely to proceed, and after consultations with Mr Bill Brawn (Consultant paediatric cardiac surgeon, Birmingham Children's Hospital) and Mr John Parker,[155] I contacted Dr Doyle and told him of my grave concerns over the safety of the patient. Professor Angelini also contacted Dr Doyle for the same reasons.'[156]

125 Mr McKinlay, in his written evidence to the Inquiry, stated:

> 'By Christmas 1994 I had reached the point where I told Dr Roylance that I wanted an independent inquiry and he agreed … it is my recollection that he or Mr Wisheart had started to explore with the Royal College of Surgeons the identification of experts who might conduct the inquiry.'[157]

126 Mr McKinlay was asked about this part of his statement when he gave oral evidence:

> ' … I can remember going away for the Christmas break and saying, "John [Dr Roylance], I think we need to have an inquiry."
>
> 'Q. That would have been into what, precisely?
>
> 'A. Into whether or not there was a problem …
>
> 'Q. Dealing only with the neonatal Switch operation … ?
>
> 'A. No, I think at that time the concerns must have been broader; they really had to cover the behaviour of the Unit as a whole. At that time I thought that the centre of [the] problem was the neonatal Switch, but it really should be a wider inquiry.' [158]

127 Mr McKinlay's evidence included the following exchange:

> 'Q. If you and Dr Roylance had agreed that by Christmas, why was one not set up by Christmas, or early in January?
>
> 'A. I thought that Dr Roylance agreed with me, but he had to go off and think about it. I thought that in January he started the mechanism for setting up an inquiry, to find the people to actually do the job.

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[155] The then President of the British Cardiac Society

[156] UBHT 0052 0175; Dr Bolsin's report: *'An account of the events occurring in the Bristol Royal Infirmary & United Bristol Healthcare Trust Department of Paediatric Cardiac Surgery 1989–1995'*, dated October 1995

[157] WIT 0102 0028 – 0029 Mr McKinlay

[158] T76 p. 49 Mr McKinlay

> ‘Q. Before any question of the Joshua Loveday operation?[159]
>
> ‘A. I thought so, but … I cannot pin that down.’ [160]

128 According to Dr Roylance, the decision to hold an inquiry was made rather later:

> ‘ … I decided to have an inquiry when I was told that the child [Joshua Loveday] had died.’[161]

129 Mr Graham Nix stated that he could not recall precisely when he first became aware of an inquiry involving independent experts to report on paediatric cardiac surgery although:

> ‘… it was probably in very late 1994 or early 1995. I understood that independent experts were to be called in, to advise Dr Roylance by providing an outside view of the problems in the paediatric cardiac service.’[162]

130 As regards the proposed operation on Joshua Loveday, sometime in December 1994 or early January 1995, Professor Angelini made a telephone call to Dr Martin, consultant paediatric cardiologist, who was at a peripheral clinic outside Bristol. Professor Angelini said of the telephone call:

> ‘I questioned to him the wisdom of doing this case in the BRI. I also told him that this was not an urgent case and there was no need to do this operation and if he felt that the child needed an operation, we could have him sent to Birmingham, to Bill Brawn, who was perhaps the best surgeon in the land, to do this operation safely.’[163]

131 Professor Angelini’s evidence continued:

> ‘Q. Did Dr Martin agree that the operation was urgent or not? Or did he agree it was not urgent?
>
> ‘A. He agreed it was not urgent.
>
> ‘Q. So what did you understand his justification being for carrying out the operation?
>
> ‘A. His justification was since this child was not a neonate, the results on the non-neonate were much better than the results on the neonate, therefore he was justified to go ahead with the operation.’[164]

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[159] The operation took place on 12 January 1995. See also Chapter 30

[160] T76 p. 49 Mr McKinlay

[161] WIT 0108 0130 Dr Roylance; Joshua Loveday died on 12 January 1995, the day of his operation

[162] WIT 0106 0070 Mr Nix

[163] T61 p. 183 Professor Angelini

132 Professor Angelini told the Inquiry that he asked Dr Martin why Joshua Loveday, who had been waiting for his operation for some time already, could not wait until Mr Pawade took up his position.[165] Professor Angelini said that Dr Martin had told him:

> '… in his view the competence of the surgeon to do this operation in a child of the age of the child we were dealing with, was adequate. Of course, I totally disagreed with this.'[166]

133 Dr Martin told the Inquiry:

> 'My understanding was that he [Professor Angelini] was questioning whether this operation that was planned as a Switch operation was a neonatal operation and I think I informed him that Joshua was an older child, I may have told him his age, I cannot remember, and I felt he [Professor Angelini] was under the misapprehension that this was a neonatal operation or a younger operation.'[167]

134 Dr Martin told the Inquiry that he did not remember how long the conversation lasted;[168] whether or not the question of transferring Joshua to another hospital was discussed;[169] whether or not the urgency of Joshua 's case was discussed;[170] or whether there was any discussion of why the operation could not wait until Mr Pawade started work.[171]

135 After spending Christmas with relatives, Joshua's parents returned home to find a letter from the BRI advising them that there was a space available in the operating schedule and that, if they wished the operation to go ahead, then Joshua could be admitted to the BRI on 10 January 1995.[172] Joshua's mother stated in her written evidence to the Inquiry that:

> 'Bert and I thought that both this letter and the previous communication from Mr Dhasmana's secretary were very odd. We had, after all, seen Mr Dhasmana in November, only a couple of weeks before his secretary telephoned. At the previous consultations with both Dr Martin and Mr Dhasmana, neither had indicated that the operation was urgent.'[173]

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[164] T61 p. 183 Professor Angelini
[165] Mr Pawade was due to start work in Bristol in May 1995
[166] T61 p. 184 Professor Angelini
[167] T77 p. 108 Dr Martin
[168] T77 p. 108 Dr Martin
[169] T77 p. 108 Dr Martin
[170] T77 p. 109 Dr Martin
[171] T77 p. 109 Dr Martin
[172] WIT 0417 0012 Ms Evans
[173] WIT 0417 0012 Ms Evans

Report of the performance of the PCS Service in 1994

136 In 1994, the figures for 1993–1994 were produced by the Unit, but not published, as had been the case prior to 1992. Figures were, however, submitted to the UK Cardiac Surgical Register (UKCSR):[174]

Operations – Over-1s	Operations – Under-1s
93 (4)	50 (14)

137 This compared with the figures for 1993–94 from the UKCSR, when produced, which were to the effect that overall mortality in the under-1 operative group was 11%, and that for the over-1s was 5.4%.[175]

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[174] UBHT 0055 0229; figures in parentheses are for deaths; mortality rates calculated by the Inquiry

[175] UBHT 0055 0373; report of the UKCSR 1993/94

Chapter 30 – Concerns 1995 and after

Concerns 1995

January

Joshua Loveday's surgery

1 In late December 1994, it was planned to operate on Joshua Loveday in January 1995.

2 His clinical history was that on 22 June 1993, he was born the second son of Amanda Jayne Evans and Robert Loveday at Gloucester Maternity Hospital.[1] Soon after returning home on 30 June 1993 Joshua's mother noticed that he was having difficulty feeding, and mentioned this to a visiting midwife. The midwife recommended that Joshua should be seen by his GP. It was decided that he needed immediate attention. He was taken to Gloucestershire Royal Hospital, and referred from there to Bristol.

3 Joshua's parents met Mr Dhasmana at the BRI. He explained that Joshua would require an immediate operation, without which he would die, and that later on he would require a 'Switch' operation. The next morning, 1 July 1993, Joshua underwent a 'banding' operation performed by Mr Dhasmana. He recovered slowly, returning after about two weeks to the main recovery ward in the Bristol Royal Hospital for Sick Children (BRHSC),[2] and after about a further month to Gloucestershire Royal Hospital, where he remained for about two weeks before returning home.[3]

4 After his return home Joshua was seen at monthly outpatient clinics at Gloucestershire Royal Hospital. His mother described the clinics in her written statement to the Inquiry:

> '… Joshua was seen once a month, in the local outpatient clinic, by a member of staff from Bristol. Normally, a man called Dr Martin saw him. Dr Martin would usually ask whether Joshua was feeding properly, and he expressed his satisfaction as Joshua got better and put on weight. Dr Martin would do simple diagnostic tests, such as weighing Joshua, and, usually, he would look at his fingers.'[4]

Joshua's mother described his general condition during this time:

> 'Generally, Joshua reached all his milestones, and, although he was small for his age, he grew steadily. He appeared to be a normal, healthy baby. He was never on tablets, and he did not suffer unduly from illness. He was still pink, although he became purple when he was upset.'[5]

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[1] WIT 0417 0002 Amanda Evans
[2] WIT 0417 0008 Amanda Evans
[3] WIT 0417 0009 Amanda Evans
[4] WIT 0417 0009 Amanda Evans
[5] WIT 0417 0009 Amanda Evans

5 In the spring of 1994, Joshua Loveday and his parents were seen again by Mr Dhasmana in Bristol. At this meeting Mr Dhasmana again explained Joshua's condition and drew diagrams of Joshua's heart and a normal heart.[6] He again mentioned that a Switch operation would be needed. Joshua's mother stated that Mr Dhasmana had said to her that there was a success rate of 80–85% in the case of the Switch operation. She stated that Mr Dhasmana did not offer any alternative to the Switch operation, did not mention the possibility of brain damage occurring during the operation, and did not make clear what 'failure' might consist of.[7] Mr Dhasmana, she stated, told her that the operation would occur when Joshua was aged between 3 and 5 years old. Joshua's mother explained that:

> 'Both Bert and I felt generally reassured by this interview'.[8]

6 On 23 May 1994 Joshua had a cardiac catheterisation which showed that the initial diagnosis of double outlet right ventricle with subpulmonary Ventricular Septal Defect (VSD) was correct.[9]

7 On 20 June 1994 Drs Joffe, Martin, Hayes, Wilde and Jones, together with Mr Wisheart and Mr Dhasmana, met at a joint cardiac surgical meeting and discussed Joshua's case.[10] At this meeting the clinicians decided that Joshua looked:

> '… suitable for an arterial switch operation with closure of VSD'.[11]

8 In November, Joshua was taken again to the outpatient clinic. Joshua's mother stated that this meeting confirmed her and Joshua's father's belief that the operation was routine but that it would not take place for some time to come.[12]

9 Dr Martin told the Inquiry that he saw Joshua at the clinic in November:

> '… I spoke to Mr Dhasmana towards the end of November when we were talking about scheduling … We were talking about the fact that I had seen Joshua Loveday in the Outpatients Department and I was concerned about his waiting.'[13]

10 Mr Dhasmana told the Inquiry that he knew Dr Martin had seen Joshua in November because:

> 'I am not exactly certain whether he [Dr Martin] wrote me a letter or sent me a memo or telephoned to say: "Janardan, what is happening with this patient, you

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[6] WIT 0417 0010 Amanda Evans
[7] WIT 0417 0010 Amanda Evans
[8] WIT 0417 0010 Amanda Evans
[9] MR 0164 0022; Medical Records of Joshua Loveday. See Chapter 3 for an explanation of these terms
[10] MR 0164 0034; Medical Records of Joshua Loveday
[11] MR 0164 0034; Medical Records of Joshua Loveday
[12] WIT 0417 0011 Amanda Evans
[13] T77 p. 81 Dr Martin

> have promised an operation in 4 to 6 months and it is more than 6 months, I saw him, he is getting quite blue?"'[14]

11 Accordingly, an operation was set for 12 January 1995. Joshua's mother stated that while she and Joshua's father had misgivings about the operation, they felt that it was an appropriate time for Joshua to have his operation as it allowed him time to recover fully before he was to start school. They decided to confirm with the hospital that they would bring Joshua for admission into the BRI on 10 January 1995.[15]

12 Mrs Herborn, a sister in cardiac theatres at the BRI, stated in her written evidence to the Inquiry:

> 'I was horrified when I saw this on the monthly list for January after the Christmas holiday, and immediately pointed it out to Dr Bolsin. He already knew about it and told me not to worry, it would not take place. Between then and the 11 January. I spoke to him again and also to Professor Angelini. I was assured each time that they were dealing with it. I had made up my mind that whatever happened I would not scrub for it, nor would I alter the daily roster when I noticed that Alison Reed had a day off on 12 January. Alison Reed was Mr Dhasmana's favourite scrub nurse. She was very experienced and would have been his first choice. Apart from her there were only Kay Armstrong and myself available … Kay Armstrong agreed with me and was also unwilling to scrub for the case.'[16]

13 Professor Angelini told the Inquiry that he went to see Mr Wisheart on 6 January 1995 to:

> '… persuade him … of how unwise it was to go ahead with this [the Joshua Loveday] operation … .'[17]

14 Mr Wisheart stated that:

> 'On Friday 6th January, six days before the scheduled operation, Professor Angelini came to me in my office on behalf of Dr Bolsin and himself and spoke to me as Medical Director. He indicated that it was the view of Dr Bolsin and himself that this operation should not proceed.'[18]

15 Mr Wisheart continued:

> 'He showed me some figures which were written on a piece of paper in his hand and which I cannot now recall, which purported to be the results of Mr Dhasmana's

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[14] T87 p. 40 Mr Dhasmana

[15] WIT 0417 0013 Amanda Evans

[16] WIT 0255 0016 – 0017 Mrs Herborn

[17] T61 p. 184 Professor Angelini

[18] WIT 0120 0455 Mr Wisheart

> surgery for the switch operation. I was familiar with his results for this operation and I did not recognise these figures. I said so.'[19]

16 Immediately after the meeting with Professor Angelini, Mr Wisheart stated that he telephoned Dr Bolsin. Mr Wisheart stated that in the course of this conversation, he and Dr Bolsin agreed on two matters:

> '… (1) that it was extremely foolish to be in a position where we were arguing about verifiable facts [Mr Dhasmana's outcome data] and that Mr Dhasmana and one of the anaesthetists should work together to establish agreed data on the results of the arterial switch operation in all age groups; and (2) that after that data had been urgently gathered there would be a meeting of the whole Paediatric Group to review this decision to operate on Joshua Loveday … . It was not possible to convene the meeting until Wednesday 11 January 1995 because of people's legitimate commitments on the Monday or Tuesday.'[20]

17 Professor Angelini wrote to Mr Wisheart on 10 January 1995. Professor Angelini explained that he wrote the letter:

> '… as the final attempt to see whether by putting my concern in writing this could have somehow convinced them or – I do not know what – but it was literally the final attempt'.[21]

18 In the letter Professor Angelini wrote:

> 'I would like to put into writing my concern with regard to the "switch"operation planned for next Thursday January 12th. Given the circumstances which we all know, and the considerable degree of pressure coming from different quarters, for example the anaesthetists and the nursing personnel, I think it would be better not to proceed with this operation.
>
> 'Sorry to have to write to you in this manner but I feel that I must disassociate myself from the potential consequences if this operation was to proceed as planned.'[22]

19 Professor Angelini told the Inquiry that he had been in contact with many other people before he both went to see and subsequently wrote to Mr Wisheart in his capacity as Medical Director:

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[19] WIT 0120 0455 Mr Wisheart

[20] WIT 0120 0455 – 0456 Mr Wisheart

[21] T61 p. 184 Professor Angelini

[22] UBHT 0052 0277; letter dated 10 January 1995

> 'I had spoken with Dr Roylance. I had spoken with Dr Doyle [Peter] at the Department of Health. Dr Sheila Willatts, Professor Farndon, you name it. I did not have anything else I could do except writing this letter, and that is the last thing.'[23]

Counsel to the Inquiry asked Professor Angelini what response he had received from Dr Roylance. He replied:

> 'The usual type [of response], the "recorded message": "This is a matter for the clinical people".'[24]

20 Professor Angelini was asked what response he would have expected Dr Roylance to give:

> 'By that time, there had been no meeting of all the people involved because the meeting took place the night before the operation, so that was after I had spoken with Dr Roylance. But the issue was a more fundamental one here. The people who were trying to take the decision on whether to go ahead or not, not only were making a decision 12 hours before an operation, but somehow they were all emotionally involved in this business of the switch operation. They were not in any position to take any sensible decision.
>
> The reason I went to see Mr Wisheart and then Dr Roylance was simply to say to them, "You are senior people, you are in a position to stop this operation which is not urgent. Why do you not just think about this. Why do we not assess this with a cool head before embarking and doing the surgery which may end catastrophically for the child, and then what we have proved?" So the people who were taking the decision were too much emotionally involved in what was going on. I think that was a wrong decision, and the Chief Executive and the Medical Director should have appreciated that the decision should not have been left to these people.'[25]

21 Joshua's parents took him to the BRI on 10 January 1995. For themselves, they were allocated accommodation in a shared house near the hospital. On 10 January, they were invited to sign a form giving consent for the operation. They were not told that there was to be a meeting on the following day to decide whether or not to proceed with the surgery. Joshua suffered from Taussig-Bing syndrome.[26] They were not told that Mr Dhasmana had operated on only one child suffering from such a syndrome beforehand. That child had died.

22 On 11 January 1995 Joshua was given two surgical baths in preparation for his operation.[27]

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[23] T61 p. 185 Professor Angelini

[24] T61 p. 186 Professor Angelini

[25] T61 p. 186 Professor Angelini

[26] See Chapter 3 for an explanation of this term

[27] WIT 0417 0014 Amanda Evans

23 Dr Martin did not see Joshua upon admission to the BRI, as indicated in the following exchange:

> 'Q. Apart from seeing him [Joshua] in outpatients in November 1994, did you see Joshua Loveday again before 11 January 1995?
>
> 'A. No, I did not see him on that admission at all.
>
> 'Q. On 11th January 1995, is it right that you had last seen Joshua on 21st November 1994?
>
> 'A. That is correct, yes.'[28]

24 Dr Peter Doyle told the Inquiry in his oral evidence that, on 11 January 1995, he had telephoned Dr Roylance to advise him of the fact that concerns had been expressed to him by Professor Angelini. Dr Doyle noted that Dr Roylance had told him that he would be guided by the Medical Director (Mr Wisheart) and that, at the very time that he and Dr Roylance were speaking, Mr Wisheart was at a meeting to discuss the situation.[29]

25 Dr Doyle stated that Mr Wisheart telephoned him on the next morning (12 January) to inform him that the outcome of the meeting had been to proceed with the planned operation, since the view of the meeting had been that the results of non-neonatal heart surgery were as good as the national average.

26 Dr Christopher Monk spoke to Mr Wisheart during the day on 11 January, expressing the view that the risks of going ahead with the proposed operation exceeded the possible benefit.[30]

27 At 5.30 pm on 11th January, a meeting of clinicians was held in the Catheter Laboratory at the BRHSC. Present were the cardiologists Drs Joffe, Hayes and Martin; the surgeons Mr Dhasmana and Mr Wisheart; and the anaesthetists Drs Masey, Monk, Bolsin and Pryn (who left midway through). Two notes of the meeting were made at or about the time: one by Dr Monk and the other by Dr Martin.

28 Both notes stated that there was a discussion first as to the outcomes at Bristol of Arterial Switch surgery, and second as to whether or not to proceed with the planned surgery on Joshua Loveday. Dr Martin's note described the discussion of outcomes as follows:

> 'The results for neonatal arterial switch for patients with intact ventricular septal were discussed in passing. The overall mortality has been 9/13 (69%). It has

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[28] T77 p. 97 Dr Martin

[29] T67 p. 86 Dr Doyle

[30] UBHT 0054 0011; Dr Monk's minute of the later meeting on 11 January 1995

previously been decided to halt the neonatal arterial switch programme for the moment pending the development of the new unit.

‘In total, since February 1988, a total of 28 patients have undergone an arterial switch operation with closure of VSD. This included patients who have undergone coarctation repair and pulmonary artery banding, those with multiple VSDs and those operated on in infancy without prior pulmonary artery banding. Four patients have been operated upon by Mr Wisheart who is no longer undertaking arterial switch operations. This leaves 24 patients operated on by Mr Dhasmana during the period of February 88 to December 94. Overall mortality for this period is 8/24 patients (33%). Mortality was higher in the first 2 years presumably reflecting the learning curve for the operation. Over the period of 1990 to 1994 15 operations were performed with 3 deaths giving an overall mortality of 20%. 8 of these patients were over one year of age with one death (12½% mortality).

‘Reviewing the figures it was clear that the mortality at the start of the programme was high but had improved significantly over the latter few years. These mortality rates were compared to published data. From the multi-centre study in the United States, the mortality for transposition with multiple VSDs was 22% and for transposition with single VSD was 16%. Based on the UK registry the mortality for treatment of transposition with VSD (majority would have had an arterial switch operation) was 19.5% in 1990, 17.6% in 1991 and 12% in 1992. There was discussion on these results and it was felt that our more recent results were similar to that for published data and, therefore, acceptable.

‘There was a discussion amongst the group on these results and there was general agreement that, based on the mortality figures it was appropriate to continue with an arterial switch programme in children outside of the neonatal period.’[31]

29 Dr Monk’s note recorded that:

‘Under discussion it was decided that the outcomes of Bristol were within the expected range of mortalities but not in line with the best reports from centres such as Melbourne, Great Ormond Street, Birmingham or Boston. These figures did not support the withdrawal or stopping of the present non-neonatal programme, the question was asked distinctly by CRM [Dr Monk] and all members with the exception of SP [Dr Pryn] (absent) agreed that the programme should continue.’[32]

30 Dr Monk’s note, but not Dr Martin’s, recorded that:

‘General and specific discussion on the risks of performing surgery with a fatal outcome was discussed and the option of delaying for a week or until the arrival of

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[31] UBHT 0054 0013; Dr Martin’s minutes of the meeting

[32] UBHT 0054 0011; Dr Monk’s minutes of the meeting

> the new surgeon was proposed strongly by SNB [Dr Bolsin] as much could be lost by the death of the child.'[33]

31 Mr Wisheart set out his recollections of the meeting in his written evidence to the Inquiry:

> 'Data was presented and, after adjustment to a detail, was agreed. In as much as one could derive reliable and relevant information from recent publications, the literature was reviewed. My recollection is that it was agreed by all present that Mr Dhasmana's results for the switch operation outside the neonatal period lay within what would be expected from this review of the literature. His results in children over 1 year of age were better. Mr Dhasmana's results were for the period 1990 to 1994.
>
> 'I believe that Dr Bolsin also accepted this view of the data, but he put the point that the operation should nevertheless not be done for "institutional reasons"and because of the possible "political consequences". There followed a discussion at the end of which most of us remained quite unclear as to what he meant by these two phrases. Most people felt that the decision should be made on clinical grounds and in the best interests of this individual patient and not for extraneous or political grounds. All those present with the exception of Dr Bolsin confirmed the decision and plan to operate on Joshua Loveday.'[34]

32 In his evidence to the Inquiry, Dr Bolsin explained what he had meant by what he described as an 'institutional reasons', in the following exchanges:

> 'The focus in 1992 in setting up a data collection was that we were looking at the major factors in which we had intuitively surmised that some of the surgical factors may be important. So we had confined ourselves to the surgeons as opposed to including cardiologists and anaesthetists and other things, so the whole thing had evolved over that period.'[35]

33 Counsel to the Inquiry explored the issue further with Dr Bolsin:

> 'Q. Again going back to the process of question and answer about being quite rightly self-critical and excluding yourself as a cause of excess mortality because your procedures were exactly the same as others —
>
> 'A. Yes.
>
> 'Q. — the intuitive approach you have described arose, did it, out of essentially that process, your logbook, your focus on your logbook, your focus upon your own experience with children and in essence was it perhaps a question "It is nothing

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[33] UBHT 0054 0011; Dr Monk's minutes of the meeting

[34] WIT 0120 0456 – 0457 Mr Wisheart

[35] T82 p. 105 Dr Bolsin

> I am doing, so it must be something the surgeons are doing"? It is a very crude way of putting it, but is that broadly how the intuition arose, do you think?
>
> 'A. Yes, I think what we were wondering was whether the surgical techniques and the surgical management of the cases was one of the major causes for serious morbidity and mortality.'[36]

34 In a written account Dr Bolsin described the meeting of 11 January 1995:

> 'One of the features of the meeting was the production (for the first time) of the mortality figures for all "switch" operations undertaken by both surgeons from 1988–95. These data had been collated by both the surgeons and Dr Underwood and Dr Pryn (Consultant paediatric cardiac anaesthetists involved in the "switch" programme). The fact that the surgeons' figures had to be modified at that meeting to produce the actual results suggested that these figures had only just become available. This was the first time that the results for this operation were reviewed by a multidisciplinary team. The results confirmed that the overall mortality rate for the neonatal arterial "switch" operation was 67%. These figures were worse than my estimates of July 1994.
>
> 'I put forward the view that there was an obvious institutional problem with the arterial "switch" operation in Bristol and that, particularly in view of the recent events, to expose a child to unnecessary risk when the Trust was already committed to a new surgeon and a new site was unwise. The meeting was presented with data from the "switch" programme which had been sub-divided by age (over or under 1 year) and year of operation (before or after 1990). The meeting was asked whether, on the information presented for the specific category into which the prospective patient fell, there was enough evidence that the results in Bristol were "significantly worse" than the "national average"? It was apparent that the effect of the precise subdivision of the data was to create a small group, in comparison to which the Bristol results could not be said to be worse. The numbers were small and the "national average" comparator was itself contentious containing an unknown number of non-"switch" operations for transposition of the great vessels. I had to agree that the data, as it was presented, would make it very difficult to demonstrate with any degree of certainty that the Bristol performance for the small subgroup selected was statistically worse. This disregards the context of the unit's long standing poor record with complex operations. The group was asked if the operation should proceed. *I asked for my opposition to be minuted; I was a minority of 1.*'[37]

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[36] T82 p. 105 Dr Bolsin

[37] UBHT 0052 0176 – 0177; *'An account of the events occurring in the Bristol Royal Infirmary and United Bristol Healthcare Trust Department of Paediatric Cardiac Surgery 1989–1995',* Dr Bolsin, October 1995 (emphasis in original)

35 Dr Sally Masey, consultant anaesthetist, stated in her written evidence to the Inquiry that she attended the meeting of 11 January 1995. She stated that she had been part of the group that put together the statistics that were discussed during the meeting:

> 'Prior to this meeting, Dr Pryn, Dr Underwood and myself had made an effort to try and have a list of all the non-neonatal switches performed with their outcomes. Dr Underwood and myself looked at our personal records of cases for which we had anaesthetised and checked through theatre books. Dr Pryn referred to computer-generated information. Dr Pryn took this information to the meeting so it could be cross-referenced with information supplied by Mr Dhasmana.'[38]

36 Dr Masey explained that the conclusion reached at the meeting was:

> '… unanimous agreement, including Dr Bolsin, that there was nothing in the figures to suggest that Mr Dhasmana should not proceed with Joshua's operation the following day.'[39]

37 Dr Stephen Pryn, consultant anaesthetist, stated that he helped Dr Masey and Dr Underwood to prepare the figures which were presented at the meeting on 11 January. He explained in his written evidence to the Inquiry that, notwithstanding that the figures that he had helped to prepare which seemed to show that Mr Dhasmana's results were comparable to those in the rest of the country, he felt that:

> '… it would be preferable for this patient either to await the arrival of Mr Pawade or to be transferred to Birmingham. However, Dr Martin, the cardiologist involved, explained that Joshua's condition was poor and he required urgent surgery, such that it was not reasonable either to defer operating until May or to transfer him to Birmingham. I had to leave the meeting early, but at the time I left my understanding was that, since Mr Dhasmana's recent survival rates for children over a year old appeared to be within the range of other UK centres, and given the apparent urgency, the operation was to go ahead.'[40]

38 In his note of the meeting of 11 January 1995, Dr Monk wrote:

> 'SNB [Dr Bolsin] was pressed for an explanation of the reasons behind informing the Department of Health prior to the meeting to discuss whether the programme should proceed the next day. The working relationship between himself [Dr Bolsin], Peter Doyle and the Department of Health funding for his audit programme was so intertwined that SNB felt unable not to tell Peter Doyle of the forthcoming event.'[41]

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[38] WIT 0270 0016 Dr Masey

[39] WIT 0270 0016 Dr Masey

[40] WIT 0341 0045 Dr Pryn

[41] UBHT 0054 0011; Dr Monk's minute

39 Dr Martin also prepared a minute of a side-meeting between him, Mr Wisheart and Mr Dhasmana, which took place after the discussions in the meeting:[42]

> 'After this general discussion there was a joint discussion between myself, Mr Dhasmana and Mr Wisheart regarding whether it was clinically appropriate to proceed with Joshua's operation the following day. Joshua is already 18 months old and quite severely blue. We have recently reviewed the clinical and angiographic data and felt that he is suitable for an arterial switch in our unit. With his cyanosis being quite severe it was felt unwise to postpone surgery for a matter of months. Based on the results that we have discussed, we did not feel it was appropriate for referral to another centre. The decision, therefore, was made to proceed with the planned arterial switch operation the following day.'[43]

40 Dr Martin explained his view further in the following exchange:

> 'Q. … is it right that a decision that there is no reason not to do a particular series of operations becomes, in any individual case, a reason to do it?
>
> 'A. I think we felt that there was no reason not to do it. There are many reasons to go ahead and do an operation in that setting that we were faced with there. We had a child already in hospital, prepared for surgery. You had a child that was well at that stage, no intercurrent infections, so there is an opportunity to do it. His parents were, if you like, ready to go ahead, so there are many reasons why you would go ahead in that situation. You do not cancel operations lightly the night before, so there are positive reasons to proceed.'[44]

41 Dr Monk's note also dealt with the side-meeting. Not being present, he could not note what happened at the side-meeting, only its outcome. His note recorded:

> 'The meeting dissolved with the support for the continuation of the programme but with an awareness of the political dangers. Doctors Dhasmana, Wisheart and Martin discussed the need for the child's operation and decided that its clinical condition merited an immediate intervention and considered a delay inappropriate. This was accepted with a greater or lesser degree of happiness and conversation outside of the meeting was held between JDW, SNB and CRM regarding the representation of the Trust by SNB and the inappropriate channels of communication that the Department of Health were using.
>
> 'The meeting decided that immediate action by the Medical Director and John Roylance to contact the Department of Health to submit the figures for the paediatric programme was an absolute priority.'[45]

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[42] UBHT 0340 0350; Dr Martin's minute

[43] UBHT 0340 0350; Dr Martin's minute

[44] T77 p. 138 Dr Martin

[45] UBHT 0054 0012; Dr Monk's minute

42 In his written evidence to the Inquiry Mr Wisheart gave his account of the side-meeting:

> '… I then had a conversation with Mr Dhasmana and Dr Martin. I asked Dr Martin what his views on the urgency of the operation were. My recollection is that he said it should be carried out within a week, although his recollection is that he said it should be carried out within a month. I spoke to Mr Dhasmana [*sic*] that the circumstances of the debate and this meeting were such that there would be considerable pressure on him while undertaking the operation. He indicated, without any ambiguity, that he felt he would be able to do the operation and that this extrinsic pressure would not [be] a factor.'[46]

43 Mr Dhasmana told the Inquiry of his view of the side-meeting:

> '… I was myself quite surprised, really. Maybe Mr Wisheart would have another answer, but I was surprised that if this has been discussed in there, then why call outside?'[47]

44 Mr Dhasmana was asked by Counsel to the Inquiry whether the side-meeting may have been called because he was to be Joshua's surgeon and Dr Martin was his cardiologist and so a separate meeting with only him and Dr Martin might have been useful. Mr Dhasmana replied:

> '… there was nothing new which we mentioned there to Mr Wisheart'.[48]

45 Dr Martin told the Inquiry that he thought:

> '… he [Mr Wisheart] was concerned about the potential political repercussions if you like of it going ahead and questioned whether — there was certainly discussion as to whether that might influence Mr Dhasmana's performance in the operation and that was a concern I shared.'[49]

46 Mr Wisheart told the Inquiry of his view of the background to the discussion that took place at the side-meeting. He said:

> 'The meeting took place on a Wednesday, 11th January. Certainly on the Wednesday, possibly on the Tuesday, I had two conversations. One was with Dr Willatts[50] and one was with Dr Monk. What I remember of the two conversations, because they were both quite long and I may not remember everything, but what I do remember was what was similar in them both. What each of them represented to me was the point of view that this present difference of

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[46] WIT 0120 0457 Mr Wisheart

[47] T87 p. 68 Mr Dhasmana

[48] T87 p. 69 Mr Dhasmana

[49] T77 p. 132 Dr Martin

[50] Dr Sheila Willatts, a consultant in anaesthesia and intensive care medicine at the BRI, and consultant in charge of ICU at the BRI since 1985

opinion created an additional pressure for the people who would be caring for Joshua Loveday. On the one hand I felt the point they were making to me was a relevant and important one. I did not, as has been suggested by some, feel that it constituted a veto to the operation, I felt it was an important consideration.

'On the other hand, as a surgeon I do know that surgeons frequently have to operate under pressure of a whole variety of types. So pressure is not unusual. However, in the light of the importance of the point they had made to me I felt it was very important that I should represent that point to Janardan, to Mr Dhasmana, with Dr Martin. That is why we had the conversation. I know I made the point, and it is certainly possible that in making the point I suggested to them that the operation should be postponed, suggested how that might be done and so forth; that is certainly possible, in trying to put the point to them in a range of different ways so that I was satisfied it had been properly considered.'[51]

47 Counsel to the Inquiry explored the reasons for a possible postponement of the operation with Mr Wisheart:

'Q. If you sought a postponement or proposed that the operation should be postponed in the wording that you used to the Clinical Directors[52] [which referred to pressure on the surgeon and the surgical team], you were using as an argument, matters which had no direct bearing on the clinical needs of the patient, were you?

'A. Well, they had a direct bearing on the clinical ability of the team to provide a service to the patient.

'Q. So you queried —

'A. At least they had a potential direct bearing, excuse me.

'Q. You queried the clinical ability of the team given the circumstances?

'A. I asked the question.

'Q. That is where we come back to the semantic difference possibly between asking the question and proposing postponement.

'A. I did not just want to ask a question, get an answer and go away. I was putting it quite seriously and expecting it to be seriously considered. I think it is clear, although the recollection has escaped me, that I probably put it in a variety of

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[51] T92 p. 118 Mr Wisheart

[52] Mr Wisheart's *'Statement to the Clinical Directors of United Bristol Healthcare Trust'*, 3 June 1996, at UBHT 0054 0004 – 0008

> different ways and that this was perceived at any rate, certainly by them, possibly by me at the time, to be a proposal, an attempt to persuade them.
>
> 'Q. What did you want to achieve?
>
> 'A. I wanted to protect everybody involved from the possibility that an operation would have been carried out by somebody who was not truly fit on that day to do it.'[53]

48 Mr Wisheart continued in the following exchange:

> 'Q. Did you at the start of this conversation consider that there was a risk to the patient given the ability of the team under the pressure that they were to perform the operation?
>
> 'A. I considered there was the possibility.
>
> 'Q. Tell me, you go on in your description to the Clinical Directors to describe Dr Martin's advice.[54] How do you now recollect Dr Martin's words?
>
> 'A. In the same way.
>
> 'Q. So you saw him as saying "This operation should not be postponed for longer than a week"?
>
> 'A. Yes.'[55]

49 Mr Wisheart went on:

> '… Dr Martin joined with me in putting the question [of extra pressure affecting Mr Dhasmana's ability to work] to Mr Dhasmana once I had articulated it — Mr Dhasmana was positive that the discussion was over, that was past and it would have no impact on his ability to undertake the operation. So the subsequent discussion was pushing him and exploring that, but he remained resolute.'[56]

50 Mr Wisheart stated in his written evidence to the Inquiry:

> 'He [Mr Dhasmana] indicated, without any ambiguity, that he felt he would be able to do the operation and that this extrinsic pressure would not [be] a factor.'[57]

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[53] T92 p. 119 Mr Wisheart

[54] UBHT 0054 0007. In his '*Statement to the Clinical Directors of United Bristol Healthcare Trust'* dated 3 June 1996, Mr Wisheart stated: 'Dr Martin advised that the operation should not be postponed for longer than one week on account of the patient's severe cyanosis. When pressed he adamantly insisted that one week was the absolute maximum'

[55] T92 p. 120 Mr Wisheart

[56] T92 p. 122 Mr Wisheart

[57] WIT 0120 0457 Mr Wisheart

51 Dr Martin was asked about the degree of urgency of the operation on Joshua:

> '… I did not personally feel that was in Joshua's best interests [to delay the operation] because any further prolonged delay without any obvious gain to him in the longer run, I did not see that that was in his best interests. You know the question was whether, if you like, the political considerations should take precedence over the clinical considerations for Joshua and being one of the clinicians involved I felt that his clinical status was important.'[58]

52 Mr Wisheart said that, had Dr Martin expressed the view that the operation was urgent in that it had to be carried out within three months:

> 'I think it might have led me to prolong the conversation a little bit but I think that the essential points had been covered in the larger meeting and — I mean this was not a passing conversation, the one we are discussing, this was a 20 to 30 [minute] conversation. The points were seriously and repeatedly put and I did feel that I had received a serious answer and one that I was prepared to accept.'[59]

53 Mr Wisheart was asked whether the question of referring Joshua to a different centre was explored:

> 'It did not really impact as an issue. Had the decision been that the team were not competent to undertake the operation, then whether the operation had been needed within 24 hours or a week or whatever, the patient could have been referred. The issue in my mind was never that the patient could not be referred physically, or because of his immediate clinical need; the issue primarily was, were the team competent to undertake the operation? Then the other considerations were secondary to that.'[60]

54 Dr Martin was also asked whether there was anything which had prevented the referral of Joshua to another centre:

> 'No, I would have been quite happy referring him elsewhere, in fact we referred many patients after this to other centres, but I was basing that assessment in the letter on the group review of the figures and also of Joshua's situation which unanimously suggested it was clinically reasonable to proceed with the planned surgery. There was nothing stopping me referring him away. Mr Dhasmana could have referred him away.'[61]

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[58] T77 p. 133 Dr Martin

[59] T92 p. 127 Mr Wisheart

[60] T92 p. 123 Mr Wisheart

[61] T77 p. 136 Dr Martin. In Dr Martin's minute of the meeting he states that referral was discussed but thought to be inappropriate in Joshua's case; UBHT 0054 0013

55 Mr Wisheart was asked about his knowledge of a proposed independent review of the results of paediatric cardiac surgery:

> ‘Q. Were you the only person, do you think, at the meeting who had any inkling that Dr Roylance was minded to call for an independent [review] —
>
> ‘A.Yes, I think that is probably correct.’[62]

56 Asked why he had not told Mr Dhasmana that a review of results was in all probability imminent, Mr Wisheart replied:

> ‘… in essence I felt that that would be to add further to the pressure on Mr Dhasmana. I do not know whether that was a right judgement or a wrong judgement, but that was my recollection of what I thought at the time.’[63]

57 Mr Wisheart continued in the following exchange:

> ‘Q. Did you know at the time that had he [Mr Dhasmana] known that there was to be a review in the paediatric cardiac surgery generally, he would have chosen not to operate?
>
> ‘A. No, I did not know that.
>
> ‘Q. That might suggest he was actually quite fragile in his confidence at the time?
>
> ‘A. Yes, he has said that.
>
> ‘Q. And he is a person, is he, who is perhaps more than most self-critical?
>
> ‘A. He is self-critical, but not lacking in determination or concentration.
>
> ‘Q. Is determination sufficient, do you think, to avert some of the potential effects of the stresses?
>
> ‘A. I do not know whether it is sufficient, but it is certainly necessary. I am sure many things are necessary in order to cope with the stresses but I think determination and mental discipline is certainly one of them and I believe he showed that he had that, at least to the best of my ability to understand him, knowing him.’[64]

58 Mr Wisheart agreed with Counsel’s suggestion that perhaps Mr Dhasmana could be so keen to help his patients that he could sometimes be prone to ignore external

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[62] T92 p. 116 Mr Wisheart
[63] T92 p. 127 Mr Wisheart
[64] T92 p. 125 Mr Wisheart

pressures and think that once in the operating theatre he would be focused on the operation and nothing else:

> 'I suppose it is because of that possibility that I pursued the matter from a number of different angles with him and extended the conversation to the length it was and so I thought I was exploring that with him.'[65]

59 Counsel to the Inquiry asked Dr Martin for his view on Mr Dhasmana's state of mind:

> 'I guess it is something you are going to have to ask him, exactly what his feelings were, but the impression I gained was that he was not reluctant to proceed. I certainly did not gain that impression. He naturally listened to everyone's concerns and I think he took careful notes of what people said. I presume he was reassured by the fact that as a group we had all sat down and looked at it and felt it was appropriate for him to continue. We specifically, in that separate meeting, did discuss whether we thought, if you like, the political aspects, perhaps the implied criticism there had been, might affect his performance in theatre. That was a concern. But he assured us that that was not the case and I was happy under those circumstances to give my approval, or support him, if you like, in the decision to proceed with the operation. When it comes down to it, it has to be his decision. I cannot make him do an operation. I was concerned that we might be put in a situation where he was going into it, as you put it, reluctantly, but I did not gain the impression that was the case.'[66]

60 Mr Dhasmana described his feelings before and after the meeting, in the following exchange:

> 'Q. There must have been great pressure on you?
>
> 'A. Going into the meeting, but coming out, I felt very good, because people supported, I thought, you know, people supported me. People expressed their trust and belief in me, so I was feeling very much better.'[67]

61 Mr Dhasmana was then asked:

> 'Q. When you came out of the meeting, you knew what you had not known when you went in, that the Department of Health had been contacted; that Mr Wisheart's view was that the operation should be postponed if at all possible?
>
> 'A. It was not his view like that. He was asking the question, whether it can be postponed. I mean, that was the question and he said, you know, "Here we have in a way a loose cannon, and if the patient dies, which is possible with any cardiac

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[65] T92 p. 129 Mr Wisheart

[66] T77 p. 140 Dr Martin

[67] T87 p. 70 Mr Dhasmana

> patient, this could happen". And we felt that this was a clinical meeting and we should not really be deciding on the basis of political repercussion.'[68]

62 Mr Wisheart was asked by Counsel to the Inquiry whether he had any regrets about the fact that the operation on Joshua Loveday was neither stopped nor referred to a different centre:

> 'In the light of the outcome of the operation in relation to Joshua and in the light of all the other outcomes of the operation, it is impossible not to regret that decision. Looking back at the actual basis of the decision, I am conscious of this point that you raised about not telling Janardan of the decision to have the outside advice and of course that has been an issue elsewhere as well, but that apart, I feel that the discussion at the meeting — first of all the decision to have the meeting and the discussion at the meeting and the subsequent discussion, all those steps I felt were open and were very clear-cut in their outcome.'[69]

63 Counsel to the Inquiry asked Mr Wisheart what he meant by 'that apart':

> 'From what you tell me if that information had been made known then Mr Dhasmana — says he would have decided not to do the operation. I can say no more.'[70]

64 Joshua's parents met Mr Dhasmana on the evening of 11 January 1995. Joshua's mother stated that once again Mr Dhasmana drew a diagram for them. She stated that he quoted a success rate of 80–85% for the operation and asked them to sign a consent form. Mr Loveday signed this form. Joshua's mother stated that she was keen that they should see Joshua before he was given his pre-operative medication the next morning. She explained that she had already asked a nurse to call them before Joshua was given the medication and she confirmed with Mr Dhasmana that this would happen.[71]

65 Mr Dhasmana was asked by Counsel to the Inquiry whether he informed Joshua's parents about the meeting of clinicians which had taken place before he met them on the evening of 11 January:

> 'That is my deepest regret, really. With what happened at the end, I regret that I did not really tell them everything when I met them. I wish I had. But at that time, I just had come out from a long tiring meeting, having heard the supporting ways, and I felt quite confident that there would be no problem and this child would be moving about tomorrow or the day after, and I do believe that I felt, you know, that I would be causing more anxiety by telling them what had happened, which, in

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[68] T87 p. 70 Mr Dhasmana

[69] T92 p. 129 Mr Wisheart

[70] T92 p. 130 Mr Wisheart

[71] WIT 0417 0015 Amanda Evans

> retrospect, I accept is not right. I do regret that very sincerely and I wish I could really have told them what had happened before.'[72]

66 On the morning of 12 January Joshua's parents stayed with him until he went into the operating theatre. At that point they stated that they were advised to go out for the day and then to telephone the hospital at about 4.00 pm.[73]

67 In her written evidence to the Inquiry, Joshua's mother stated that they duly returned to the hospital at around 4.00 pm. Joshua was not out of surgery so a nurse showed them round the Intensive Care Unit (ICU), to acclimatise them to the setting that Joshua would be in on his return from the operating theatre. The nurse who was showing them around telephoned the operating theatre to find out how Joshua was progressing. She returned to tell Joshua's parents that the operation was still going on as there had been some complications. The nurse then showed them where they would be staying whilst Joshua was in the ICU.[74]

68 Joshua's mother stated that, at around 6.00 pm, the nurse who had been looking after them came into the room where they were watching television and told them that Joshua had died. The nurse sat with them both for a short time and told them that there would need to be an autopsy and an inquest.[75]

69 Joshua's mother stated that Mr Dhasmana arrived to speak to them about half an hour later. Joshua's mother described the meeting in this manner:

> 'He [Mr Dhasmana] was still dressed in his surgical green gown, and even had his white cap on; he must have walked straight over from theatre. There was blood spattered all down the front of his gown. He looked remorseful, and said, "I'm really sorry". He kept repeating, "I'm so sorry", all through the subsequent meeting with us. By this time, I could not function, let alone talk to him — I just kept saying "Oh my God, oh my God". Because this was the case, Bert talked to Mr Dhasmana, who explained that the part he had tried to fix was too small. Bert shook his hand, and said, "Thanks, mate, you've tried your best".'[76]

70 Joshua's mother stated in her written evidence to the Inquiry that, on arrival home, they telephoned the hospital and were told that Joshua would be in the Chapel of Rest and that family and friends could visit when they wanted. Joshua's parents decided to go to see Joshua the next day. They met Helen Vegoda, Counsellor in Paediatric Cardiology, who described what the Chapel of Rest would be like. After they had seen Joshua, Joshua's parents went to see Mrs Vegoda again. At this meeting she explained that they could have a meeting with Mr Dhasmana if they wished. Joshua's mother

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[72] T87 p. 89 Mr Dhasmana

[73] WIT 0417 0016 Amanda Evans

[74] WIT 0417 0017 Amanda Evans

[75] WIT 0417 0019 Amanda Evans

[76] WIT 0417 0019 Amanda Evans

stated that they felt that they had said everything they wished and, therefore, declined the offer.

71 Joshua's mother stated that a few days later she telephoned Mrs Vegoda to enquire when the inquest, which the nurse at the hospital had mentioned, would be taking place. Joshua's mother stated that, in reply, Mrs Vegoda told her that there would not be an inquest and that she and Joshua's father:

> '… had received all the investigative care to which [they] were entitled.'[77]

72 Mrs Vegoda, commenting on this, stated:

> 'I cannot recall such a telephone conversation but it was not uncommon for bereaved parents to see me, as a first point of contact after a bereavement, … I would never have dismissed a parent's query regarding a post mortem or inquest … I most certainly would never have suggested that a family were not entitled to any investigation they felt were [*sic*] appropriate.'[78]

73 A coroner's post-mortem was carried out on Joshua on 13 January 1995.[79] The post-mortem report described Joshua's condition up to the point of his admittance to the BRI on 10 January 1995. The report described how, during the operation on 12 January 1995, the pulmonary banding, which Mr Dhasmana had inserted on 2 July 1993, was removed after heart-lung bypass was established. After this procedure was carried out the repair of the transposition of the arteries was attempted.[80] The post-mortem report stated:

> 'The pulmonary artery was transected just below the band and the two coronary arteries implanted in the pulmonary artery. The right coronary artery appeared rather taut at this stage.'[81]

74 It was later noted in the post-mortem report that:

> 'It was realised that the right coronary artery was very taut … . An attempt was made to mobilise the right coronary artery but this caused injury to the main artery, and it was then decided to re-implant the right internal mammary artery to the right coronary artery at the site of the injury … right ventricular function did not show improvement.'[82]

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[77] WIT 0417 0021 Amanda Evans

[78] WIT 0417 0027 Mrs Vegoda

[79] MR 0164 0021; Medical Records of Joshua Loveday

[80] See Chapter 3 for an explanation of these clinical terms

[81] MR 0164 0022; Medical Records of Joshua Loveday

[82] MR 0164 0022; Medical Records of Joshua Loveday; see Chapter 3 for an explanation of these clinical terms

75 In his letter to Joshua's GP, after Joshua's death, Mr Dhasmana explained:

> 'This was a rather tricky anastomosis as both of these vessels were very small, less than 1mm in diameter.'[83]

76 After examining the body, Dr Michael Ashworth, the consultant paediatric pathologist, stated:

> 'The abnormalities present were complex and the surgery complicated by difficult coronary artery transfer.'[84]

Further events in January

77 On 16 January 1995, Dr Doyle wrote an internal memorandum to Dr Graham Winyard, Deputy Chief Medical Officer, and Dr Gabriel Scally, Director of Public Health, South & West NHS Executive. The memorandum was entitled 'Paediatric Cardiac Surgery: Bristol Royal Infirmary'. In the memorandum Dr Doyle described how Professor Angelini had approached him about concerns over paediatric cardiac surgery at the BRI. Dr Doyle explained that Dr Bolsin contacted him on 11 January 1995 to inform him that a 'Switch' operation had been listed for the following day. Dr Doyle stated that he advised Dr Bolsin to discuss the matter with Professor Angelini and Dr Bolsin's anaesthetic colleagues and, if enough of them agreed that the operation should not take place, to:

> '… make every effort to persuade their colleagues to postpone the operation and/or make arrangements for the operation to be done at another centre.'[85]

78 In the memorandum, Dr Doyle also indicated that the operation had taken place and that Mr Wisheart had telephoned him to inform him of the outcome:

> 'This has been a difficult and traumatic episode for all concerned. There will doubtless be a good deal of heart searching among those involved and a lot of questions have been raised. Perhaps the first question is whether the death was avoidable? We may not know the answer to that question for some time (if ever?). If it was, where does the blame lie? What could/should have been done? Possibly most importantly, how can differences of professional opinion or interpretations of audit data, be resolved without putting patients at risk? It would seem that we need a well recognised and acceptable mechanism for getting independent advice on such difficult questions.'[86]

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[83] MR 0164 0019; Medical Records of Joshua Loveday

[84] MR 0164 0028; Medical Records of Joshua Loveday

[85] DOH 0001 0009; memorandum dated 16 January 1995

[86] DOH 0001 0010; memorandum dated 16 January 1995

Dr Doyle's memorandum concluded:

> 'I have spoken to Dr Roylance (Trust CE) today who assures me that he is setting up an immediate internal enquiry to establish the facts followed by an independent enquiry using outside experts (cardiothoracic surgeons). I expect to hear the results in due course including any recommendations for the future conduct of paediatric CT [cardiothoracic] service in Bristol. I do not believe any further action is required at present but am happy to be advised by yourself or copyees.
>
> 'One other general point is whether we should consider initiating discussions with the profession about mechanisms for resolving professional differences without putting patients at risk.'[87]

79 Mr Wisheart stated in his written evidence to the Inquiry:

> 'We [he and Dr Roylance] made the decision to seek external advice to help the Trust resolve internal differences of opinion. There is uncertainty as to whether we made that decision before or after the meeting of the 11 [January 1995].'[88]

80 Dr Bolsin stated in his written evidence to the Inquiry:

> 'A meeting took place between at least one senior civil servant from the Department of Health, [Dr] Peter Doyle, Dr Roylance and senior Trust officials in Bristol. My understanding of this meeting was that the Trust was now required to undertake an investigation into paediatric cardiac surgery and abide by the findings and recommendations of the investigators.'[89]

81 Professor Angelini described in his written evidence to the Inquiry what he saw as:

> '… a general unwillingness from any quarter to draw in anybody from outside to give us an honest opinion of what we were doing, and indeed it was only after the death of Joshua Loveday that Dr Roylance sought external advice.'[90]

82 On 16 January 1995 Professor Angelini wrote to Dr Roylance:

> '… it is sad that we have failed to resolve the issue of paediatric cardiac surgery work internally. In view of this, I share your opinion that an enquiry should be held on the paediatric work carried out in the Department of Cardiac Surgery from 1988 to the present day. I think this is the minimum requirement, given the recent circumstances … .'[91]

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[87] DOH 0001 0010 – 0011; memorandum dated 16 January 1995

[88] WIT 0120 0457 Mr Wisheart

[89] WIT 0080 0126 – 0127 Dr Bolsin

[90] WIT 0073 0018 Professor Angelini

[91] UBHT 0217 0138; letter dated 16 January 1995

83 Professor Angelini was asked by Counsel to the Inquiry in the following exchange whether the letter of 16 January showed that he knew, or thought, that Dr Roylance had by then decided upon an inquiry:

> 'Q. So Dr Roylance had by this stage decided there should be an enquiry, had he not?
>
> 'A. No, he had not.
>
> 'Q. That is what the letter said?
>
> 'A. It was me putting words in his mouth to force his hand, to have the enquiry … This is the reason why I cc'd it to everybody, because I was hoping that now, forcing his hand, he could not wriggle out once more and perhaps we now were going to have a really proper look at the results of paediatric surgery.'[92]

84 In his written evidence to the Inquiry, Mr Alan Bryan, a consultant cardiac surgeon at the BRI, described the decision to commission the inquiry as 'good' but 'belated'. He considered that the decision was 'a response to crisis'.[93]

85 On 19 January Professor Vann Jones, Clinical Director of Cardiac Services, wrote to all the cardiac surgeons, stating:

> 'Dr Roylance has requested that I call a meeting between all the Cardiac Surgeons, myself and himself to discuss the present situation with regard to the "Switch" operations. I would be very grateful if you could make every effort to attend as this is a matter that has to be clarified once and for all.'[94]

86 Professor Vann Jones wrote again to his colleagues on 23 January 1995 stating:

> 'I was dismayed at the meeting of the Cardiac Surgery Associate Directorate last Tuesday to find how divided and acrimonious the atmosphere is in Cardiac Surgery. I was also sorry to hear and indeed to see how our colleagues in less favoured positions in the directorate are being abused. I don't think we should be bandying terms like "disloyalty" or "lack of co-operation" about. I also thought it was distressing to see the Perfusionist so interrupted that he couldn't get a word in edgeways particularly as the person berating him didn't even turn around to face him.
>
> 'I am not trying to single out any individual for particular attention but surely we can take steps to make these meetings more constructive and much less acrimonious. Giant steps have been taken to improve the profile of Bristol Cardiac Services in the past decade and it really is sad to see the way the present situation is

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[92] T61 p. 193 Professor Angelini

[93] WIT 0081 0028 Mr Bryan

[94] UBHT 0061 0255; letter dated 19 January 1995

> developing. I hope once again we can get the whole thing on amicable terms and if there has to be some straight talking let's not air our views quite so publicly.'[95]

87 In his written evidence to the Inquiry, Dr Doyle stated that he spoke to Dr Roylance and Mr Wisheart after the operation on Joshua Loveday and:

> '… advised that an outside independent inquiry into both the immediate case and the wider issue of the overall results of the paediatric cardiac surgical service was now essential.'[96]

88 Dr Doyle wrote a further internal memorandum on 24 January 1995 addressed to Dr Winyard and Dr Scally. In this memorandum he further updated his colleagues on the situation developing in Bristol:

> 'It is still not clear whether there is a serious problem with cardiac surgery or whether this is a serious breakdown in professional relationships. There is cause for grave concern that the Trust has not taken action to resolve the problem; that children's lives might have been put at risk and that rumour and innuendo have been allowed to spread apparently unchecked.'[97]

The memorandum continued:

> 'I spoke to Dr Roylance (Chief Executive) this morning and advised him in the strongest possible terms to stop complex neonatal and infant cardiac surgery forthwith and to expedite the proposed Enquiry that we discussed the previous Monday. … I also advised Dr Roylance that yourself and other colleagues in the Department now had to be informed of the situation.
>
> 'You will see from this that I have informed Secretary of State's office, Press Office and CA-IU [Corporate Affairs-Intelligence Unit] in case the story leaks to the media. I am not sure whether further action is required at present but am happy to be advised by you or copyees.
>
> 'Suggested line to take if required.
>
> 'We are aware that concern has been expressed about the neonatal and infant cardiac surgical services at Bristol Royal Infirmary. We do not know at present whether there is any basis for the concerns but have advised the Trust to set up an immediate Enquiry and to cease complex neonatal and infant cardiac surgery until the facts have been established.'[98]

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[95] UBHT 0082 0083; letter dated 23 January 1995

[96] WIT 0337 0003 Dr Doyle

[97] DOH 0001 0015; memorandum dated 24 January 1995

[98] DOH 0001 0015 – 0016; memorandum dated 24 January 1995

89 On 25 January 1995, Dr Doyle wrote once more to Dr Roylance:

> ‘There is clearly a growing belief that childrens’ [*sic*] lives may have been put at unnecessary risk. Until such doubts can be resolved, it would be extremely inadvisable to undertake any further neonatal or infant cardiac surgery.
>
> ‘I recognise that this is a very difficult situation for all concerned. The doubts raised can only be resolved by an impartial enquiry and I feel sure that everyone would benefit from disinterested and objective advice. I would therefore suggest that you take all reasonable steps to expedite the proposed Enquiry.
>
> ‘As you will appreciate, I will have to inform colleagues in the Department about the circumstances as they are currently known to me. I should be grateful if you would let me know as soon as possible of any additional facts that you feel are relevant and what you decide to do. I also expect to be informed, in confidence, of the outcome of the enquiry as soon as they are available.’[99]

90 Dr Roylance replied to Dr Doyle’s letter on 26 January 1995.[100] In his letter, Dr Roylance confirmed that the UBHT had ceased to perform complex neonatal and infant cardiac surgery, although he indicated that the UBHT reserved the right to perform such surgery in an emergency if it was in the best interest of the patient to do so. Dr Roylance also confirmed that the Trust was in the process of appointing outside experts to lead an inquiry into its paediatric cardiac surgery service. Dr Roylance indicated that Professor Marc de Leval[101] had already accepted an invitation to be one of the outside experts. Dr Roylance went on to express concern to Dr Doyle over the way in which the matter had come to Dr Doyle’s attention:

> ‘… this matter has developed, apparently on the basis of views or whispers by “staff of the Bristol Royal Infirmary and outside Cardiac Surgeons”. We do not know whether any facts are on your table. We have had no opportunity to inform you of the results of our work which we are always ready to do, and which was done annually in the context of being a supra-regional centre between 1984 and 1993. Yet we now find ourselves with no practical alternative to a temporary stoppage of infant work following your letter.’[102]

91 Mr Wisheart described in his written evidence to the Inquiry the action taken, once it was decided to set up an external inquiry:

> ‘Dr Roylance asked me as Medical Director to take the initial steps in setting up the enquiry. I sought the advice of Mr John Parker, who is now deceased, but was then

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[99] UBHT 0061 0282 – 0283; letter dated 25 January 1995

[100] PAR2 0001 0026 – 0027; letter dated 26 January 1995

[101] Professor Marc de Leval: consultant paediatric surgeon, Professor of Cardiothoracic Surgery, Great Ormond Street Hospital

[102] PAR2 0001 0027; letter dated 26 January 1995

> President of the British Cardiac Society. He advised me to approach Mr de Leval and Dr Hunter.'[103]

92 Professor Marc de Leval and Dr Stewart Hunter[104] were invited by Mr Wisheart to:

> '… assist us resolve some problems arising out of the fact that we are receiving conflicting professional advice in the field of paediatric cardiac surgery. The Trust is committed to the maintenance of the highest standards in this field and now ask you for your authoritative and disinterested advice. The conflicting advice has arisen in the area of the Switch operation for neonates, but has now broadened beyond that.'[105]

93 Professor de Leval explained in his written evidence to the Inquiry:

> 'I was contacted by Mr James Wisheart in his capacity of Medical Director at UBHT to assist them in resolving some problems in the field of paediatric cardiac surgery … We were urged to visit UBHT as soon as possible and to issue a report without delay.'[106]

February

94 Dr Doyle wrote to Dr Roylance on 3 February 1995:

> '… I and my colleagues are content for the Trust to act in the way agreed during our recent telephone conversation based on the advice offered by the President of the British Cardiac Society. It was agreed that at least two, and preferably three, outside advisors should be invited to look into the situation and offer advice. I was pleased to hear [that] Marc de Leval has already agreed to help.'[107]

95 Rachel Ferris, General Manager of the Directorate of Cardiothoracic Services at the BRI from 1994, stated in her written evidence to the Inquiry:

> 'My impression in late 1994 early 1995 was that the Chief Executive, … Dr John Roylance responded dismissively to the concerns raised with him. He appeared to protect Mr Wisheart, even to the extent of allowing him to organise the Marc de Leval visit himself which I believe was inappropriate.'[108]

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[103] WIT 0073 0108 Mr Wisheart

[104] Dr Stewart Hunter: consultant in paediatric cardiology, Academic Department of Cardiology, Freeman Hospital, Newcastle upon Tyne

[105] UBHT 0061 0337; letter from Mr Wisheart dated 25 January 1995

[106] WIT 0319 0001 Professor de Leval

[107] UBHT 0061 0286; letter dated 3 February 1995

[108] WIT 0089 0105 Mrs Ferris

96 Professor Angelini in his written evidence to the Inquiry stated:

> '… this culture of keeping everything under control remained, and Mr Wisheart was, I believe, put in charge of organising the external enquiry on his own practice.'[109]

97 Dr Roylance, when asked by Counsel to the Inquiry who organised the visit, told the Inquiry:

> 'Primarily, the visitors. I gave them full authority to ask for anything and guaranteed the Trust would provide them. I sent them off, I am fairly sure, with this manager as a sort of guide so they did not get lost.'[110]

98 Mr Wisheart stated that his part in the inquiry was:

> '… limited to the initial approach to Mr de Leval and Dr Hunter, acting on the advice of the President of the British Cardiac Society … Mrs Ferris … describes how she arranged the venue, the programme and the people who should attend … .'[111]

99 Mrs Ferris was responsible for making the logistical arrangements necessary for Professor de Leval and Dr Hunter to visit Bristol. She told the Inquiry that '… it was all arranged in a rush.'[112]

100 Mr McKinlay, Chairman, UBHT, from July 1994 to November 1996, commented on the arrangements for the conduct of the review in the following exchange:

> 'I actually thought at the time there would be a button you could press in the National Health Service which was marked "investigation" and the procedures would follow and I thought that something fairly normal would be put in place. I did not interfere with how the inquiry would be set up.
>
> 'Q. You thought that somewhere in the Health Service there would be an investigative unit, something of that sort?
>
> 'A. Not necessarily an investigative unit. I think I knew enough then that that was possibly unlikely. But there would be an accepted procedure.'[113]

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[109] WIT 0073 0018 Professor Angelini

[110] T89 p. 76 Dr Roylance

[111] WIT 0089 0114 Mr Wisheart

[112] T87 p. 167–8 Mrs Ferris

[113] T76 p. 67–8 Mr McKinlay

101 Dr Hunter and Professor de Leval spent one day visiting Bristol. Professor de Leval stated:

> 'We were urged to visit UBHT as soon as possible and to issue a report without delay. I made it clear that I had booked one week's holiday from 11.2.95 and that if the visit to UBHT had to take place before I went away I could come only on 10.2.95. This was found to be acceptable.'[114]

102 Dr Hunter told the Inquiry:

> '… basically if we were going to be able to do anything significant in the time which we were being given … it is a continuing problem that I have just been through in another centre recently, where you are asked for very important decisions and to do very detailed examination of facts in a very short time. I think the sort of gun that was pointed at our heads was that it was critical and crucial to know whether the surgery should continue, or whether the decision had to be made that it should be referred elsewhere before Mr Pawade arrived.'[115]

103 The experts' remit was recorded in the first version of their report as follows:

> 'To advise the Trust on the best action to take following recent recommendations received by the Department of Health to stop complex neonatal and infant open-heart surgery.
>
> 'To make recommendations on the future of the paediatric cardiac services in the Trust.'[116]

104 In the second version of the report, the reference to the DoH's recommendations was omitted. In this version of the report, the remit of the review was expressed as:

> 'To advise the Trust on the best action to take to resolve conflicting professional advice in the field of paediatric cardiac surgery in general and, in particular, complex neonatal and infant open-heart surgery'.[117]

105 Dr Hunter's contemporaneous notes of the visit recorded that:

> 'Dr Roylance offered carte blanche in the investigation and stated his concerns about the service and also about professional loyalty in some members of staff involved in the dispute.'[118]

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[114] WIT 0319 0001 Professor de Leval

[115] T60 p. 127–8; Dr Hunter. Mr Ashwinikumar Pawade, consultant paediatric cardiac surgeon, BRHSC (1 May 1995–)

[116] UBHT 0052 0263; first version of the Hunter/de Leval report

[117] UBHT 0061 0378; revised draft of the Hunter/de Leval report; (the differences in the two versions of the remit are considered later in this chapter)

[118] WIT 0319 0013; Dr Hunter's notes

He told the Inquiry that Dr Roylance '… was very general in saying he wanted us to have free access to whatever information we wished … .'[119]

106 Dr Roylance, in his written evidence to the Inquiry, stated that he '… wanted Mr de Leval and Dr Hunter to be completely frank (and blunt, if necessary) in their report … .'[120]

107 Dr Roylance told the Inquiry that when speaking to Dr Hunter and Professor de Leval at the outset, he told them that there were:

> '… three things [he needed] to know: first of all, is it right that the appointment of the paediatric cardiac surgeon is a proper solution to the problem? … Secondly, is moving up the hill [to the BRHSC] proper? Thirdly, what should the Trust, the service, do between the time of them reporting and the arrival of Ash Pawade?'[121]

108 Professor de Leval recalled Dr Roylance's alluding to:

> '… the difficulty of Mr Wisheart's position being on the one hand investigated in this particular problem, and at the same time, being Medical Director. … He explained to us that there had been complaints about the results of cardiac surgery and that he wanted to have an outside opinion … and asked again that [the] report be issued with the shortest possible delay … .'[122]

109 Mrs Ferris stated that she accompanied Professor de Leval around the Trust on the day of his visit. She stated that Professor de Leval took the opportunity of asking her whether she thought there were any problems with paediatric cardiac surgery, to which she replied that she did not think so. She was asked about this reply by Counsel to the Inquiry:

> 'Q. … did you think there were any problems with paediatric cardiac surgery as at 10th February 1995?
>
> 'A. I really think my answer at that stage would be, "I do not really know, but perhaps possibly I think there may be something to this". That was the view I was starting to form, and really around that visit, so when I said "No, I do not think so", I was not being absolutely straight with him.

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[119] T60 p. 128 Dr Hunter
[120] WIT 0108 0130 Dr Roylance
[121] T89 p. 75 Dr Roylance
[122] T60 p. 17–20 Professor de Leval

> ‘Q. If in fact you thought that the true answer was, “I do not really know but there might be”, to say “I do not think so” gave a false impression to Mr de Leval of your true feeling?
>
> ‘A. Yes, it did, and I obviously regret having given him the false impression. I was very worried that this had been presented to me as something that came about as a result of troublemaking and I think at the same sort of time, when I was advised about this, although we were having external advisers coming in, there was this sense that I had that this was something we did not want to be dealt with outside of the Trust.’[123]

110 Mrs Ferris also stated that she saw Dr Roylance on the day of the visit. She recalled that she:

> ‘… walked over to Trust Headquarters with [him]. He made some comment that he “should not really have let James organise the day”, but thought “it might be good for him”. He gave the impression of treating the whole day very casually.’[124]

111 Dr Roylance denied making such a comment to Mrs Ferris:

> ‘… that is quite wrong … I would not have discussed, with her, the review … . I certainly would not have said to her that it might be good for him.’[125]

112 Mrs Ferris in her written evidence to the Inquiry stated:

> ‘I recall, probably towards the end of February [or] the beginning of March 1995 (but I cannot be precise about the date), Mr Wisheart asked me to come into his office, to discuss his figures. I felt intimidated by this request and during the meeting itself. Mr Wisheart gave the impression that he had heard I had been asking questions, and wanted to put me right. I could tell that Mr Wisheart was angry because he was so quiet and controlled. He spoke slowly. I felt I was being “warned off” and that Mr Wisheart felt I had no role in a discussion of clinical outcomes.’[126]

113 Mr Wisheart was questioned by Counsel to the Inquiry about the meeting in the following exchange:

> ‘Q. … Did a meeting to that effect happen?
>
> ‘A. It may have done, I do not have a precise recollection of the details of such a meeting; I have a vague recollection that we had such a conversation, that is all.

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[123] T87 p. 171–2 Mrs Ferris
[124] WIT 0089 0099 Mrs Ferris
[125] T89 p. 76 Dr Roylance
[126] WIT 0089 0100 Mrs Ferris

> 'Q. Mrs Ferris gives a description here of you wanting to put her right and her description of your being angry because you were quiet and controlled and feeling that she had been warned off; do you recognise yourself in that?
>
> 'A. I was quite confused by that sentence, I was not really sure how much was fact, how much was interpretation and how much was accurate.'[127]

114 Dr Hunter and Professor de Leval stated that they met many of those involved in paediatric cardiac surgery for interview and discussion. They stated that the cardiac surgeons produced the detailed results of the neonatal Switch; and mortality data relating to closed-heart surgery during the period 1990 to March 1994 and, in respect of open-heart surgery, from January 1992 to January 1995.[128] Dr Bolsin stated in his written evidence to the Inquiry that, when he met them, he provided Dr Hunter and Professor de Leval with the 'best evidence' he had, which included:

> '1. The Bolsin/Black data collection and analysis.
>
> '2. The most complete record for the arterial switch available.
>
> '3. My data on neonatal and non-neonatal arterial switch record.
>
> '4. The unit's data from the annual report of 1990–91.'[129]

115 Dr Hunter stated that the fact that two sets of data covering different periods of time were produced was confusing.[130]

116 Dr Bolsin stated in his written evidence to the Inquiry that he faced a 'tirade of hostile questions'[131] from Professor de Leval in relation to the data he presented. He was asked about this in the following exchange:

> 'Q. You talk about a "tirade of hostile questions" from Mr de Leval?
>
> 'A. Yes.
>
> 'Q. Was it all like that?
>
> 'A. No, no, it was just this very early bit and when I went through my explanation that the bit that seemed to have got him worked up was actually not my data, that was data produced within the unit by Mr Wisheart, he suddenly changed, he changed his whole effect completely.'[132]

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[127] T94 p. 128–9 Mr Wisheart
[128] WIT 0322 0005 Dr Hunter, WIT 0319 0002 Professor de Leval
[129] WIT 0080 0127 Dr Bolsin
[130] WIT 0322 0005 Dr Hunter
[131] WIT 0080 0127 Dr Bolsin
[132] T83 p. 126 Dr Bolsin

117 Dr Hunter stated in his written evidence to the Inquiry:

> 'Those who initiated the auditing activities gave the impression that they were intent on policing the surgical activities rather than working together to see a solution. The figures presented by Dr Bolsin were incomplete and failed to give a total view of the problem. There was in general a lack of understanding of the problems of paediatric cardiac surgery.'[133]

118 Professor de Leval told the Inquiry:

> 'What I recollect is that during the meeting there was a sense of conflict which was present there and I think the way Dr Bolsin presented his data or the calendar of events was conflictural. Obviously it is difficult to blame someone, to adopt that attitude knowing what he had done for several years to try to solve the problem.'[134]

119 Dr Hunter's notes record discussions with Mr Dhasmana and Mr Wisheart.[135] They indicate that discussion took place about the impending move of the paediatric cardiac surgery department to the BRHSC and the arrival of the new surgeon, Mr Pawade. There was also discussion of the Switch programme at Bristol and the results which had been achieved.

120 Dr Hunter and Professor de Leval stated that they also interviewed the cardiologists Dr Martin and Dr Hayes (Dr Joffe was on holiday at the time), although it was not clear from their notes whether they saw the cardiologists at the same time as they saw Mr Wisheart and Mr Dhasmana, or whether they were seen separately. Dr Hunter told the Inquiry that he thought that they were seen separately but added that the Inquiry may have information to the contrary.[136] Dr Martin also was not sure:

> 'My general feeling was that we had met separately, but whether that is correct or not, I do not know.'[137]

121 Dr Hunter told the Inquiry that, having spoken to the cardiologists, he formed the view that there was:

> '… a general support for the attempts by Mr Dhasmana and concern that he was having problems with the switch. … I think they were generally supportive of their colleagues and worried about the effect of surgery, obviously, and where they should go from there.'[138]

122 Professor de Leval and Dr Hunter saw various other staff over the course of the day.

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[133] WIT 0322 0006 Dr Hunter

[134] T60 p. 30 Professor de Leval

[135] WIT 0319 0014 – 0015; Dr Hunter's note

[136] T60 p. 139–40; the Inquiry did not have information to the contrary

[137] T77 p. 79 Dr Martin

[138] T60 p. 141–2 Dr Hunter

123 Professor de Leval stated that Dr Stephen Pryn, consultant intensivist, felt the:

> '… surgical results were suboptimal but deplored the lack of hard data to prove it.'[139]

124 Dr Pryn told the Inquiry:

> '… It frustrated me that people were having these grumbling conversations without any data to go with it, and the night before the meeting with Marc de Leval was the first time I had seen those results … I was frustrated that we could not move the unit forwards in a constructive way.'[140]

125 Professor de Leval stated that Sister Fiona Thomas, the Clinical Nurse Manager, expressed concerns to him and Dr Hunter about the post-operative care of patients who had undergone paediatric cardiac surgery, and told them that there were 'considerable conflicts between surgeons and anaesthetists and a lack of expertise for children.'[141]

126 Professor de Leval told the Inquiry that he formed the impression from talking to Sister Thomas that:

> '… the decision-making [in intensive care] was highly disorganised … There was a complete lack of cohesion in the management of those patients. Nobody knew who was in charge of the patients.'[142]

127 Both of the visiting experts stated that they found Dr Monk, the Clinical Director of Anaesthesia, to be '… one of the most lucid and logical of the people they met during the visit.'[143] Professor de Leval told the Inquiry that he was impressed by Dr Monk's overall view of the problem, which went wider than the conduct of surgery to cover the overall management of the patient.[144]

128 Dr Hunter told the Inquiry that he thought that Professor Angelini's attitude would '… not have made the department a happier place to work in, and would not have been conducive to healing and improving matters.'[145] Professor de Leval commented that Professor Angelini:

> '… had reached a stage of being rather aggressive vis-à-vis the other two surgeons … . I felt that he was rather hostile and aggressive … .'[146]

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[139] WIT 0319 0003 Professor de Leval
[140] T72 p. 120 Dr Pryn
[141] WIT 0319 0003 Professor de Leval
[142] T60 p. 39 Professor de Leval
[143] WIT 0319 0017; Dr Hunter's note
[144] T60 p. 44 Professor de Leval
[145] T60 p. 144 Dr Hunter
[146] T60 p. 111 Professor de Leval

129 Professor de Leval accepted that Professor Angelini's attitude could have been 'just an indication of desperation' on his part.[147]

130 At the end of the day's visit an open meeting was held. Mr Wisheart told the Inquiry:

> '… The only comment I can make is that that was the meeting at which it emerged for the first time, to me, that Dr Bolsin had undertaken an audit, and that he had given it to Dr Hunter and Mr de Leval, and I am not always good at concealing my feelings, and it is quite possible that my body language was visible on that occasion. I mean, I was absolutely shocked; profoundly shocked.
>
> 'Q. Just shocked?
>
> 'A. Yes.
>
> 'Q. Angry?
>
> 'A. Well, I expect so.'[148]

131 Professor de Leval and Dr Hunter set out a number of preliminary conclusions arising from their visit, including:

> '… A major review of post-operative care was needed. The chain of command in the existing intensive care unit was hopelessly vague. … Better communication and trust between the various parts of the service was essential to solve the problems existing and to heal the serious divisions that had arisen. … A monthly morbidity and mortality conference attended by all parties where results, policies and practices would be openly discussed within the department … The critical factor in solving the overall problem was the appointment and imminent arrival (April 1995) of a new surgeon with a proven track record in a major centre.'[149]

132 Professor de Leval was asked about the methods he and Dr Hunter had used in the following exchange:

> 'Q. How confident are you, or how happy are you, with the method of investigation that you were obliged to adopt as a means of reaching a conclusion upon the adequacy of care at the Unit?'
>
> 'A. I think that the report was carefully written. I think that the report indicated its weaknesses and the report mentioned the fact that the investigation should go well beyond the surgeons but through the systems. I think that was in the initial report. So I do not think that the report was misleading or that the report did not achieve what it had to do; I believe that the report provided some information which could

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[147] T60 p. 111 Professor de Leval

[148] T94 p. 163 Mr Wisheart

[149] WIT 0322 0006 – 0007 Dr Hunter

> have been useful for the Chief Executive to investigate further, to try to have a better understanding of what was happening and what had to be done.'[150]

133 Professor de Leval told the Inquiry that he recognised that reports were:

> '… as robust or as weak as the data we received to make the report. We certainly agreed that there was a problem. We commented on ways to alleviate some of those problems and make recommendations for the future based on the decision that the Trust had already made when we visited them. But I think that the strengths or weaknesses of the report is parallel or relates to the strengths or weaknesses of the data we had.'[151]

134 Professor de Leval stated in his written evidence to the Inquiry that there was:

> '… no evidence that the data collection had been validated. We did not have any form of risk stratification and we did not have the figures of the other UK units for comparison. With hindsight one could argue that it was unwise to produce a report based on such weak data.'[152]

135 Professor de Leval told the Inquiry:

> 'I think that the lack of a statistician is a deficiency of the report. There is more than that. I think that first of all the data we were presented with were deficient themselves, and I think that a statistician is as good as the data you provide to the statistician. I think that the deficiency was the weakness of the data and the pressure of time which just made it impossible to have good data. I do not disagree that a statistician would have been much more demanding than we were to produce a report, and any competent statistician would have simply refused to comment on this … .'[153]

136 Professor de Leval explained:

> 'It was quite clear from Dr Bolsin's interview and from the head of anaesthesiology [Dr Monk], that they had great difficulties to obtain the results. It was, I think, clear also that when they met in 1993, the surgeons made a statement which was not supported by data and that a number of the people we had seen on that particular day in February had been presented with the surgical results for the first time, so there was an obvious reticence from the surgeons … .'[154]

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[150] T60 p. 28–9 Professor de Leval
[151] T60 p. 96 Professor de Leval
[152] WIT 0319 0002 Professor de Leval
[153] T60 p. 5–6 Professor de Leval
[154] T60 p. 59 Professor de Leval

137 Professor Angelini stated in his written evidence to the Inquiry:

> 'I never received from Mr Dhasmana or Mr Wisheart specific data relating to their individual surgical performance. The first time I was provided with a full picture of results was literally half an hour before I was invited to speak to Mr de Leval and Dr Hunter on their visit to Bristol. … I had no way of verifying whether the data were correct … .'[155]

138 Commenting on Professor Angelini's observation, Mr Dhasmana told the Inquiry:

> '… he would have seen it [the data] for the year 1993/94. … The copy of annual unit returns to the Society's Annual Cardiac Register was regularly circulated to him along with other consultant members of staff. He never asked me for the surgeon specific figures and also never showed me the data provided by Dr Bolsin.'[156]

139 Dr Martin told the Inquiry:

> 'I did not get the impression that they [Mr Dhasmana and Mr Wisheart] were reluctant to reveal their figures … My perception was that the surgeons were analysing their own results.[157]

140 Dr Joffe, when asked by Counsel to the Inquiry about the comment in the Hunter/de Leval report that the surgeons were reticent in producing their results, told the Inquiry: 'It was not [the cardiologists'] experience. We always had access to those results … .'[158]

141 Dr Hunter told the Inquiry that he remembered 'a number of people saying to us that they had not been aware of the surgical data until literally a few days before, or shortly before'[159] his and Professor de Leval's visit.

142 Mr Wisheart stated in his written evidence to the Inquiry that the more detailed material was not provided to other clinicians until shortly before the arrival of Dr Hunter and Professor de Leval because:

> 'In less than two weeks and in addition to our regular commitments we had to (1) prepare the summarised results for 1992–95 and (2) complete a data sheet for each of 450 open-heart procedures carried out during those years.'[160]

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[155] WIT 0073 0010 Professor Angelini
[156] WIT 0073 0059 – 0060 Mr Dhasmana
[157] T77 p. 4 Dr Martin
[158] T90 p. 123 Dr Joffe
[159] T60 p. 147 Dr Hunter
[160] WIT 0073 0097 Mr Wisheart

143 Dr Monk, who had been aware of Dr Bolsin's audit from September 1993,[161] told the Inquiry about attempts to establish its meaning:

> 'The final meeting … was just preceding the de Leval/Hunter external audit. Even at that stage we had still not sat down with Dr Bolsin and said: "What about this data?" We held that meeting and he did not come. So even when I went in to see de Leval and Hunter, we still did not have a joint opinion amongst the Cardiac anaesthetists of what the data actually meant, nor, as a group, what we should be doing about it.'[162]

The first version of the Hunter/de Leval report

144 The full text of the first version of the Hunter/de Leval report was as follows:

> '**VISIT OF CARDIAC SERVICES DIRECTORATE OF THE UNITED BRISTOL HEALTH CARE NHS TRUST. FRIDAY, 10 FEBRUARY 1995**
>
> 'REMIT OF THE VISIT
>
> 'To advise the Trust on the best action to take following recent recommendations received by the Department of Health to stop complex neonatal and infant open-heart surgery.
>
> 'To make recommendations on the future of the paediatric cardiac services in the Trust.
>
> 'PROGRAMME OF THE VISIT
>
> 'Following a welcome meeting by the Chief Executive, Dr Roylance, who briefly outlined the problem, we met first the two paediatric cardiac surgeons, Mr Dhasmana and Mr Wisheart, who were then joined by two of the paediatric cardiologists, Dr Martin and Dr Hayes. We then met Dr Bolsin, consultant anaesthetist, Dr Monk, clinical director of anaesthesia, Sister Thomas, clinical nurse manager, and Professor Angelini, Professor of department of cardiac surgery. After lunch we met Dr Hughes, clinical director, and Mr Barrington, general manager, of the Bristol Children's Hospital, and then we met Dr Brynn [*sic*], consultant anaesthetist. The visit was closed by a general meeting that attempted to put forward a satisfactory proposal for the immediate future.

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[161] WIT 0105 0020 Dr Monk

[162] T73 p. 123–4 Dr Monk

‘CURRENT PAEDIATRIC CARDIAC SERVICES

‘Paediatric cardiac services are currently provided on the two sites, the Bristol Children’s Hospital and the Royal Infirmary. The paediatric cardiology services are in the Children’s Hospital where closed-heart surgery is performed. Open-heart surgery is carried out at the Royal Infirmary. The operations are done by two surgeons, Mr Wisheart and Mr Dhasmana. The latter seems to have taken over the greater bulk of the paediatric practice. Anaesthesia is provided by three anaesthetists working on both sites. The postoperative care in the Children’s Hospital is done by the surgeons, supported by paediatricians, cardiologists and anaesthetists. The junior staff on site is a paediatric SHO. At the Royal Infirmary the postoperative management is dealt with by the cardiac surgical team (adult) and the anaesthetic team. The person on site on a 24-hour basis is a surgical SHO. During the daytime there are currently two or three anaesthetic sessions which are dedicated to postoperative care. The paediatric cardiologists help with the postoperative management of the children at the Royal Infirmary. The overall postoperative management at the Royal Infirmary appears to be highly disorganised with conflicting decisions between the surgical senior registrar and the SHO who do rounds at 8.00 am, the anaesthetists who see the patients at 9.00 am, and the intensivists who work three days a week.

‘BACKGROUND OF CURRENT PROBLEM

‘From 1989 concerns about the surgical results of the paediatric cardiac surgeons have been raised by members of the anaesthetic department. Dr Bolsin undertook an audit of the paediatric cardiac surgical results from 1990–1992. The auditing showed: (1) that the results of the arterial Switch operation were poor; (2) the results of Bristol for more classical conditions, such as tetralogy of Fallot, AV canal and VSD, were worse than the national average; and (3) that one surgeon had results statistically worse than the other one.

‘In 1993 one paediatric cardiac surgeon went to the Children’s Hospital in Birmingham to improve his technique on the Switch operation.

‘Professor Angelini, who joined the Trust in 1992, was informed as well as Professor Farndon (Professor of Surgery) of the results of the audit. A joint meeting between the cardiac surgeons, the paediatric cardiologists and the cardiac anaesthetists was called and the surgeons reassured their colleagues that the results were improving.

‘Several members of staff who were interviewed during the visit confirmed that the surgeons failed to report and update their results until the day before our visit. Meanwhile, the results of the neonatal arterial Switch failed to improve and sometime in 1994 four cardiac anaesthetists agreed that they could no longer anaesthetise patients for a neonatal arterial Switch.

‘On 19 July 1994 Dr P Doyle (Senior Medical Officer, DoH) visited Bristol and was shown the results of the audit (we assume that those were the 1990–1992 results). Three alternatives were proposed by Dr Doyle: inform the Secretary of State, ask Mr John Parker as President of the Cardiac Society to conduct an inquiry, or ask the President of the Royal College of Surgeons to conduct an inquiry. We understand that Mr John Parker was contacted to deal with the matter.

‘On 24 July 1994 Professor Angelini and Professor Farndon informed the UBHT Chairman of the problem with paediatric cardiac surgery.

‘This calendar of events was obtained in part from the interviews but mainly from a detailed report written by Dr Bolsin.

‘In January 1995 a *non-infant* Switch was put on the surgical schedule. The wisdom of operating on this patient was discussed by a committee with representatives of all parties involved and an agreement was reached to proceed with the operation. The patient unfortunately did not survive and this allegedly led to the letter received from the Department of Health, advising to stop open-heart surgery for neonates and complex infants (we have not seen the letter from the Department of Health).

‘FORWARD PLANNING

‘The Trust has taken a number of positive steps to improve the paediatric cardiac services. They can be summarised as follows:

‘From next October all paediatric cardiac services will be provided at the Children’s Hospital where an operating theatre will be dedicated to cardiac work. The intensive care unit will expand from five to twelve beds. Professor Peter Fleming will run the paediatric intensive care unit and provision for a round-the-clock service will be made.

‘Mr Ash Pawade has been appointed as paediatric cardiac surgeon and he is expected to take up his post within the next two or three months with the intention of putting him in charge of neonatal and complex paediatric cardiac surgery.

‘The anaesthetic department will provide four paediatric cardiac anaesthetists. The fourth post will be created after the forthcoming retirement of a senior paediatric anaesthetist.

‘PERCEPTIONS COLLECTED DURING THE VISIT

‘1. Although well intentioned, the auditing activities of the surgical results by the anaesthetic department was lacking the collaborative attitude that such a delicate endeavour would have required.

‘2. The surgeons’ reticence to produce and analyse their own results has obviously contributed to tension and eventually conflict between the department of cardiac surgery and the department of anaesthetics.

‘3. The channel that was followed by those concerned about the problem that led to the Department of Health before professional bodies is unfortunate. Admittedly, Dr Doyle has rectified this situation in suggesting to approach the Cardiac Society or the Royal College of Surgeons.

‘4. The members of the anaesthetic department were unanimous in claiming that not only the mortality but the morbidity was excessive. Mortality figures will be discussed later. There was no hard data on morbidity.

‘5. The tension which has arisen from this long saga has created an atmosphere of distrust and lack of confidence, which have made the working conditions for the surgeons nearly untenable.

‘DATA ANALYSIS

‘Two sets of data were displayed during the meeting. The data produced by Dr Bolsin were the results of the 1990–1992 audit which compared the results of Bristol with the national average performance of 1991. They concluded that the results of tetralogy of Fallot (all ages), ventricular septal defect (all ages) and atrioventricular canals (under one year) were significantly worse in Bristol than the rest of the UK. Leaving aside the neonatal arterial Switch operation, “the data for other procedures do not show any statistically significant differences”(Dr Bolsin’s report). Dr Bolsin also produced the results of the arterial Switch operation up to July 1994: there were thirty-three arterial Switch operations with a mortality of 66% (eight out of twelve) under one month of age, and 42% (nine out of twenty-one) over the age of one month. He also summarises the results of AV canals operated by Mr Wisheart between 1992 and 1994.

‘The second set of data received from the cardiac surgeons included a detailed report of the results of the neonatal arterial Switch operation, the results of closed heart surgery from 1990 to March 1994 and the results of open-heart surgery from January 1992 to January 1995.

‘There were nine deaths out of thirteen neonatal arterial Switches: one patient had an undiagnosed coarctation of the aorta, two patients had the whole coronary system arising from the same sinus, one of them with an intramural pathway:

neither of those patients survived. Two patients had a circumflex coronary artery arising from sinus 2 (known to be a risk factor in a multi-institutional study); one of these patients died.

‘The results of closed heart surgery are excellent with a mortality of 5.3% for patients under one year of age and a mortality of 2.8% for patients over the age of one year.

‘For the results of open-heart surgery from January 1992 to January 1995, we have extracted the results of tetralogy of Fallot, VSD and AV canal to compare them with the 1990–1992 results produced by Dr Bolsin and we individualised the two surgeons (Consultant 1 and Consultant 2) (Fig 1, 2 & 3).

‘Consultant 1 has a mortality of 0% for ventricular septal defects, 13.5% for tetralogy of Fallot and 87% for AV canals.

‘Consultant 2 has a mortality of 0% for ventricular septal defects, 0% for tetralogy of Fallot and 8.6% for AV canals.

‘The current results of the other UK units are not available to us. There is little doubt that Consultant 2 would certainly compare very favourably with the best UK institutions. Consultant 1 would be amongst the higher risk surgeons.

‘WEAKNESSES AND DEFICIENCIES OF THE ANALYSIS

‘1. We assume that the mortality figures relate to the hospital mortality, though we have not specified this.

‘2. There is no recommended standard against which the performance of a unit can be compared. This emphasises the great need for a proper audit of the performance of each UK unit dealing with paediatric cardiac surgery. The use of the average UK results may be misleading. If one postulates, for example, that two or three larger units have better results than two or three smaller units, the poor results of the latter will be hidden, so to speak, by the average figures.

‘3. It is therefore not possible to make any objective and fair recommendations to a unit without knowing what the performance of every single unit in the UK is, so as to set up a standard.

‘4. Performance assessment should also take into consideration morbidity.
Dr Bolsin’s report includes an attempt to compare the performance of the two surgeons in looking at bypass time, extubation time, ITU time and hospital time for tetralogy of Fallot and AV canals. Here again, those data suffer the lack of standard to which they should be compared.

‘CONCLUSIONS AND RECOMMENDATIONS

‘The following has to be taken in the context of the above described deficiencies of this report.

‘1. On the basis of the mortality figures presented to us, there is a significant improvement between the 1990–1992 results and the 1992–1995 results.

‘2. The results of the neonatal arterial Switch operation should improve. It is not possible to determine the cause of these poor results. To blame surgical skill as the sole reason would be shortsighted. It is most likely a multifactorial and multidisciplinary problem.

‘3. Leaving aside the neonatal arterial Switch repairs, based on the mortality figures produced for 1992–1995, the results produced by Consultant 2 are, we believe, comparable to the results of the so-called low risk institutions (although the hard data for the UK are not available).

‘4. We understand that Consultant 1 has decided to concentrate his activities on adult cardiac surgery when the new appointee starts.

‘5. We believe that it would be a great mistake to ask the new appointee to do all neonatal and complex cardiac surgery using Mr Dhasmana as a “spare wheel”. We would recommend that both surgeons help each other for the most complex pathologies. For this Mr Dhasmana should be relieved from part of his duties in adult cardiac surgery. The Trust may have therefore to consider appointing another adult cardiac surgeon should their workload justify it. This might be the case as the move of the paediatric cardiac surgery to the Children’s Hospital will create more facilities at the Royal Infirmary.

‘6. There is a great need for improving communications between the various departments. We would strongly recommend to organise multidisciplinary audit meetings (at least monthly). We would also recommend joint cardiac conferences, attended by the cardiologists, the anaesthetists, the intensivists and the surgeons weekly to discuss cases which have been investigated and those who are on the operating schedule for the following week.

‘7. An atmosphere of cooperation and understanding between the various departments is essential, so as to alleviate the tension, the distrust and the present untenable atmosphere which without any doubt jeopardise the outcome of the patients.

‘8. We believe that it would be inappropriate to do neonatal arterial Switch operations before the new appointee takes up his post. From the mortality figures presented to us, we have no reason to believe that Mr Dhasmana should not continue to carry on operating on the other conditions. *This, however, would be*

> *possible only if he receives the full support he deserves from his colleagues.* This requires a change of attitude to alleviate the stressful conditions under which he has had to work in the recent past.
>
> '9. It is hoped that the new appointee will be more successful with the arterial Switch repair and that when the failure rate has returned to low values Mr Dhasmana will start afresh with the operation.'[163]

BRISTOL **Open-heart surgery January 1992 – January 1995**				
FALLOT				
	< 1 year Patients	< 1 year Deaths	> 1 year Patients	> 1 year Deaths
Consultant 1	1	1	21	2
Consultant 2	2	0	23	0
VSD				
	< 1 year Patients	< 1 year Deaths	> 1 year Patients	> 1 year Deaths
Consultant 1	20	0	13	0
Consultant 2	21	0	20	0
AV CANAL				
	< 1 year Patients	< 1 year Deaths	> 1 year Patients	> 1 year Deaths
Consultant 1	7	6	1	1
Consultant 2	18	2	5	0

NB UBHT 0052 0263 – 0269; first version of the Hunter/de Leval report

145 Mrs Ferris told the Inquiry that she thought that the comment about post-operative care being 'disorganised' was fair.[164]

146 Mr Wisheart told the Inquiry that this conclusion was based solely on information given to the visiting experts by Fiona Thomas and was not therefore a conclusion 'based on canvassing a broad spectrum of opinion'.[165]

147 Dr Roylance stated in his written evidence to the Inquiry that he gave the visiting experts his assurance that the report was confidential to him.[166] Dr Roylance told the Inquiry that the reason for the confidentiality of the report was that:

> '… it was not refined, it was blunt, it was clear and it was helpful to me … and to make sure there were no punches that were pulled, I promised them they could say

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[163] UBHT 0052 0263 – 0269; first version of the Hunter/de Leval report (emphasis in original); see Chapter 3 for an explanation of clinical terms

[164] T87 p. 180 Mrs Ferris

[165] T93 p. 79 Mr Wisheart

[166] WIT 0108 0131 Dr Roylance

> whatever they liked and it would remain confidential to me and I would act on their advice.'[167]

148 Dr Roylance told the Inquiry that a further reason was because Dr Hunter and Professor de Leval were 'to a certain extent, dealing on hunch and impression.'[168]

149 Professor de Leval stated in his written evidence to the Inquiry that the report was not written for public consumption: '… [The] report contained a number of statements which, in my opinion, could not be in the public domain without further investigation.'[169]

150 He told the Inquiry:

> 'The report was produced as a confidential document to the Chief Executive … I think that if I had known that the document was going to be part of the public domain, I would have been more careful in the wording of the document. I think that it is totally unfair to say that a surgeon is a high risk surgeon with that type of data, and I think that it was irresponsible to say that with the data we had.'[170]

151 Dr Hunter discussed the status of the first version of the report in the following exchange:

> 'Q. [The report] has been described as being variously "confidential" or "a draft". What did you understand it to be?
>
> 'A. I understood it was a confidential report which was for the UBHT.
>
> 'Q. And by "confidential", who did you understand it would be circulated to?
>
> 'A. I assumed that that would be up to the UBHT. We were asked by the UBHT, by Mr Wisheart on its behalf, to do the report, and therefore our remit was to send it to them.
>
> 'Q. Did you understand that the first report that you had sent through was, as it were, a working draft that other people might comment on and ask you to revise, or a final version that —
>
> 'A. I thought that it was a draft.

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[167] T89 p. 81–3 Dr Roylance
[168] T89 p. 84 Dr Roylance
[169] WIT 0319 0001 Professor de Leval
[170] T60 p. 84 Professor de Leval

> ‘Q. By which you mean what?
>
> ‘A. That “this is what we intend to say and we would like to hear your comments”. That is what I have done on other reports.’[171]

152 Dr Roylance went on annual leave on 24 February 1995. Mr Graham Nix was acting Chief Executive in his absence. Mr Nix, in his written evidence to the Inquiry, recalled:

> ‘Within a few days of Dr Roylance going on leave, the Trust began to be approached by people from outside the Trust asking for information, which tended to suggest that the fact of there being a report available and to some extent its contents were already in the public domain … My own first involvement was I believe some time during the week of 27 February 1995 when the faxed report became known to me following Press interest.’[172]

153 Mr Nix stated that he consulted Mr McKinlay (Chairman, UBHT) about the appropriate response to be made by the UBHT.[173] Mr McKinlay stated that Dr Roylance had told the Board on 24 February 1995 that:

> ‘Mr Wisheart would review the contents of the report with Dr [Professor] Vann Jones and Dr Hyam Joffe and would have discussions with Dr Winyard, who was Medical Director of the NHS Executive.’[174]

154 Mr McKinlay, in a letter to Ms Rennie Fritchie, Chair of the South & West Regional Health Authority (S&WRHA) dated 3 March 1995, wrote:

> ‘To protect Mr Wisheart, I have requested him not to deal with the media queries and to leave the internal action in the hands of Gabriel Laszlo [Chairman, Hospital Medical Committee].’[175]

155 Mr Nix stated that:

> ‘The report was immediately considered by Dr Laszlo, as Chairman of the Hospital Medical Committee [HMC], Dr Joffe, Consultant Paediatric Cardiologist, Dr Monk as Clinical Director of the Directorate of Anaesthesia and Dr [Professor] John Vann Jones as Clinical Director of the Directorate of Cardiac Services. This led to a report of their combined views dated 3 March 1995, which was produced to assist Mr McKinlay and myself.’[176]

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[171] T60 p. 60 Dr Hunter
[172] WIT 0106 0071 Mr Nix
[173] WIT 0106 0072 Mr Nix
[174] WIT 0102 0030 Mr McKinlay
[175] UBHT 0052 0260; letter dated 3 March 1995
[176] WIT 0106 0072 Mr Nix

156 The report of the HMC concluded:

> ‘No data are presented to show how [Mr Wisheart] is ranked nationally. In the tables provided, there is no significant difference between the mortality figures of the two surgeons. The total number of deaths in 1992–5 was very similar; the team which operated on the smaller number of children had a non-significantly higher mortality. A total of only four fewer deaths would have yielded equal percentages. There were four excess deaths in the “miscellaneous” group among patients with very unusual diagnoses not all of whom had operations.’[177]

157 Mr McKinlay wrote to Ms Fritchie confirming the UBHT’s intention to act on the report’s recommendations and stating that: ‘… While disagreeing with several of the comments made in the report we accept the recommendations.’[178]

March

158 On 6 March 1995, the NHS Executive arranged a meeting between the Regional Health Authority, the UBHT and NHS Executive representatives, to take place on 9 March.[179] The minutes of that meeting record Mr McKinlay as saying that he:

> ‘… believed that the Trust had the situation under control from the middle of 1994 but, following an unsuccessful “switch” operation on an older child in January this year, earlier concerns had resurfaced. It was then decided that external paediatric cardiac experts should be brought in to analyse the paediatric surgical audit results and make recommendations.’[180]

159 At the meeting, the UBHT representatives, Mr McKinlay, Mr Nix, Professor Vann Jones, Dr Laszlo and Dr Joffe,indicated that they felt that:

> ‘… some sections [of the report] could have been better worded and the conclusions to be drawn were open to interpretation.’[181]

It was also noted that disappointment was expressed that more detailed analysis had not been performed on the data, but it was acknowledged that such analyses would have taken much longer. Mr Nix is recorded as saying that, because of the wording of parts of the report, wider circulation within the UBHT was not desirable.[182]

160 The representatives of both the Region and NHSE stated at the meeting that they would not support the report’s being kept confidential and that the UBHT should be prepared to make it public.[183]

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[177] UBHT 0061 0371; HMC report

[178] UBHT 0052 0260; letter dated 3 March 1995

[179] WIT 0106 0104 – 0106; note of meeting on 9 March 1995. Those attending were Ms Fritchie, Mr McKinlay, Mr Nix, Professor Vann Jones, Dr Laszlo, Dr Joffe, Dr Gabriel Scally, Dr P Doyle, Isabel Nisbet, John Churchill and Billy Flynn

[180] WIT 0106 0104; note of meeting on 9 March 1995

[181] WIT 0106 0106; note of meeting on 9 March 1995

[182] WIT 0106 0106; note of meeting on 9 March 1995

[183] WIT 0102 0032 Mr McKinlay

161 It was agreed at the meeting that the approach set out in Dr Roylance's letter to Dr Doyle of 26 January 1995 would be adhered to, namely that:

> '… the Trust has decided not to carry out complex neonatal or infant open heart surgery until there has been resolution of the conflicting professional advice.'[184]

162 At Mr McKinlay's request, Mr Nix organised two meetings of all relevant consultants to discuss the report. These were held on 13 and 14 March. Mr Nix stated in his written evidence to the Inquiry that:

> '… both of the meetings were attended by… Mr Hutter, Mr Bryan, Mr Dhasmana, Mr Wisheart; Drs Davies, Bolsin, Pryn, Masey, Underwood, Joffe, Wilde; Prof. Angelini, Prof. Vann Jones. Dr Gabriel Laszlo also attended, as Chairman of the Hospital Medical Committee. Mr McKinlay chaired both meetings. I prepared the overheads for the meetings, which were of copies of the report.'[185]

163 Mr Nix went on:

> 'At each meeting, we went through the report paragraph by paragraph. Everyone was encouraged to say what they wanted to say, and they did so. There were a number of issues that were raised in the course of the discussions. These included a debate about the naming of individual clinicians in the report … There were concerns about the accuracy of the data set out in the report … There were some concerns about the wording of the report, including matters of emphasis and use of particular words … It emerged in the course of the meetings that a number of consultants had not seen Dr Bolsin's data. … It was also noted that Mr Wisheart had already agreed to stop operating on paediatric cases when Mr Ash Pawade took up his appointment.'[186]

164 Mr Bryan stated in his written evidence to the Inquiry:

> '… those invited were shown acetates of selected passages from the original report … The meeting was asked to endorse the findings of the report. A number of people at the meeting, including myself, found the request to endorse the original report unacceptable since we were asked to endorse a report we had not read. Professor Angelini expressed this view most vociferously, but it was my impression that it was the general view of the meeting that people wished to read the report.'[187]

165 Mr Nix explained in a statement to the Inquiry that:

> '… it was not appropriate to distribute widely copies of the report in its current form. … [so we] instead arranged for [the consultants involved] to read a copy of

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[184] WIT 0106 0106; note of meeting on 9 March 1995
[185] WIT 0106 0073 Mr Nix
[186] WIT 0106 0073 – 0074 Mr Nix
[187] WIT 0081 0029 Mr Bryan

> the report in Mr McKinlay's office … There was some disquiet about this, but in view of the various concerns raised, it was felt at the time that this was the most appropriate way to deal with it, until some of the concerns and anxieties could be addressed.'[188]

166 Professor Angelini said that he felt Mr McKinlay was asking them to 'underwrite' the report. He continued:

> 'After a longer argument, the people were allowed to look at the report. This was literally for less than five minutes. In my case, with Dr Laszlo looking over my shoulder, I could take no notes whatsoever. I did not have more than five minutes to read it and this created, obviously, a lot of dissatisfaction and complaint.
>
> 'After that, Mr McKinlay decided then that the full report was going to be shown to this group of 10 or 15 people, and there were two meetings … during which the report was discussed literally word by word. None of us had the opportunity to actually have the report copy in front of us, but there were acetates which discussed the report word by word.'[189]

167 Mr Bryan in his written evidence to the Inquiry recalled discussion about the future of the Switch programme:

> 'There was a lot of emotional discussion, principally from Dr Joffe and Mr Dhasmana, that the "switch" programme should continue with Mr Dhasmana continuing to lead the paediatric cardiac surgery service up to and following Mr Pawade's arrival. I expressed my view clearly that no further "switch" operations should be performed in any age group before Mr Pawade's arrival.'[190]

168 Professor Angelini told the Inquiry:

> 'To me that report was absolutely shocking. In a way, if you like, it was a vindication of what people like me had been saying for a very long time. Despite that report, I felt that particularly myself and Dr Bolsin, we were very much victimised by Mr McKinlay and some of the other people present, almost like accused of having been responsible, of having dragged the Trust into this situation and we were responsible for this report and everything else.'[191]

169 Mr Bryan stated that:

> 'Dr Bolsin and Professor Angelini were admonished for their involvement in this affair by Mr McKinlay. I found this both inappropriate and unacceptable.'[192]

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[188] WIT 0106 0075 Mr Nix
[189] T61 p. 194–5 Professor Angelini
[190] WIT 0081 0029 Mr Bryan
[191] T61 p. 195 Professor Angelini
[192] WIT 0081 0030 Mr Bryan

Mr McKinlay told the Inquiry that Professor Angelini was 'being a little sensitive there'and that Professor Angelini 'had a slight tendency to ignore some of the statistics'.[193]

The revised draft Hunter/de Leval report

170 Dr Bolsin stated in his written evidence to the Inquiry that when Dr Roylance returned from holiday he immediately stopped the circulation and reading of the first report and insisted that the report was an interim document, to be used as a draft from which a final report would be produced.[194]

171 Dr Roylance told the Inquiry that when he returned from holiday, and found that the report had achieved a wide circulation in his absence and had been promised to Harlech Television (HTV), he:

> '… informed the authors that a decision had been made to make their report public and asked them whether they would wish to modify it in that knowledge.'

Dr Roylance told the Inquiry that release to HTV 'would not have been a proper step', given the terms upon which the report was commissioned and written.[195]

172 Dr Roylance was asked by Counsel to the Inquiry whether he had objections to the information about the report being in the public domain:

> 'I had no objection at the time to the fact of the review, the fact of the independent inquiry and the nature of the response, in other words the report being in the public domain, no anxiety about that at all.
>
> 'I did have an anxiety that I could not place the authors in a position of risk by breaking my word to them.
>
> '… I was a Chief Executive of a public organisation which lived in the public sector. … There was never any question that the issue was to be debated in public. At the absolute minimum, it would have been debated at a public meeting of the Health Authority:
>
> 'The reason for two reports was nothing to do with publication or not publication; it was because I had not asked them for a report which was fit for public view.'[196]

173 He told the Inquiry that Professor de Leval was responsible for deciding what parts of the report were to be changed.[197]

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[193] T76 p. 81 Mr McKinlay

[194] WIT 0080 0129 Dr Bolsin

[195] T89 p. 80–1 Dr Roylance

[196] T89 p. 111–12 Dr Roylance

[197] T89 p. 80 Dr Roylance

174 Mr McKinlay in his written evidence to the Inquiry stated:

> '… the Trust's endorsement of a report with conclusions based on unreconciled data could constitute defamation of Mr Wisheart. I recall that Dr Roylance communicated this to Mr de Leval, whereupon Mr de Leval altered the report.'[198]

175 Professor de Leval told the Inquiry that he did not think it was fair:

> '… to have a public document which is making a very strong comment … without having this confirmed by the people most involved with the patients, who are the anaesthetists, the surgeons and the cardiologists and intensivists … . I spoke with Mr Wisheart and Mr Nix after the first report, some discussions I think over the telephone, not in writing, that I have to make some amendments.'[199]

176 Changes were made to the report. Professor de Leval explained that:

> 'The main reason for changing the document was that we did not expect this document to be part of the public domain as it stood. … I think that the truth is that I did not expect to have to change the document if it had remained within the knowledge of the Chief Executive. The reason for changing it is that the nature of the document had changed, in my view, after it had been sent to the Chief Executive.'[200]

177 Dr Laszlo in his written evidence to the Inquiry stated that some of the minor amendments emanated from within the UBHT:

> '… Mr Nix and Mr Wisheart showed me a few amendments to the Report which they hoped to have made in the event of the Trust being asked to publish the document. These were only minor, and in one or two places they asked for some of the phrases to be softened and made less colloquial. … I was assured that Professor de Leval himself had made the major changes, on the basis that he had not expected the original report to be made public.'[201]

178 Dr Hunter told the Inquiry that Professor de Leval telephoned him and said that he had spoken to Mr Nix about softening some of the statements in the report. Dr Hunter said that Professor de Leval made the changes and sent the report to Dr Hunter for his approval.[202]

179 The Inquiry was unable to establish precisely when the amended report was sent to the UBHT.

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[198] WIT 0102 0032 Mr McKinlay; see also T89 p. 84 –5, where Dr Roylance told the Inquiry that he took the advice of the District Solicitor, who stated that the contents of the report as they stood might be libellous; and UBHT 0332 0001 (letter from Osborne Clark, solicitors, which contained advice to the same effect)

[199] T60 p. 88 Professor de Leval

[200] T60 p. 81–2 Professor de Leval

[201] WIT 0100 0026 Dr Laszlo

[202] T60 p. 158–60 Dr Hunter

180 Dr Bolsin in his written evidence to the Inquiry described the amended report as a 'much more benign document.'[203] He said:

> 'When I read the revised report I immediately asked for an appointment to see Dr Roylance to explain my unhappiness with this conclusion and the removal of the critical elements of the first report.'[204]

181 The full revised report, with the amendments made to it noted, is reproduced below:[205]

> '**VISIT OF CARDIAC SERVICES DIRECTORATE OF THE UNITED BRISTOL HEALTH CARE NHS TRUST. FRIDAY, 10 FEBRUARY 1995**
>
> 'REMIT OF THE VISIT
>
> 'To advise the Trust on the best action to take ~~following recent recommendations received by the Department of Health to stop complex neonatal and infant open-heart surgery~~ to resolve conflicting professional advice in the field of paediatric cardiac surgery in general and, in particular, complex neonatal and infant open-heart surgery.
>
> 'To make recommendations on the future of the paediatric cardiac services in the Trust.
>
> 'PROGRAMME OF THE VISIT
>
> 'Following a welcome meeting by the Chief Executive, Dr Roylance, who briefly outlined the problem, we met first the two paediatric cardiac surgeons, Mr Dhasmana and Mr Wisheart, who were then joined by two of the paediatric cardiologists, Dr Martin and Dr Hayes. We then met Dr Bolsin, consultant anaesthetist, Dr Monk, clinical director of anaesthesia, Sister Thomas, clinical nurse manager, and Professor Angelini, Professor of department of cardiac surgery. After lunch we met Dr Hughes, clinical director, and Mr Barrington, general manager, of the Bristol Children's Hospital, and then we met Dr Prynn, consultant anaesthetist. The visit was closed by a general meeting that attempted to put forward a satisfactory proposal for the immediate future.
>
> 'CURRENT PAEDIATRIC CARDIAC SERVICES
>
> 'Paediatric cardiac services are currently provided on the two sites, the Bristol Children's Hospital and the Royal Infirmary. The paediatric cardiology services are in the Children's Hospital where closed-heart surgery is performed. Open-heart

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[203] WIT 0080 0129 Dr Bolsin

[204] WIT 0080 0129 Dr Bolsin. The Inquiry received no confirmation that such a meeting actually took place. Dr Roylance was able to recollect only one meeting with Dr Bolsin in 1995 (see T89 p. 87)

[205] UBHT 0061 0378 – 0387. The parts removed from the previous version of the report are struck through, whilst the additions are underlined

surgery is carried out at the Royal Infirmary. The operations are done by two surgeons, Mr Wisheart and Mr Dhasmana. The latter ~~seems to have~~ has taken over the greater bulk of the paediatric practice since Mr Wisheart became Medical Director of the Trust. Anaesthesia is provided by three anaesthetists working on ~~both~~ each of two sites. The postoperative care in the Children's Hospital is done by the surgeons, supported by paediatricians, cardiologists and anaesthetists. The junior staff on site is a paediatric SHO. At the Royal Infirmary the postoperative management is dealt with by the cardiac surgical team (adult) and the anaesthetic team. The person on site on a 24-hour basis is a surgical SHO. During the daytime there are currently two or three anaesthetic sessions which are dedicated to postoperative care. The paediatric cardiologists help with the postoperative management of the children at the Royal Infirmary. The overall postoperative management at the Royal Infirmary appears to be ~~highly disorganised with conflicting decisions~~ less organised with multiple decision making processes between the surgical senior registrar and the SHO who do rounds at 8.00 am, the anaesthetists who see the patients at 9.00 am, and the intensivists who work three days a week. Consultant surgeons appear to have the last say in management.

'BACKGROUND OF CURRENT PROBLEM

'This calendar of events was obtained in part from the interviews but mainly from a detailed report written by Dr Bolsin.

'From 1989 concerns about the surgical results of the paediatric cardiac surgeons have been raised by members of the anaesthetic department. Dr Bolsin undertook an audit of the paediatric cardiac surgical results from 1990–92. The auditing showed~~: (1)~~ that the results of the arterial Switch operation were poor~~; (2)~~ and that the results of Bristol for more classical conditions, such as tetralogy of Fallot, AV Canal and VSD, were worse than the national average~~; and (3) that one surgeon had results statistically worse than the other one~~.

'In 1993 one paediatric cardiac surgeon went to the Children's Hospital in Birmingham to improve his technique on the Switch operation.

'Professor Angelini, who joined the Trust in 1992, was informed as well as Professor Farndon (Professor of Surgery) of the results of the audit. A joint meeting between the cardiac surgeons, the paediatric cardiologists and the cardiac anaesthetists was called and the surgeons reassured their colleagues that the results were improving.

'Several members of staff who were interviewed during the visit confirmed that the surgeons failed to report and update their results until the day before our visit. Meanwhile, the results of the neonatal arterial Switch failed to improve and sometime in 1994 four cardiac anaesthetists agreed that they could no longer anaesthetise patients for neonatal arterial Switch.

‘On 19 July 1994 Dr P Doyle (Senior Medical Officer, DoH) visited Bristol and was shown the results of the audit (we assume that those were the 1990–92 results). ~~Three~~ Various alternatives were proposed by Dr Doyle~~: inform the Secretary of State,~~ amongst them to ask Mr John Parker as President of the Cardiac Society to conduct an inquiry, or ask the President of the Royal College of Surgeons to conduct an inquiry. We understand that Mr John Parker was contacted to deal with the matter.

‘On 24 July 1994 Professor Angelini and Professor Farndon informed the UBHT Chairman of the problem with paediatric cardiac surgery.

~~‘This calendar of events was obtained in part from the interviews but mainly from a detailed report written by Dr Bolsin.~~

‘These events were followed in ~~In~~ January 1995 when a non-infant Switch was put on the surgical schedule. The wisdom of operating on this patient was discussed by a committee with representatives of all parties involved and an agreement was reached to proceed with the operation. The patient unfortunately did not survive and this allegedly led to the letter received from the Department of Health, advising to stop open-heart surgery for neonates and complex infants (we have not seen the letter from the Department of Health).

‘FORWARD PLANNING

‘The Trust has taken a number of positive steps to improve the paediatric cardiac services. They can be summarised as follows:

‘From next October all paediatric cardiac services will be provided at the Children’s Hospital where an operating theatre will be dedicated to cardiac work. The intensive care unit will expand from five to twelve beds ~~Professor Peter Fleming will run the paediatric intensive care unit~~ and ~~provision for~~ a round-the-clock service will be made.

‘Mr Ash Pawade has been appointed as paediatric cardiac surgeon and he is expected to take up his post within the next two or three months with the ~~intention of putting him in charge of neonatal and complex paediatric cardiac surgery.~~ expectation that he will contribute to the future development of neonatal and complex paediatric cardiac surgery.

‘The anaesthetic department will provide four paediatric cardiac anaesthetists. The fourth post will be created after the forthcoming retirement of a senior paediatric anaesthetist.

‘Mr Wisheart has decided to divide his activities between adult cardiac surgery and administration and to give up paediatric cardiac surgery when Mr Pawade starts.

‘PERCEPTIONS COLLECTED DURING THE VISIT

‘1. Although well intentioned, the auditing activities of the surgical results by the anaesthetic department was lacking the collaborative attitude that such a delicate endeavour would have required.

‘2. The surgeons’ reticence to produce and analyse their own results has obviously contributed to tension and eventually conflict between the department of cardiac surgery and the department of anaesthetics.

‘3. The channel that was followed by those concerned about the problem that led to the Department of Health before professional bodies is unfortunate. Admittedly, Dr Doyle has rectified this situation in suggesting to approach the Cardiac Society or the Royal College of Surgeons.

‘4. The members of the anaesthetic department ~~were unanimous in claiming that not only~~ by and large claimed that the mortality~~but the~~ and the morbidity ~~was~~ were excessive. Mortality figures will be discussed later. There was no hard data on morbidity.

‘5. The tension which has arisen from this long saga has created an atmosphere of distrust and lack of confidence, which has made the working conditions for the surgeons ~~nearly untenable~~ very difficult indeed.

‘DATA ANALYSIS

‘Two sets of data were displayed during the meeting. The data produced by Dr Bolsin were the results of the 1990–92 audit which compared the results of Bristol with the national average performance of 1991. They concluded that the results of tetralogy of Fallot (all ages), ventricular septal defect (all ages) and atrioventricular canals (under one year) were significantly worse in Bristol than the rest of the UK. Leaving aside the neonatal arterial Switch operation, “the data for other procedures do not show any statistically significant differences”(Dr Bolsin’s report). Dr Bolsin also produced the results of the arterial Switch operation up to July 1994: there were thirty-three arterial Switch operations with a mortality of 66% (eight out of twelve) under one month of age, and 42% (nine out of twenty-one) over the age of one month. ~~He also summarises the results of AV canals operated by Mr Wisheart between 1992 and 1994.~~

‘The second set of data received from the cardiac surgeons and the paediatric cardiologists included a detailed report of the results of the neonatal arterial Switch operation, the results of closed heart surgery from 1990 to March 1994 and the results of open-heart surgery from January 1992 to January 1995.

‘There were nine deaths out of thirteen neonatal arterial Switches: one patient had an undiagnosed coarctation of the aorta, two patients had the whole coronary system arising from the same sinus, one of them with an intramural pathway: neither of those patients survived. Two patients had a circumflex coronary artery arising from sinus 2 (known to be a risk factor in a multi-institutional study); one of these patients died.

‘The results of closed-heart surgery that is carried out at the Children’s Hospital are excellent with a mortality of 5.3% for patients under one year of age and a mortality of 2.8% for patients over the age of one year.

‘For the results of open-heart surgery from January 1992 to January 1995, we have extracted the results of tetralogy of Fallot, VSD and AV canal repaired by Mr Dhasmana, who currently does the majority of these operations to compare them with the 1990–92 results produced by Dr Bolsin ~~and we individualised the two surgeons (Consultant 1 and Consultant 2)~~.

~~‘Consultant 1 has a mortality of 0% for ventricular septal defects, 13.5% for tetralogy of Fallot and 87% for AV canals.~~

~~‘Consultant 2 has a mortality of 0% for ventricular septal defects, 0% for tetralogy of Fallot and 8.6% for AV canals.~~

‘There was 0% mortality for ventricular septal defects (41 patients), 0% mortality for tetralogy of Fallot (25 patients) and 8.6% mortality for AV canals (23 patients). The current results ~~of the other UK units~~ for individual units in the UK are not available to us. There is little doubt ~~that Consultant 2 would certainly~~, however that the above results compare very favourably with the best UK institutions. ~~Consultant 1 would be amongst the higher risk surgeons.~~

‘WEAKNESSES AND DEFICIENCIES OF THE ANALYSIS

‘1. We assume that the mortality figures relate to the hospital mortality, though we have not specified this.

‘2. There is no recommended standard against which the performance of a unit can be compared. This emphasises the great need for a proper audit of the performance of each UK unit dealing with paediatric cardiac surgery. The use of the average UK results may be misleading. If one postulates, for example, that two or three larger units have better results than two or three small~~er~~ units, the poor results of the latter will be hidden, so to speak, by the average figures.

‘3. It is therefore not possible to make any objective and fair recommendations to a unit without knowing what the performance of every single unit in the UK is, so as to set up a standard.

‘4. Performance assessment should also take into consideration morbidity. Dr Bolsin’s report includes an attempt to ~~compare the performance of the two surgeons~~ assess surgical performance in looking at bypass time, extubation time, ITU time and hospital time for tetralogy of Fallot and AV canals. Here again, those data suffer the lack of standard to which they should be compared.

‘CONCLUSIONS AND RECOMMENDATIONS

‘The following has to be taken in the context of the above described deficiencies of this report.

‘1. On the basis of the mortality figures presented to us, there is a significant improvement between the 1990–92 results and the 1992–95 results.

‘2. The results of the neonatal arterial Switch operation should improve. It is not possible to determine the cause of these poor results. To blame surgical skill as the sole reason would be shortsighted. It is most likely a multifactorial and multidisciplinary problem. An arterial Switch procedure fulfils all the criteria of high-technology activity with complex sociotechnical interfaces. Some of the deaths were probably related to patients’ risk factors (presence of a coarctation in the patient, single coronary system in two patients). The excellence of the results obtained for closed-heart surgery even in sick neonates in the Children’s Hospital may suggest that the paediatric environment provides more appropriate skills for the overall management of those patients. The interface between the various teams has probably suffered from the recent conflictual events. Last but not least, whatever the causes of the failures, there is an inevitable lack of confidence amongst those at the sharp end which in itself could become a vicious circle.

~~‘3. Leaving aside the neonatal arterial Switch repairs, based on the mortality figures for 1992-1995, the results produced by Consultant 2 are, we believe, comparable to the results of the so-called low risk institutions (although the hard data for the UK are not available).~~

~~‘4. We understand that Consultant 1 has decided to concentrate his activities on adult cardiac surgery when the new appointee starts.~~

> ‘~~5~~.3. We believe that it would be a great mistake to ask the new appointee to do all neonatal and complex cardiac surgery using Mr Dhasmana as a “spare wheel”. We would recommend that both surgeons help each other for the most complex pathologies. For this Mr Dhasmana should be relieved from part of his duties in adult cardiac surgery. The Trust may have therefore to consider appointing another adult cardiac surgeon should their workload justify it. This might be the case as the move of the paediatric cardiac surgery to the Children’s Hospital will create more facilities at the Royal Infirmary.
>
> ‘~~6~~.4.There is a great need for improving communications between the various departments. We would strongly recommend to organise multidisciplinary meetings (at least monthly). We would also recommend joint cardiac conferences, attended by the cardiologists, the anaesthetists, the intensivists and the surgeons weekly to discuss cases which have been investigated and those who are on the operating schedule for the following week.
>
> ‘~~7~~.5.An atmosphere of cooperation and understanding between the various departments is essential, so as to alleviate the tension, the distrust and the present ~~untenable~~ unhappy atmosphere which ~~without any doubt~~ could jeopardise the outcome of the patients.
>
> ‘~~8~~.6.We believe that it would be inappropriate to do neonatal arterial Switch operations before the new appointee takes up his post. From the mortality figures presented to us, we have no reason to believe that Mr Dhasmana should not continue to carry on operating on the other conditions. *This, however, would be possible only if he receives the full support he deserves from his colleagues.* This requires a change of attitude to alleviate the stressful conditions under which he has had to work in the past.
>
> ‘~~9~~.7.It is hoped that the new appointee will be more successful with the arterial Switch repair and that when the failure rate has returned to low values Mr Dhasmana will start afresh with the operation.’

182 Various changes had been made to the report. In particular, references in the first version of the report to Mr Wisheart as a ‘higher risk surgeon’ had been removed.

183 The second version of the report also omitted reference to Mr Wisheart’s AV canal results.[206] Professor de Leval told the Inquiry that he thought that he:

> ‘… should have left in comments on the poor results for AV canal requiring full investigation’.[207]

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[206] See Chapter 3 for an explanation of clinical terms

[207] T60 p. 95 Professor de Leval

Dr Hunter told the Inquiry that he was surprised, on seeing the second version of the report again while he was giving evidence, that the adverse comments in the first version about Mr Wisheart's AV canal series had been removed.[208]

184 The Chairman asked Dr Hunter about this further:

> 'Q. When you said you thought something had been left in, … who are you saying took it out?
>
> 'A. I am assuming that Mr de Leval felt that that was one of the points where we had been over-strong in what we said. I was not aware of the fact that it was out until I looked at it earlier today … .'[209]

185 There was also a change in the description of the role that Mr Pawade would play. In the first version, mention was made of his being 'in charge of neonatal and complex paediatric surgery.' The second version removed reference to his being 'in charge'.

Protocol for paediatric cardiac surgery

186 After the meetings with the consultants, Mr Nix and Mr McKinlay stated that they set out what they believed was the consensus view of the way forward in the department, in a draft protocol dated 15 March 1995. The draft protocol was circulated under cover of letters of the same date, to clinicians[210] and to Professor de Leval and Dr Hunter[211] for their approval. Professor de Leval indicated his satisfaction in a letter dated 21 March 1995.[212] Dr Hunter did likewise by a letter of 27 March 1995.[213]

187 Mr McKinlay sent a copy of the protocol to Ms Fritchie inviting comment.[214] Avon Health's officials were also notified, and discussed the proposals with Dr Roylance.[215]

188 The protocol stated that for the period until the arrival of Mr Pawade on 1 May 1995:

> '1.1 No arterial switch operations will be undertaken at the Bristol Royal Infirmary by either Paediatric Cardiac surgeon.

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[208] T60 p. 158 Dr Hunter

[209] T60 p. 160 Dr Hunter

[210] WIT 0106 0125 – 0126; letter from Mr Nix dated 15 March 1995 to: Dr Hughes, Mr Dhasmana, Professor Vann Jones, Dr Monk and copied to Mr Wisheart, Dr Joffe, Dr Laszlo and Mr McKinlay

[211] WIT 0106 0133 and WIT 0106 0132; letters from Mr Nix to Professor de Leval and Dr Hunter dated 15 March 1995

[212] WIT 0106 0135; letter dated 21 March 1995

[213] WIT 0106 0136; letter dated 27 March 1995

[214] WIT 0106 0075; letter from Mr McKinlay dated 15 March 1995 to Ms Fritchie, copied to Dr Scally and Mr Nix

[215] WIT 0038 0035 – 0036. Ms Pamela Charlwood, Chief Executive of Avon Health Commission and Avon Health Authority from 1994, told the Inquiry: 'On 15 March 1995 the Deputy Chief Executive of UBHT wrote to Cardiac Services Directors … Dr Baker and I had meetings with Dr Roylance during April 1995. On 21 April 1995 Dr Morgan circulated a briefing note to members of the Avon Health Commission. On 27 April 1995 Avon Health Commission heard an oral report from Dr Morgan about concerns about paediatric cardiac surgery at BRI. … This was the first notification to the Health Authority at a formal meeting that there was a concern about paediatric cardiac surgery at BRI.' See WIT 0038 0036. See further: WIT 0074 1465; letter from Dr Roylance to Dr Baker dated 2 May 1995, and WIT 0074 1467; memorandum from Dr Baker to Ms Charlwood dated 5 May 1995

> ‘1.2 Mr Dhasmana will continue to operate on all other conditions in neonatal, infant and older children.
>
> ‘1.3 Mr Wisheart will continue to operate on children over 1 year of age for all conditions excluding the AV canal.
>
> ‘1.4 Mr Wisheart will continue to see new paediatric referrals up to 1 May 1995.’[216]

189 For the period after Mr Pawade’s arrival (from 1 May 1995), the protocol stated:

> ‘2.1 Mr Wisheart, Mr Dhasmana, Mr Pawade and the Paediatric Cardiologists will discuss Mr Wisheart’s outstanding waiting list, and the transfer of patients will be agreed. Mr Wisheart will continue to operate on a few children, in the couple of months following the 1st May, where the parents, children and cardiologists wish.
>
> ‘2.2 Mr Dhasmana and Mr Pawade will discuss the resumption of the arterial switch operation; timing at their discretion. It is recognised that such a resumption of service will follow discussion with the Paediatric Cardiac Services Team of paediatric cardiologists, paediatric anaesthetists, paediatric radiologists etc.’[217]

190 The protocol further provided:

> ‘3.2 Any member of staff who has concerns that they consider are not being actioned should, after discussion within the group, contact the Clinical Director or Chief Executive and, if appropriate, the Chairman of UBHT.’[218]

191 Dr Roylance agreed that Mr Wisheart should no longer continue as a paediatric cardiac surgeon.[219] Dr Roylance told the Inquiry that this had been Mr Wisheart’s:

> ‘… intention for some considerable time and he merely implemented his stated intention. There clearly was not room for three paediatric cardiac surgeons with the workload that was there …’[220]

192 The protocol contemplated that Mr Dhasmana would continue to carry out paediatric cardiac surgery. As matters turned out, once Mr Pawade arrived, Mr Dhasmana ceased to do paediatric work.[221]

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[216] WIT 0106 0127; protocol

[217] WIT 0106 0127; protocol

[218] WIT 0106 0128; protocol

[219] The District Health Authority held meetings with Dr Roylance in April 1995. Pamela Charlwood stated: ‘Following a meeting on 10 April, I wrote to the Chief Executive of the UBHT asking specific questions on the arrangements … He replied on 2 May [WIT 0074 1465]. On 9 May 1995, I wrote to Dr Roylance approving arrangements to relieve Mr Wisheart’s paediatric workload, appoint an Associate Director of Cardiac Services for children within the Directorate of Children’s Services, and to set up a multi-disciplinary audit supported by the Health Authority’s contract for clinical audit with Dr Baker. I noted that other purchasers using UBHT would be informed of our view of service development.’(WIT 0038 0036)

[220] T89 p. 79 Dr Roylance

[221] See para 259

Public and press attention

193 UBHT's first draft press statement in relation to the performance of the paediatric cardiac surgery team was dated 3 March 1995.[222] The final version of that statement was dated 6 March 1995.[223] It stated:

> 'As a result of the need to increase adult cardiac surgery at the Bristol Royal Infirmary (BRI) and a wish to develop paediatric cardiac surgery at the Bristol Royal Hospital for Sick Children (BRHSC) the Trust took the following actions during the summer of 1994:
>
> - 'Appointed a new paediatric surgeon, already distinguished in the field of neonatal cardiac surgery, due to commence in May 1995.
> - 'Planned expansion in the theatre and intensive care provision at the BRHSC to accommodate open heart paediatric cardiac surgery transferring from the BRI. This project will be complete by September 1995.
> - 'During 1992/3 the doctors involved in paediatric cardiac surgery had expressed some concerns that the results of one particularly complex operation (the neonatal switch) were not as good as would be wished. This operation involves treating a complex congenital heart abnormality shortly after birth.
>
> 'The Trust took the following action:
>
> - 'In October 1993, as a result of these concerns, the Trust decided to stop this particular operation and to refer the small number of cases that arise to another hospital. This is standard practice for rare and complex conditions.
> - 'No operations of this type have been performed in neonates since then.
> - 'In January 1995 a case conference was held regarding whether to conduct a switch operation on [an] older child (18 months) — the decision was taken to go ahead and unfortunately, there were additional complications and the child died.
>
> 'Further Action
>
> - 'As a result of all these events the Trust sought independent advice which has now been received.
>
> 'The advice:–
>
> - 'endorses the work being done by the paediatric cardiac surgery team and states that this work should continue;

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[222] PAR2 0001 0116; draft press statement dated 3 March 1995

[223] PAR2 0001 0137; press statement dated 6 March 1995

- ‘supports the action already proposed and implemented by the UBHT (as above);
- ‘made some additional suggestions. These are:
  - ‘increased regularity of multidisciplinary clinical audit;
  - ‘improved liaison within the paediatric cardiac team;
  - ‘developing the provision of neonatal switches locally when the new surgeon takes up his appointment and the new facilities at the Children’s Hospital are ready for use.
- ‘All other paediatric cardiac operations continue to be performed with excellent results.’

April

194 The UBHT was informed that the programme entitled *‘Close up West’*, to be broadcast on the evening of Thursday, 6 April, would refer to the results in paediatric cardiac surgery at the UBHT. As a result, it arranged for a helpline to be available for concerned parents following the broadcast. The line would provide direct access to a consultant cardiologist, plus additional back-up support to take details from callers when the cardiologist was already occupied by a call.[224]

195 It became evident during Tuesday, 4 April that the story would be broadcast by the media that evening. Accordingly, the plans for a helpline were brought forward and the number of the BRI switchboard was broadcast on both local news programmes. The BRI switchboard was instructed to pass any calls from the press to the Trust’s Public Relations Officer at home, and calls from concerned parents to Dr Joffe, who would also be available on his home number.[225]

196 On 5 April 1995, the ‘*Daily Telegraph*’ reported:

> **‘100 baby deaths linked to errors**
>
> ‘A leading hospital announced yesterday that it had halted open-heart surgery on children after an anaesthetist claimed that 50–100 babies born with correctable heart defects may have died because of avoidable errors. … Operations were stopped in October 1993 and cases were referred to another hospital although in January this year surgeons decided to operate on an 18-month-old child.

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[224] PAR2 0001 0137 – 0138; ‘Press Statement: Paediatric cardiac surgery at the United Bristol Healthcare NHS Trust’, dated 6 April 1995

[225] PAR2 0001 0137 – 0138; ‘Press Statement: Paediatric cardiac surgery at the United Bristol Healthcare NHS Trust’, dated 6 April 1995

‘Dr Stephen Bolton [*sic*], the anaesthetist who questioned the safety of open-heart procedures, said of that operation: “It was only at a clinical case conference preceding the operation that the team fully realised what its record for the switch was.

‘“There was an institutional problem within the unit but everyone said we should go ahead. The child died the next day and, at that point the Department of Health said we should put a ban on switches.”

‘The incident prompted the hospital to commission experts headed by Mr Marc de Leval of Great Ormond Street Hospital, to investigate the high mortality rates.

‘They produced a damning report criticising doctors and managers and recommended a regular audit of cases and better liaison within the surgical team.

‘Hospital officials suppressed the report claiming that they feared legal action by those who were criticised.

‘The senior cardiac surgeon at the Infirmary is Mr James Wisheart, who is also medical director of the trust.

‘The Infirmary has already moved to appoint a new paediatric surgeon and improve theatre facilities at the Bristol Hospital for Sick Children which is now handling the infirmary’s neonatal surgical caseload.

‘The Infirmary has been doing 120–140 open-heart procedures a year. Dr Bolton [*sic*] said that the overall mortality for these operations has been twice the expected rate.

‘Dr Bolton [*sic*] said that he became alarmed in 1990 when an audit of 14 neonatal switch operations carried out by one surgeon on babies under one month old in 1988 showed that nine had died.

‘Figures for two other operations – hole in the heart, and a more complicated variant in which several defects are repaired – showed that death rates overall in the unit were twice the expected proportion.

‘Dr Bolton [*sic*], then a newly-qualified consultant anaesthetist, claimed that his superiors brushed aside his protestations when he raised questions.

‘He began to keep his own records, and, in 1993, audited them with the help of Dr Andrew Black, a senior lecturer in anaesthetics.

‘“We found mortality rates were twice the expected average. But when I raised this I met only opposition,” said Dr Bolton [*sic*].

> ‘He said he raised concerns with Mr Wisheart, and later showed the figures to Dr Peter Doyle, senior medical officer at the Department of Health, who was said to be “appalled”. Further switches were then banned.
>
> ‘Mr Robert McKinlay, chairman of United Bristol Healthcare Trust, which incorporates the Infirmary and the children’s hospital, said: “In this situation with patients involved we would all wish things would have been done quicker.”
>
> ‘The Infirmary’s spokesman said: “We had a successful switch then a series of failures, then some success then more failures. So we stopped. It is a complex operation and in some cases additional problems were not diagnosed in advance of surgery.”’[226]

197 Dr Bolsin told the Inquiry about the article in the ‘*Daily Telegraph*’ in the following exchange:

> ‘A. What happened was, I was phoned up and I was given the story of what had happened at the Bristol Royal Infirmary and my error —
>
> ‘Q. And you were asked what?
>
> ‘A. “Have you got any comments to make?” My error was to say, “I am not in a position to comment but you seem to have got most of the story”.
>
> ‘Q. The only thing I then want to ask you about is this: having seen your name in print and comments attributed to you which you had not given, you merely endorsed in the way you described, did you write to the “*Daily Telegraph*” to complain about the fact that they had abused your trust in this way?
>
> ‘A. I discussed it, I think — what I actually did, that morning I spoke to —
>
> ‘Q. Perhaps it is easier if you answer the question, and then tell us what follows.
>
> ‘A. The answer is no, I did not.
>
> ‘Q. You were going to tell us why not. Because you discussed it and you were advised not to?
>
> ‘A. I spoke to Dr Roylance and he said, “It is unlikely to do any good, and it is just going to make the whole thing more protracted; I am happy with your explanation, do not worry about it”, sort of thing. “Yes, it is a difficulty but we can deal with it.”’

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[226] PAR1 0001 0090 – 0091; article in the *‘Daily Telegraph’* dated 5 April 1995

198 Dr Bolsin was asked by Counsel to the Inquiry about the effect of the story in the '*Daily Telegraph'* on his relationships with colleagues within the Trust:

> 'Q. Did the fact that you were quoted in the "*Telegraph"* affect your working relationships within the unit, do you think?
>
> 'A. I think it may well have done, yes.
>
> 'Q. In what way do you think it did so?
>
> 'A. I think that there was probably a level of distrust of me personally for having now been associated with the paediatric cardiac surgical record getting into a national newspaper.
>
> 'Having said that, it was not necessarily my view, because I knew that the Trust had released the Hunter/de Leval report to a local television station and that they had been ordered to do so by the Department of Health.
>
> 'Q. But it is perceptions that I am concerned with. With whom do you think it may have affected your relationship?
>
> 'A. I think that the two paediatric cardiac surgeons, it would certainly have affected my relationship with them; however, I knew that Mr Wisheart knew that the Trust had been ordered to release the Hunter/de Leval report, therefore he should not necessarily have blamed me for any ensuing publicity.
>
> 'Q. Did he blame you?
>
> 'A. That was the perception I had, yes.
>
> 'Q. Based on anything he said, or upon your assumption?
>
> 'A. It was based on the assumption that we then went into reconciliation with consultant psychiatrists.'[227]

199 A number of further articles in the press and reports on television followed.[228] Dr Bolsin appeared on the BBC regional news programme on 6 April 1995. He sought advice from the British Medical Association, and was advised that his contract did not prevent him from speaking to the media.[229]

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[227] T83 p. 140–2 Dr Bolsin

[228] Including an article in the *'British Medical Journal'* on 15 April 1995 (BMA 0001 0007) and an article published in *'Private Eye'* on 4 May 1995 (JDW 0003 0150). Dr Joffe responded to the *'BMJ'* article by letter published on 6 May 1995 (BMA 0001 0008) and a 'correction' was also published on 20 May (BMA 0001 0014)

[229] BMA 0001 0004; note of advice

200 Mr Wisheart stated in his written evidence to the Inquiry that, even if Dr Bolsin had not sought to give information to the '*Daily Telegraph*':

> '… in addition to the Daily Telegraph, and on the same day as its publication, there was a television programme on BBC locally. Dr Bolsin appeared on this programme, participated in it extensively and clearly had provided them with similar information. So I was in no doubt, and I have remained in no doubt, that Dr Bolsin had placed this information in the public arena and this was the basis for my feeling that the necessary trust between him and myself did not exist for the purpose of operating on patients.'[230]

201 Maria Shortis, mother of Jacinta who had heart surgery at the BRI, stated in her written evidence to the Inquiry that she had seen Dr Bolsin appear on a BBC news programme on 6 April 1995. As a result of this:

> 'On Friday April 8th I saw Dr Bolsin at his home and asked him if he would tell me what had led him to make his concerns known publicly.'[231] She stated that Dr Bolsin explained "in great detail" the events which had led him to speak publicly about paediatric cardiac surgery at the Trust.[232] She also stated that Dr Bolsin said: "… he would be a target for victimisation. He had already experienced some isolation from his colleagues. He also realised that he could probably not continue his career in Bristol and would have to look for another job."'[233]

202 Dr Roylance in his written evidence to the Inquiry gave this account of his approach to 'whistleblowers':

> 'I repeatedly emphasized that "whistleblowers" would not be victimized in any way. It was over time increasingly clearly emphasized that members of staff with concerns were expected to make them clear to an appropriate person within the Trust and only to go outside in the event of a continuing problem. When external complaints were made the Trust did expect people to make clear that they were making a personal observation and not representing the views of the Trust. The Chairman joined me in requesting that before such a move was made they should ensure that he and I were aware of the nature of the complaint so that we could rectify it if that was appropriate.'[234]

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[230] WIT 0120 0467 Mr Wisheart

[231] WIT 0222 0026 Maria Shortis

[232] WIT 0222 0026 Maria Shortis

[233] WIT 0222 0027. Maria Shortis subsequently made arrangements to speak to other clinicians, including Professor Angelini and Dr Joffe. She had a further discussion with Dr Bolsin and Professor Angelini on 19 August 1995 (WIT 0222 0035) and with Dr Bolsin, James Garrett (Head of Current Affairs, HTV) and Michaela Willis on 14 September 1995. 'Soon after this meeting Penny Cotter, assistant producer for Channel Four, began the investigation work into the *"Dispatches"* television programme.'(WIT 0222 0037)

[234] WIT 0108 0029 – 0030 Dr Roylance

203 He told the Inquiry that he made this policy clear from the early days of trust status.[235] He contrasted the UBHT's approach with the position of trusts trying to insert confidentiality clauses into contracts: 'We made it clear that there was no way the Trust would or could prevent them [employees] expressing their views in public.'[236]

Meeting between Dr Bolsin and Dr Roylance

204 Dr Bolsin referred in his written evidence to the Inquiry to a meeting with Dr Roylance which it was agreed took place in 1995:

> '… 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.[237] Dr Roylance explained that the hospital was in the process of negotiating compensation for the patient's relatives and that in the aircraft industry if a worker was paid to bolt the blades on a helicopter and the blades fall off and passengers are injured, then that worker never bolts the blades on helicopters again.'[238]

205 Dr Bolsin continued:

> '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 …'[239]

206 Dr Roylance in his written comment on Dr Bolsin's statement stated:

> 'I repeated the conversation that I had with Dr Bolsin to the place of work accredited representative, Dr Coates, in order that he could understand the policy which I was hoping to steer the Trust Board towards and so that he might also support Dr Bolsin's position whilst fulfilling his duties both to Dr Bolsin and the Trust.'[240]

207 Dr Roylance told the Inquiry that he telephoned Dr Coates to explain the position because 'I was so concerned he was misunderstanding me … .'[241]

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[235] T88 p. 20 Dr Roylance

[236] T88 p. 20 Dr Roylance. Professor Stirrat stated in his written evidence to the Inquiry that: '… there was no policy of exclusion of Dr Bolsin – indeed, it was to the contrary.' WIT 0245 0009

[237] See WIT 0080 0422 for the comments of the UBHT upon this incident; and WIT 0080 0444 for the comments of Mr Hutter (consultant cardiac surgeon), who refers to it and other criticisms of the clinical practice or care offered by Dr Bolsin as a reason why 'Dr Bolsin did not have the full respect of many of the consultants within the cardiac surgery unit. For this reason, they may have been less willing to take note of his comments on the basis that he did not appear to be pulling in the same direction as the main body of consultants, whose only aim was to work hard, continuously making improvements to the unit.'(WIT 0080 0444)

[238] WIT 0080 0002 – 0003, 0121

[239] WIT 0080 0003 Dr Bolsin

[240] WIT 0080 0019 Dr Roylance

[241] T89 p. 93 Dr Roylance

208 Dr Roylance stated that, at that time, trust boards were developing their responses to the civil actions in negligence that had become a trust's responsibility, by virtue of the cessation of Crown Immunity.[242] He noted that:

> 'A patient under Dr Bolsin's care had received an incompatible blood transfusion and died. Dr Bolsin was, for a time, under investigation by the Police for a possible manslaughter charge and an inquest was held into the death. Subsequently, no criminal charges were brought.[243] In view of the serious nature of the potential manslaughter investigation, the Trust Board were aware of this particular case.[244] In addition, civil proceedings for negligence were afoot.'[245]

209 Dr Roylance stated:

> 'At the time I saw Dr Bolsin, Matthew Hill of the BBC was preparing a programme for television, based on the report of Mr Marc de Leval and Dr Stewart Hunter. Dr Bolsin thought that this report criticized him unfairly and wished to make a personal contribution to the programme.[246] I was aware that Mr McKinlay was involved in detailed discussions with Mr Hill about the proposed content of the programme and I offered Dr Bolsin my advice that, if he became involved within the programme, he might be undermining the Chairman's discussions with Mr Hill and/or might be seen by Mr McKinlay to be doing so. This was simply meant as friendly advice and was not intended to be threatening, nor did Dr Bolsin give me any reason to believe he took it to be a threat. Indeed, he disregarded my advice, as he was entitled to do and appeared in person on the television programme.
>
> 'I used the analogy of the helicopter, which I may have chosen simply because this was the business that Mr McKinlay had been in prior to joining the Trust, because I wanted Dr Bolsin to understand that I did not want the Trust Board to adopt this "commercial" type approach to medical negligence and that I was trying to steer them in a different direction that would be supportive of and sympathetic to, doctors. I was concerned that Dr Bolsin's involvement in this programme at this time, when his own case was likely to be coming before the Board, might jeopardise my efforts to establish an appropriate policy at Board level.'[247]

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[242] WIT 0080 0017 Dr Roylance's response to a statement prepared by Dr Bolsin

[243] According to Mr Wisheart, the decision not to bring charges was taken by the Crown Prosecution Service in February 1995 (WIT 0080 0336)

[244] See, e.g., UBHT 0007 0088; notes of the meeting of the Executive Committe of the UBHT Board on 14 October 1994, at which the incident was recorded

[245] WIT 0080 0016 – 0017 Dr Roylance's response to a statement prepared by Dr Bolsin

[246] Dr Roylance subsequently told the Inquiry that he agreed that Dr Bolsin was further seeking his assurance that he would say something publicly to exculpate Dr Bolsin from any criticism contained in the report (T89 p. 97)

[247] WIT 0080 0018 – 0019 Dr Roylance. Dr Roylance told the Inquiry that the conversation was not 'a personal threat to Steve Bolsin. It was not. It was a personal request of mine to Steve Bolsin for help.' (T89 p. 94.) Mr Wisheart stated in his written evidence to the Inquiry that he supported Dr Bolsin: 'When the Crown Prosecution Service were considering charging him in connection with the blood transfusion error, I advised the Chief Executive that he should not be suspended.' (WIT 0080 0322)

210 Dr Bolsin recalled that he was telephoned by Dr David Coates, who was the place of work accredited representative for the BRI, and one of his consultant anaesthetist colleagues, on the evening of Dr Bolsin's meeting with Dr Roylance. Dr Coates told him that he had just received a serious threat to Dr Bolsin's career from Dr Roylance, in which the helicopter analogy had been used. [248]

211 It was put to Dr Roylance that:

> 'The natural interpretation from someone in … Dr Bolsin's position, of the analogy that if a man was paid to bolt on helicopter blades and does not do the job properly, he will not do the job again, is that if he, someone in his position, makes a mistake, then he will get sacked.'

The question went on:

> 'Q. Was that part of the message you were trying to get across to him?
>
> 'A. That was a concern. I was endeavouring to ensure that it did not happen and did not arise. I used the analogy, I have to say, because I found Steve Bolsin rather difficult to communicate with.'[249]

212 When asked what message he wanted Dr Bolsin to take from the analogy, Dr Roylance replied:

> 'I wanted him not to irritate the Trust Board … .
>
> 'Q. What was he to do to avoid irritating the Trust Board?
>
> 'A. Anything. I was appealing for his co-operation with me to ensure that we did not have any disruption of the normal relationships.'[250]

213 Dr Roylance accepted that he had spoken to Dr Coates, and repeated the analogy. The questioning followed:

> 'Q. So putting it in crude vernacular, what you were saying to him was, was it: "Nice little job you have here. Shame if anything were to happen to it. You ought to be careful it does not."
>
> 'A. No. You are converting this as a personal threat to Steve Bolsin. It was not. It was a personal request of mine to Steve Bolsin for help. It was not the reverse, as you have implied. It was because I was having difficulty in communicating with him that I asked his colleague to reinforce that message.'[251]

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[248] T83 p. 138 Dr Bolsin

[249] T89 p. 92 Dr Roylance

[250] T89 p. 91–2 Dr Roylance

[251] T89 p. 94 Dr Roylance

He added that what he was asking Dr Bolsin to specifically avoid doing was:

> 'Anything that would irritate the directors of the Trust Board which might precipitate them to take a posture I did not want them to take. Anything. There is no mention of any particular event. I did not want him to be a fall-guy. I wanted to protect him.'[252]

The cardiac anaesthetic rota

214 Dr Bolsin's anaesthetising rota was altered in April 1995. Following an initial meeting at which Dr Roylance raised the issue with Dr Monk, a meeting was held to discuss changes in Dr Bolsin's cardiac commitments, attended by Dr Bolsin, Dr Monk, Dr Trevor Thomas, consultant anaesthetist, and Professor Prys-Roberts.[253] Dr Bolsin in his written evidence to the Inquiry stated:

> 'Dr Monk presented the view that there were perceived difficulties with the staffing of paediatric and adult cardiac surgery. These were being contributed to by my request to maintain my adult cardiac surgical workload at two days per week. The situation that Dr Monk wished to communicate to me was that if I persisted with my request to maintain two days of adult cardiac surgery per week the Trust would consider that it was more likely to be able to dismiss one cardiac anaesthetist than two cardiac surgeons.
>
> 'I was shocked to hear this projection of Trust Board thinking and offered the information that nobody needed to be dismissed; all that was required was that I was allowed to work to my contract.
>
> '… This meeting represented an undeniable threat to my employment at the Trust … It now became a matter of considerable importance to me that I should leave the UBHT and find alternative employment.'[254]

215 Mr McKinlay, in his written comment to the Inquiry on Dr Bolsin's statement, stated:

> 'The Trust Board did not discuss the dismissal of Dr Bolsin and if "Trust Board thinking" was a projection by Dr Roylance it was not justified.'[255]

216 Dr Monk in his written evidence to the Inquiry stated:

> 'On many occasions following the early press coverage in 1995, it was necessary for me to defend SB [Dr Bolsin]. I was told, by JR [Dr Roylance] and JDW [Mr Wisheart], in JR's office that JDW and JD [Mr Dhasmana] had received legal advice that they should not work with SB on planned paediatric cases. I gained the impression that if this should occur the legal implications would necessitate the cancellation of the case and/or the removal of the anaesthetist concerned. To avoid

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[252] T89 p. 95 Dr Roylance
[253] WIT 0080 0130 Dr Bolsin
[254] WIT 0080 0130 Dr Bolsin
[255] WIT 0080 0417 Mr McKinlay

> this conflict between SB and the cardiac surgeons I had to adjust his clinical programme to avoid the threat of suspension … .'[256]

217 Dr Monk stated that he was first told of the need to change Dr Bolsin's rota by Dr Roylance.[257] Dr Monk stated that if agreement to this effect could not be reached with Dr Bolsin:

> 'I gained the impression that the alternative solution would be the suspension of Dr Bolsin from his cardiac commitments. At this point I informed Dr Roylance that he should not suspend Dr Bolsin, that he had no grounds to do so and that Dr Bolsin would have a case for constructive dismissal. I offered to resolve the situation to allow time for the differing views on outcome to be addressed.'[258]

218 Dr Monk stated:

> 'At another time, after the press publicity, JR with JDW raised the suggestion of dismissing SB. I argued that this would be an inappropriate action and bore no relation to the problems within the paediatric cardiac service.'[259]

219 Dr Monk continued:

> 'In an attempt to underline the effect that the continued publicity was having on his [Dr Bolsin's] own future I arranged a meeting (25th April '95) to discuss this with him in the presence of Professor Prys-Roberts and Dr Thomas. I asked my two colleagues to attend as they had both supported SB in raising the issue of the P.C.S [paediatric cardiac surgery]. At this meeting I attempted to make SB aware of the feelings held in the Trust HQ and of the progress made in achieving changes in the P.C.S.'[260]

220 Dr Monk stated that at the meeting:

> 'I believed then that Dr Bolsin gained the impression that I was supportive of the position taken by the Trust. This was incorrect. My concerns were over the possible suspension of my colleague by the Trust, that the conflict over the audit remained unresolved and the publicity over a suspension would obscure the true problem of the PCSS. I regretted at the time that I was unable to communicate to Dr Bolsin my concerns and support for him and my desire to speedily resolve all the issues regarding the PCSS.'[261]

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[256] WIT 0105 0029 Dr Monk
[257] WIT 0080 0030 Dr Monk
[258] WIT 0080 0030 Dr Monk
[259] WIT 0105 0029 Dr Monk
[260] WIT 0105 0029 Dr Monk
[261] WIT 0080 0030 Dr Monk

221 On 24 April 1995, Dr Bolsin had written to Dr Monk expressing his concerns about the 'unofficial change' to his contract that had occurred in the previous two weeks, and stating that he was willing to work with all the cardiac surgeons.[262] Dr Monk replied two days later, i.e. the day after the meeting with Dr Bolsin.[263] Dr Monk asked Dr Bolsin:

> '… to agree to flexibility in your work pattern, in site but not in time, to avoid interpersonal conflict in the theatre environment, this was on an informal, temporary basis.'[264]

222 He continued:

> 'Great tensions remain unresolved between you and your colleagues and these conflicts can be viewed as an avoidable risk factor. This issue and many others have been discussed between us on a number of occasions, the action to temporarily change your programme had your active agreement in order to allow the "breathing space" to correct the breakdown in relationships, communication and trust. Your happiness at working with all the cardiac surgeons is not reciprocated and displays a lack of insight into the personal effects of recent events.'[265]

223 Dr Monk in his written evidence to the Inquiry described the changes which resulted in Dr Bolsin's rota:

> 'The initial change to Dr Bolsin's cardiac commitment was complicated by the daily commitments of the cardiac anaesthetists being planned in three monthly blocks around which clinical and personal plans are made. Therefore for the remaining weeks of the published rota an exchange between Dr Bolsin's Thursday cardiac commitment and Dr Masey's Thursday general surgery list was made, obviously this would not be needed if Dr Bolsin had no Thursday commitment. It resulted in a small decrease in his cardiac activity. The next rota was constructed by Dr Masey after my request to ensure that the cardiac workload of Dr Bolsin was restored whilst avoiding the need for the two paediatric surgeons and him working together with children. This was possible because of the flexible approach to the days worked in cardiac theatre by the anaesthetists i.e. they work two days each week out of three cardiac days defined in their job plan.'[266]

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[262] WIT 0080 0303; letter dated 24 April 1995
[263] WIT 0080 0304 – 0305; letter dated 26 April 1995
[264] WIT 0080 0304; letter dated 26 April 1995
[265] WIT 0080 0304; letter dated 26 April 1995
[266] WIT 0080 0031 Dr Monk

Dr Bolsin's departure from Bristol

224 Arrangements for counselling were made by the UBHT by the summer of 1995, to mediate between the cardiac surgeons and Dr Bolsin.

225 Dr Roylance stated in his written evidence to the Inquiry:

> 'The counselling sessions which I arranged with the agreement of the Trust Board for the two cardiac surgeons and Dr Bolsin were an attempt to reestablish a proper working relationship between them. Throughout the time that Dr Bolsin had apparently been making disparaging remarks outside the Trust about the two cardiac surgeons he had been happily working with them and anaesthetizing patients on whom the surgeons were operating. It was clearly essential that efforts were made to re-establish the necessary trust between anaesthetist and surgeon to restore a proper working relationship. The need for counselling was brought about by the mutual loss of trust and was not an attempt to persuade anyone to change their professional opinion.'[267]

226 Dr Bolsin stated in his evidence to the Inquiry that he was:

> '… advised to attend … The purpose of the contacts was to attempt to reconcile the differing opinions betraying [*sic*] myself and the cardiac surgeons concerning the outcomes for paediatric cardiac surgery.'[268]

227 Mr Wisheart stated in his written evidence to the Inquiry:

> 'The publication of his opinions in the *"Daily Telegraph"* … in April and May 1995, some of which he has since acknowledged to be factually incorrect, destroyed the mutual confidence which is essential if a surgeon and an anaesthetist are to work together in the operating theatre in the patient's best interest. Surprisingly it was *his* wish to revert to his original working programme and work with me, despite the views that he had expressed.'[269]

228 He continued:

> 'It is my belief that the Trust *never* wished to dismiss Dr Bolsin, either by constructive dismissal or any other way. On the contrary, the Trust set up a process of conciliation to resolve the differences between Dr Bolsin, Mr Dhasmana and myself. This conciliation process was conducted by two consultant psychiatrists and was carried forward actively during the months of June, July and August, 1995. During this time there were a series of meetings when the psychiatrists interviewed

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[267] WIT 0080 0019 Dr Roylance

[268] WIT 0080 0003 Dr Bolsin

[269] WIT 0080 0049 Mr Wisheart (emphasis in original)

> us individually and subsequently we all met together. All parties were acting positively until Dr Bolsin withdrew from the process in the autumn of 1995.'[270]

229 Mr Wisheart also stated:

> 'The fact that the Trust set up this process seems to contradict the suggestions of a threat to his employment.'[271]

And:

> 'At no stage was there any serious consideration, discussion or proposal to the effect that Dr Bolsin might be sacked. On the contrary there were repeated statements that Whistleblowers would not be victimised, and in the summer of 1995 there was an attempted conciliation. Dr Bolsin appeared to participate actively and positively in this process; he then walked away from it to go to Australia.'[272]

230 Dr Bolsin stated that a diminution in the volume of his private practice also had 'some impact' on his decision not to stay in Bristol:

> 'The number of cardiac surgery cases being referred to me had diminished in the 1990s and I believed that this was related to the fact that I was criticising the paediatric cardiac surgery service at the BRI.'[273]

231 Dr Monk in his written evidence to the Inquiry stated:

> 'I am unaware of the background to the statements concerning private practice nor am I aware of any reduction in his [Dr Bolsin's] practice.'[274]

232 Dr Bolsin left the Trust's employment in late February 1996, to take up an appointment in Australia.[275] Before doing so, he sought advice from the BMA as to whether he had a claim against the UBHT for constructive dismissal. He was advised that there was 'very little evidence' to sustain such a case. Whereas the Trust:

> '… may not have supported you as you would have liked, they do not appear to have left you out in the cold and appear to have tried to remain impartial to minimise the arguments between consultants.'[276]

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[270] WIT 0080 0049 – 0050 Mr Wisheart. See also Mr Wisheart's comments in his 'Response to the talk entitled "The Whistleblower in Medicine" given by Dr Stephen Bolsin to the Medical Legal Society of Victoria on Friday 19 March 1999' at WIT 0080 0407– 0408

[271] WIT 0080 0345 Mr Wisheart

[272] WIT 0080 0412 Mr Wisheart

[273] WIT 0080 0132 Dr Bolsin. In his statement Dr Bolsin implied that Mr Wisheart suggested to at least one surgeon that private cases should not be referred to Dr Bolsin. Mr Wisheart commented: 'Again this is a matter of which Dr Bolsin has no direct knowledge. I did not ask any surgeon not to refer private patients to Dr Bolsin, or seek to influence any surgeons not to refer private patients to Dr Bolsin.'(WIT 0080 0347). In BMA 0001 0023, Dr Bolsin estimated that the loss of work in private practice had cost him 'in excess of £30,000 this year'[1995]

[274] WIT 0080 0031 Dr Monk

[275] GMC 0004 0112; letter from Mr Ross to Dr Bolsin dated 31 January 1996

[276] BMA 0001 0027; letter from Mr S Cusack, Industrial Relations Officer at the BMA, to Dr Bolsin dated 28 December 1995

233 Before Dr Bolsin left, Mr Hugh Ross (the newly appointed Chief Executive of the UBHT) wrote to him in the following terms:

> 'I write further to the series of meetings we have held in recent months. I recognise that your departure to a new career in Australia is imminent. The Chairman and I felt we should put on record our belief that your actions in recent years have been motivated throughout by your concern for the best interests of patient care. The records available to us confirm that you did raise your concerns internally within the Trust in the first instance, and only when you felt they were not being adequately recognised did you raise them outside the Trust.
>
> 'Best wishes for the future.'[277]

Andrew Peacock's surgery

234 The protocol agreed following the Hunter/de Leval report envisaged that Mr Wisheart would withdraw from paediatric practice.[278]

235 Sharon Peacock, mother of Andrew, set out in her written statement to the Inquiry that Andrew, who was born on 29 November 1993, suffered from a Coarctation of the Aorta.[279] He was admitted to the BRHSC on 8 December 1993, and operated upon by Mr Wisheart the following day.[280] Andrew was able to return home in the week before Christmas.[281] He was followed up in the outpatient clinic, but subsequently required re-admission for investigation and catheterisation. This was performed, by Dr Martin, on 5 January 1994.[282] Mrs Peacock was soon told that a further operation on the aorta would be required, in order to place a patch on the aorta.[283] This took place on 9 March 1994. Again, the operation was conducted by Mr Wisheart.[284]

236 A second catherisation took place in September 1994. Mrs Peacock was informed that a further operation on the aorta would be needed in 6–12 months' time.[285] She saw Mr Wisheart in November 1994. Mrs Peacock stated in her written evidence to the Inquiry that Mr Wisheart discussed the risks of the procedure with her, giving Andrew's operation a 94% chance of success.[286] She stated that he also explained the risks of paraplegia.[287]

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[277] GMC 0004 0113; letter dated 20 February 1996

[278] WIT 0106 0127 – 0128 and see above for the text of the protocol

[279] WIT 0011 0002 and WIT 0011 0004 Sharon Peacock; see Chapter 3 for an explanation of this term

[280] WIT 0011 0003 and WIT 0011 0006 Sharon Peacock

[281] WIT 0011 0007 Sharon Peacock

[282] WIT 0011 0009 Sharon Peacock

[283] WIT 0011 0010 Sharon Peacock

[284] WIT 0011 0011 Sharon Peacock

[285] WIT 0011 0014 Sharon Peacock

[286] WIT 0011 0015 Mrs Peacock added, 'He did not explain what the 6% chance of failure referred to, or what it consisted of.' Mr Wisheart in his written comment on Mrs Peacock's evidence responded: 'As this operation followed two others, which Mrs Peacock knew carried a risk of not surviving, it is hard to imagine that there would not have been a risk of death associated with this operation also. Moreover, in my explanations I always made it absolutely explicit that I was talking of the risk of a certain number of children *not surviving* the operation or the recovery period afterwards.'(WIT 0011 0041; emphasis in original)

[287] WIT 0011 0015 Sharon Peacock

237 Before she received a date for the operation, Mrs Peacock stated that she saw an item on BBC television's local news:

> '… which mentioned problems with the paediatric heart surgeons in Bristol. The programme said that there was a problem with the "Switch" operation, and talked far more about Mr Dhasmana than about Mr Wisheart. There was a helpline given out at the end of the bulletin, and I called it immediately, as I felt extremely concerned for Andrew. A man, who identified himself as a cardiologist from Bristol Children's Hospital, answered the telephone. He said that there was not a problem with the type of surgery that Andrew was to undergo, and that the media had blown things out of proportion'.[288]

Mrs Peacock stated that she spoke to Mrs Vegoda, Counsellor in Paediatric Cardiology, who 'also said that the media were getting things out of proportion.'[289]

238 At his clinic on 25 April 1995, when a date for the operation had not yet been fixed, Mrs Peacock stated that Dr Martin told her of the new surgeon, and asked her who she wanted to perform surgery on Andrew. Mrs Peacock stated:

> 'I felt that Dr Martin would know who was best to carry out Andrew's surgery. I told Dr Martin that I could not make this choice, in case I made the wrong decision. He did not offer me an appointment with the new surgeon in order to discuss Andrew's case.'[290]

Andrew therefore remained Mr Wisheart's patient.

239 On the next day, 26 April, Mrs Peacock stated that she telephoned Mr Wisheart's secretary, to inquire about the state of the operating list, and was told to bring in Andrew for surgery the following day (27 April). Andrew was in fact admitted to the BRI on 28 April and surgery took place on 1 May 1995.[291]

240 Andrew did not recover after the surgery, and died on 30 May 1995. The post-mortem results revealed that he had suffered brain damage.[292]

241 Mrs Peacock stated in her written evidence to the Inquiry:

> 'If I had realised what the true state of paediatric cardiac surgery was at the BRI … I would never have taken Andrew there for his operation. Neither would I have

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[288] WIT 0011 0017 Sharon Peacock. On the creation of the helpline, see para 194

[289] WIT 0011 0017 Sharon Peacock. Mrs Vegoda agreed 'It is possible I said that the media is known to get things out of proportion. I would certainly have suggested that she speak directly to Dr Martin and may have offered to arrange this … I may have tried to re-assure her that if Dr Martin and Mr Winspur were advising surgery for Andrew then this was necessary'(WIT 0011 0032). Mrs Peacock acknowledged in her written evidence to the Inquiry the help and support which she received, after Andrew's death, from Mrs Vegoda and Helena Cermakova, a Hospital Chaplain (WIT 0011 0031)

[290] WIT 0011 0017 Sharon Peacock

[291] WIT 0011 0018 Sharon Peacock

[292] WIT 0011 0043 Mr Wisheart; the timing of any such damage was a matter of controversy or uncertainty

allowed Mr Wisheart to operate on Andrew. I would have waited for Ash Pawade (who arrived on 1 May, the day of Andrew's third operation) to perform the surgery…'[293]

242 Mr Wisheart, in his written comment on Mrs Peacock's evidence, stated that:

- 'Initially (October to November 1994) Andrew's third operation was expected to take place in early 1995 before Mr Pawadi [*sic*] came, so the question simply did not arise at that time.
- 'I had already operated twice on Andrew and felt that there was a good relationship with the Peacock family.
- 'I had considerable experience in all forms of surgery for coarctation of the aorta.
- 'The events of 1995 and findings of the Hunter and de Leval report did not apply to Andrew or to surgery for coarctation. The reservations expressed were only about open heart surgery and were chiefly in relation to my surgery for complete AVSDs.
- 'The agreement of the 15 March 1995 provided for me to continue to operate on children but not on infants and not to correct complete AVSDs during the period until Mr Pawadi [*sic*] arrived. It further provided that I would do some open heart surgery in the months after Mr Pawadi [*sic*] arrived, with the agreement of the cardiologist and the parents.
- 'I understood that there was such agreement following the consultation between Dr Martin and Mrs Peacock on 25 April 1995.
- 'Mr Pawadi's [*sic*] employment did begin in Bristol on 1 May 1995 which was also the day of Andrew's operation. Mr Pawadi [*sic*] would hardly have wished to undertake such an unusual or complex operation on his very first day in Bristol before [he] had got to know either the surroundings or his colleagues.'[294]

243 Maria Shortis stated that she, and other members of the public, had been led to believe that Mr Wisheart intended to give up all paediatric cardiac surgery even before Mr Pawade came to the UBHT.[295] She referred to a letter written by Dr Joffe, Dr Martin, Dr Hayes, Mr Wisheart and Mr Dhasmana.[296] Addressed to medical colleagues who would be coping with 'questions from anxious and confused parents without the facts being available to you', it discussed the Bristol results and the investigation by Professor de Leval and Dr Hunter, and continued:

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[293] WIT 0011 0030 Sharon Peacock

[294] WIT 0011 0042 Mr Wisheart; see Chapter 3 for an explanation of clinical terms

[295] WIT 0222 0038 Maria Shortis

[296] Maria Shortis stated that the letter was dated 21 April 1995, but the letter was written on 16 April 1995

> ‘The report concluded that the Unit should continue to perform all forms of congenital heart surgery, including *non-neonatal* switches; recommended that regular multi-disciplinary audit take place to monitor outcomes and foster teamwork; agreed with the Trust’s decision to appoint a cardiac surgeon dedicated to paediatric work to join Mr Dhasmana (Mr Ash Pawade from the Melbourne Unit arrives in May); and supported the transfer of all children’s open heart surgery to the Children’s Hospital. … Babies with TGA who are found to be suitable for the arterial switch operation (about 10 per annum) will be referred to another centre until Janardan, Ash and the cardiologists are confident to recommence the programme. James Wisheart has decided to confine his work to adults in the future because of increasing managerial responsibilities within the trust.’[297]

Quoting risks

244 Ms Sheena Disley, Ward Sister, Ward 5, since 1984, told the Inquiry in the following exchange about Mr Wisheart’s reference to risks in a conversation with parents:

> ‘Q. Do you ever remember attending one of these discussions and hearing a risk or a benefit quoted to a patient, or a parent of a patient, that you disagreed with?
>
> ‘A. I do recall such an occasion, but it was actually after the child had had surgery.
>
> ‘Q. What was the occasion?
>
> ‘A. It was an occasion where the child was — I cannot even recall the surgery he had. He had made slower than expected progress, and was beginning to fit, if I can recall.
>
> ‘Q. What was said that you disagreed with?
>
> ‘A. I cannot recall the details of the discussion, but I felt that it seemed optimistic.
>
> ‘Q. The chances of survival being quoted? What was being quoted that was optimistic?
>
> ‘A. The recovery that the child would make.
>
> ‘Q. What did you do when you heard this being quoted that you thought was optimistic? How did you react?
>
> ‘A. At the time, I did not do anything — at the time, no, I did not do anything.
>
> ‘Q. When was this incident that you recall?
>
> ‘A. It must have been 1995.

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[297] UBHT 0052 0240 – 0241; emphasis in original; see Chapter 3 for an explanation of clinical terms

> ‘Q. Who was the clinician who was giving what you thought was an optimistic prognosis?
>
> ‘A. Mr Wisheart.
>
> ‘Q. If you had a similar experience tomorrow at work with a patient and a clinician, would you react differently now?
>
> ‘A. Yes, I think there are occasions perhaps when we are discussing the care of long-term patients, and — yes, I would.’[298]

May onwards

Further clarification of the ‘audit figures’

245 Dr Joffe replied to the article of 15 April in the ‘*British Medical Journal*’ in a letter published on 6 May 1995.[299]

246 Dr Black,[300] who had collaborated with Dr Bolsin in his analysis of data on PCS, responded to Dr Joffe’s letter by writing to Dr Joffe on 23 May.[301] Dr Black, in his written evidence to the Inquiry, stated:

> ‘… I expressed surprise that no attempt had been made to check the accuracy of our tabulations. I invited Dr Joffe to check at least that the patients whom he had classified as dead were indeed dead. Dr Joffe replied on 9 June[302] … and accepted my offer to supply the names and hospital numbers of the patients we believed had died after undergoing operations in the three categories about which we had concerns. This I did with the covering letter of 15 June 1995 …’.[303],[304]

247 A meeting took place in June 1995, chaired by Dr Roylance, involving Dr Joffe, Mr Wisheart, Mr Dhasmana, Dr Bolsin and Dr Black.

248 Dr Black stated that it became apparent that there were:

> ‘… serious errors in our tabulation of operations with VSD. There was 1 duplicate entry of a patient (who had been entered in error from each of the two main registers and whom I already mentioned in my covering letter): there was 1 who died after hospital discharge and readmission and, in 3 of the remaining 4, patients had undergone more serious operations than had been entered into the original registers.’[305]

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[298] T32 p. 121–2

[299] See footnote 228

[300] A letter was also written by Dr Bolsin to the *‘BMJ’* on 25 May 1995: BMA 0001 0015

[301] WIT 0326 0033; letter from Dr Black to Dr Joffe

[302] WIT 0326 0037; letter from Dr Joffe to Dr Black

[303] WIT 0326 0039; Dr Black’s letter

[304] WIT 0326 0018 – 0019 Dr Black

[305] WIT 0326 0019 Dr Black; see Chapter 3 for an explanation of clinical terms

249 Dr Black stated:

> 'Dr Joffe, Mr Wisheart and Mr Dhasmana were justifiably indignant and we were profoundly embarrassed over our errors in classifying the VSD operations. We apologised immediately and agreed that a full and public apology was due.'[306]

250 In September 1995, Dr Bolsin wrote to Dr Roylance indicating that he and Dr Black were 'dismayed and embarrassed to have made the mistake'[307] in relation to the VSD operations.

251 Counsel to the Inquiry discussed the figures with Dr Bolsin in the following exchange:

> 'Q. Were those figures when it came to VSD in fact in error?
>
> 'A. They were, yes.
>
> 'Q. To the tune of 500 per cent?
>
> 'A. I think we come to that "lies, damn lies and statistics". There were some errors. Another way of looking at it would be to say that we collected something like 3,000 data sets on 286 patients and we got six or seven of the fields wrong, so exactly how you look at it lies somewhere between the spectrum you have put and the spectrum I have put.
>
> 'Q. If one focused on VSDs, so this is a conclusion of the report analysis, is it right or is it wrong to say the result, as produced by the analysis, is 500 per cent wrong?
>
> 'A. That is a factual statement.'[308]

252 Mr Wisheart discussed the figures in the following exchange:

> 'Q. … in fact there was an arithmetical error which was subsequently acknowledged in that series which showed that, instead of there being the number of deaths claimed, that had been overstated by something like 500 per cent?
>
> 'A. 500 per cent, that is correct.
>
> 'Q. Far from being a miserable failure, the VSD series would be, would you say, one of the success stories of the unit in the 1990s?
>
> 'A. I believe it was, yes.'[309]

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[306] WIT 0326 0019 Dr Black; see Chapter 3 for an explanation of clincial terms

[307] UBHT 0061 0053; letter from Dr Bolsin to Dr Roylance (undated)

[308] T80 p. 16 Dr Bolsin; see Chapter 3 for an explanation of clincial terms

[309] T92 p. 98–9 Mr Wisheart; see Chapter 3 for an explanation of clincial terms

253 Mr Wisheart continued in the following exchange:

> ‘Q. When ultimately were those errors corrected so that others knew they were in fact errors?
>
> ‘A. The first one, the one regarding ventricular septal defect correction, was eventually corrected, in the sense that it was agreed by Dr Bolsin and Dr Black that there was an error, in the second half of September 1995 and there was a letter from Dr Bolsin to Dr Roylance following that meeting in which he acknowledges the error.
>
> ‘Q. We have that letter in the Inquiry.
>
> ‘A. Unfortunately, although he had placed the information in the public arena he had never placed the correction in the public arena prior to the GMC findings.’[310]

254 During the course of Counsel’s questioning regarding his relationship with Dr Bolsin, Mr Wisheart was asked:

> ‘Q. … do you feel that there was any impediment preventing Dr Bolsin from telling you about the results of his own audit?
>
> ‘A. I absolutely do not. I mean, we worked together week in and week out in the Infirmary. I rarely operated on private patients and occasionally did so, and he shared in that practice with the other anaesthetists. We discussed his research. I believe there was every opportunity.’[311]

255 In a letter to Dr Black on 24 July 1996, Professor Farndon expressed his attitude towards the concerns over paediatric cardiac surgery:

> ‘My conversations with James were prompted by anxieties expressed to me by Sheila Willatts and Cedric[312] among others. … If Sheila and yourself continue to have reservations why are these not examined openly and with a disinterested party to reach definitive decisions? If the data requires further analysis then let it be done. If the data is clear in its statement then let that statement be declared. I think I am correct in remembering from Wednesday’s meeting that you had a meeting with James and that this meeting discussed the data and its meaning further. This must mean that there is still not a clear view on whether there is a problem or not. For my part, making comment on your stance, I cannot now understand how you can relinquish any responsibility to continue the search for truth. I do not know why you cannot continue to strive and correct the situation that you feel is “fundamentally wrong”.

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[310] T94 p. 134 Mr Wisheart

[311] T94 p. 185 Mr Wisheart

[312] Dr Sheila Willatts and Professor Cedric Prys-Roberts

> '… All I have ever wanted to do in this whole business is to see data that we can all agree states the matter as fairly and objectively as we can. I desperately hope that I would not point the finger at a colleague unless I was absolutely sure of the reason that I were pointing that finger.'[313]

Mr Dhasmana's paediatric practice

256 The March 1995 protocol contemplated that Mr Dhasmana would continue to perform paediatric cardiac surgery.[314] Once Mr Pawade arrived, Mr Dhasmana's work began to dwindle. Mr Dhasmana told the Inquiry that he was 'very upset' that he was no longer performing paediatric cardiac surgery because:

> '… I have shown in my record that I was improving, and the last five years of my work … except for the arterial switch, was better than average in the country. The de Leval and Hunter committee also in a way supported that.'[315]

257 Dr Roylance stated in his written evidence to the Inquiry:

> 'As it turned out, the total number of paediatric operations required was within Mr Pawade's capacity and the Paediatric Cardiologists tended to refer all of their cases to him as the dedicated Paediatric Cardiac Surgeon.'[316]

258 Dr Roylance stated in his written evidence to the Inquiry that he began discussing with Mr Dhasmana the amendment of his contract to limit him to operating on adults.[317] Dr Roylance stated that he recognised that Mr Dhasmana '… was, at first, reluctant to give up paediatric cardiac surgery, which he very much enjoyed …'.[318]

259 On 1 September 1995, Professor Vann Jones wrote to Dr Roylance:

> 'I came back from holiday and learned with some dismay that the recommendation of myself, Chris Monk and David Hughes has not been implemented, namely, that all the operations on children should be done by Mr Pawade. I gather that Janardan is scheduled to do five operations this month. I feel an opportunity has been missed for a reasonable honourable withdrawal from the Paediatric Service for Janardan and we would be grateful to know what course of action you are planning considering that the advice of the three Clinical Directors involved seems to have been rejected.'[319]

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[313] UBHT 0150 0024 – 0025; letter dated 24 July 1996
[314] WIT 0106 0127; protocol
[315] T87 p. 109 Mr Dhasmana
[316] WIT 0115 0031 Dr Roylance
[317] WIT 0115 0031 Dr Roylance
[318] WIT 0115 0031 Dr Roylance
[319] UBHT 0146 0027; letter dated 1 September 1995

260 Professor Vann Jones accepted:

> 'If John Roylance had been getting opinions or advice from two different sources, he was not obliged to take mine … that there were two sides to the argument, I totally accept that.'[320]

261 Mr Wisheart stated that:

> 'The Trust did not stop Mr Dhasmana or myself from operating … Dating back to the spring of 1994 (and before that to 1990–91) the proposal was that when the new paediatric cardiac surgeon came, he and Mr Dhasmana would do the paediatric work and I would withdraw. That is what happened. Later, in 1995, Mr Dhasmana also withdrew from paediatric cardiac surgery.'[321]

262 In a letter dated 13 September 1995 to Dr Roylance, Professor de Leval wrote:

> 'I am led to believe that the quality of Mr Dhasmana's work is not disputed and that the main reason for his dismissal is the public perception that he is part of the bad image that has tarnished the institution during the recent months. If that is correct it is … an extremely serious precedent and I believe that the matter ought to be discussed at the highest levels.'[322]

263 Professor de Leval sent a copy of this letter to various people, including Sir Terence English, who was by then President of the British Medical Association. Sir Terence wrote to Dr Roylance:

> 'I was aware that the review conducted by Mr de Leval and Dr Hunter this year exonerated Mr Dhasmana from any hint of professional incompetence with regard to his paediatric cardiac surgery. It does seem therefore completely unjust that he should be treated in this way which will inevitably be seen by the local community as evidence that he was indeed incompetent at his job.'[323]

264 Professor de Leval pursued the matter further, sending another letter to Dr Roylance reiterating the points made in his first letter.[324] Dr Roylance responded on 17 October 1995:

> 'I tried hard to encourage Janardan to make the decision to withdraw from paediatric cardiac surgery himself … Janardan was unwilling to make this decision, and I understand and sympathise with his reasons. I have … invited him to

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[320] T59 p. 199–200 Professor Vann Jones

[321] WIT 0115 0029 Mr Wisheart

[322] UBHT 0061 0346; letter dated 13 September 1995. Mr Dhasmana's contract of employment was terminated by the UBHT with effect from 3 September 1998

[323] UBHT 0061 0348; letter dated 25 September 1995

[324] UBHT 0061 0349; letter dated 12 October 1995

> renegotiate his programme to provide for some of the increase in adult cardiac surgery for which we now have contracts.'[325]

Concerns 1996 and later

Professor de Leval's report

265 In November 1995, Professor de Leval was invited to write a report on the updated paediatric cardiac surgical results of the UBHT, which were included in the UBHT's final report on paediatric cardiac surgery published in January 1996.[326] Professor de Leval's report examined paediatric cardiac surgery at Bristol between January 1990 and March 1995.[327]

266 In his introduction to the report, Mr Hugh Ross, the new Chief Executive of the UBHT, wrote:

> '… it is a matter of regret that there was not an earlier in-depth and objective investigation within the Trust to resolve the concerns expressed by senior personnel. Any such investigation would have established whether concerns that were expressed were justified.'[328]

267 In the report, Professor de Leval examined the results of open- and closed-heart operations in Bristol between 1990 and 1995. These were compared with the data in UK Cardiac Surgical Register. Professor de Leval wrote:

> 'The UK Cardiac Surgical Register used in this report as a gold standard has … never been validated. The degree of reliability of the data is not known. Importantly, the confidence limits are not available; and last, but not least, the detailed results of individual units and individual surgeons are not known. It is quite possible that a number of institutions and/or surgeons have the same results for some conditions and that the worst Bristol results are actually similar to a substantial minority of their peers.'[329]

268 Professor de Leval's conclusion was:

> '… the Bristol performance over the last three years in terms of mortality matches with the average UK results as published by the UK Cardiac Surgical Register,

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[325] UBHT 0061 0352 – 0353; letter dated 17 October 1995

[326] WIT 0319 0002 Professor de Leval

[327] UBHT 0052 0097 – 0108; 'Bristol Paediatric Cardiac Surgery 1990–1995', report by Professor de Leval

[328] UBHT 0052 0098 – 0099; report by Professor de Leval

[329] UBHT 0052 0101

> including open-heart surgery in infancy, with the exception of the results of atrioventricular septal defects and arterial switch procedures.
>
> 'I also believe that the Trust and those at the sharp end of the system have taken positive steps to improve those results'.[330]

269 On 23 January 1996, Mr Ross sent Professor de Leval's report to the regional director of the NHSE to enable him to give any final advice on its contents.[331] The final report was presented to and approved by the UBHT Board on 26 January 1996 and then presented at a public meeting on 31 January 1996. Copies were sent to the clinicians involved in the paediatric cardiac service, to MPs, to families and to other NHS bodies.[332]

The Hospital Medical Committee

270 Mr Wisheart completed his two-year term as Chairman of the HMC in April 1994.[333] In June 1996 the HMC passed a unanimous motion of support for him. Mr Wisheart prepared a statement for the clinical directors dated 3 June 1996,[334] in which he sought to answer the questions or allegations raised against him. He stated that he would not continue in post without the support of his colleagues.[335]

271 Dr Monk gave evidence that:

> 'The issue of Paediatric Cardiac Surgery was not discussed at the Hospital Medical Committee until after the involvement of the Press. I recall the matter was raised in April 1995, January 1996 and June 1996. When the matter was raised, neither the data from the SB/AB [Stephen Bolsin/Andrew Black] audit or detailed data from the surgeons was presented; therefore discussion was held in the absence of adequate facts. In my opinion the HMC incorrectly believed that the problem lay more with the Anaesthetists auditing the P.C.S. performance than the performance itself. Detailed P.C.S. activity data was promised to the HMC but to my knowledge was not presented. The HMC body voted to support the surgeons and the Medical Director in their actions.'[336]

Review of adult cardiac surgery

272 The performance of the paediatric cardiac surgical service inevitably gave rise as to questions as to the performance of the adult cardiac surgical service. Accordingly, the Trust decided to have an expert external review of adult cardiac surgery. The president of the Royal College of Surgeons suggested Professor Tom Treasure of St George's Hospital and Professor Ken Taylor of the Hammersmith Hospital. They accepted this

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[330] UBHT 0052 0102; see Chapter 3 for an explanation of clinical terms

[331] WIT 0128 0044 Mr Ross

[332] WIT 0128 0044 Mr Ross

[333] WIT 0080 0397 Mr Wisheart

[334] UBHT 0054 0004 – 0010; 'Mr James Wisheart's statement to the Clinical Directors of United Bristol Healthcare Trust 3rd June 1996'

[335] UBHT 0054 0004; Mr Wisheart's statement

[336] WIT 0105 0035 Dr Monk

appointment, and were subsequently joined by Professor Nick Black of the London School of Hygiene and Tropical Medicine.

273 Their report[337] set out preliminary results from their analysis of all adult cases operated on by the five cardiac surgeons from 1 January 1993 until 30 September 1995, following an examination of 2,577 case records. The report compared the mortality rates of one surgeon (designated 'consultant 1231' for the purposes of the report) with the combined mortality rates of his four colleagues, in respect of any operation which consultants conducted.[338] The overall mortality rate of consultant 1231 was 13.6% compared with 5.9% for his colleagues. The mortality rate of consultant 1231 for all coronary artery bypass grafts (CABGs) was 13.4% compared with 4.1% for his colleagues, and his mortality rate for CABGs in risk categories one to ten was 12.2% compared with 2.6% for his colleagues.

274 The assessors reported that the results for consultant 1231 were 'significantly poorer' than the results for his colleagues.[339]

275 The number '1231' had been used to anonymise the surgeon, with a view to ensuring that knowledge of individual surgeons did not influence the results.

276 When the data were presented to the UBHT, the UBHT asked to know the identity of consultant 1231. It was Mr Wisheart.

277 The assessors concluded:

> '1. that the *overall* performance of adult cardiac surgery in UBHT is satisfactory and is in line with published average figures for UK cardiac surgical units as a whole.
>
> '2. that the *individual* performance of consultant 1231 is significantly poorer than the rest of the UBHT consultants. Furthermore, in absolute terms, the assessors consider that consultant 1231's operative mortality figures are too high. The data indicated a particular problem in the area of coronary surgery.
>
> 'The assessors recommend to UBHT that consultant 1231 should not resume operating.'[340]

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[337] External Assessors' Report 'Independent Review of Adult Cardiac Surgery – United Bristol Healthcare Trust (UBHT)

[338] As opposed to operations where the consultant was in charge whilst a junior surgeon operated

[339] UBHT 0053 0066; External Assessors' Report

[340] UBHT 0053 0071; External Assessors' Report (emphasis in original)

278 In the course of his evidence, the questioning of Mr Wisheart went as follows:

> ‘Q. The purpose of this question is not to embarrass you but to lay the groundwork for what will follow in respect of paediatric cardiac surgery. Was [surgeon 1231] you?
>
> ‘A. That was me, yes.
>
> ‘Q. Can we go to page 71? The second recommendation: “… in absolute terms, the assessors consider that [the] operative mortality figures are too high. The data indicate a particular problem in the area of coronary surgery.” You accepted their recommendation?
>
> ‘A. I accepted their recommendation.
>
> ‘Q. The adult surgical report had, had it, approached the analysis of one surgeon in respect of another by looking at risk stratification?
>
> ‘A. To an extent.
>
> ‘Q. So the results which you purported to show were results which as far as possible, gave a level playing-field for comparison?
>
> ‘A. Yes, they did that, a number of — well they did it — in the actual report they used what one might call a conventional method of risk stratification and they used it to a limited degree.
>
> ‘Q. When did you, if you did, first realise that your personal performance by this period of time, despite attempting to do your best, was not in line with the other adult surgical performances of your colleagues?
>
> ‘A. In the proceeding November[341] when the provisional results that you referred to a moment ago were drawn to our attention and that is when I stopped operating.
>
> ‘Q. But before then, despite your interest in and to an extent the retention of some of the figures relating to cardiac surgery, you had no idea?
>
> ‘A. I was surprised, that is correct, but it is not only because of my own personal views. The period we are referring to here is 1997 and over a period of approximately two and a half years, just a little less than that, questions had been

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[341] In 1996

> asked, that is, prior to Professors Treasure, Taylor and Black holding their investigation.
>
> 'At each point when those questions were asked, the figures of all the surgeons and my figures were examined by a whole range of different people who I can tell you about if you wish to know, but the point I wish to make was that it was not only my own assessment of the figures that had given me a measure of confidence up until that time, it was the advice I had received from leading people, both inside and outside the specialty, both inside and outside the hospital, so the figures had been shared, as we knew them, fully and openly, and the judgement of those to whom I had looked for advice during that two and a half year period was entirely supportive. So that is why I was surprised, not just my own judgement.'[342]

279 Mr Wisheart said that if he had had an indication of the results earlier he would have stopped operating then, rather than later.

280 On 17 November 1994 Professor Farndon had raised with him the fact that some were questioning the adult figures for cardiac surgery. He had responded that the figures for adults had been examined especially in detail in 1992 and 1993, and that if stratified for risk category, there was little difference between consultants.[343] At that time he had been noted by Professor Farndon as saying that:

> '… [the]adverse results must in part be due to (1) weighted patient population re adverse factors, and (2) natural history of AO and valves is that they will, by now, be ready for revisional surgery — : difficult? results.'[344]

He accepted that he was explaining the apparent poor results on the grounds of case mix and the fact that the surgery was revision surgery.

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[342] T92 p. 7–9 Mr Wisheart

[343] T92 p. 11–13 Mr Wisheart

[344] WIT 0087 0025; Professor Farndon's note

Chapter 31 – Chronology of Key Events Relevant to and Including Expression of Concerns

Date	Event
1984	Bristol Unit designated as a supra regional service for neonatal and infant cardiac surgery (NICS).
1984–1985	Bristol Unit performed 3 operations on children under 1 year.
1985–1986	Bristol Unit performed 14 operations on children under 1 year.
20 October 1986	Letter from Professor Henderson and others to South Glamorgan Health Authority describing the service at Bristol for neonatal cardiac surgery as being 'at the bottom of the league for quality'.
1986	Professor Henderson contacted Professor Sutherland expressing concerns about referring children from South Wales to Bristol in view of the poor surgical results.
1986	Professor Crompton raised the matter of Professor Henderson's concerns with Professor Acheson, who asked him to see Dr Halliday. Dr Halliday confirmed only that there was a problem with waiting lists. Dr Halliday said that as there was no evidence to support the concerns, he could not take the matter any further.
Autumn 1986	Bristol Unit visited by health officials from Wales to explore Professor Henderson's criticisms.
1986	Returns to the UK Cardiac Surgical Register (UKCSR) showed 24 open-heart operations on children under 1 year, with 6 deaths.
1986–1987	Dr Perham expressed concern to Dr Keeton about results in the Bristol Unit, and asked if it was appropriate for the South West Region to refer complex cases to Southampton.
May 1987	Mr Neil Hall wrote a report for the Children's Heart Circle of Wales entitled *'Meanwhile our Children are Dying'.*
16 June 1987	BBC Wales broadcast a television programme entitled *'Heart Surgery – The Second Class Service'.*
After 16 June 1987	Mr Wisheart, Mr Dhasmana, Dr Jordan and Dr Joffe wrote a joint (undated) letter to 'the Editor', which took issue with the programme's comments about Bristol.
3 August 1987	Mr Wisheart, Mr Dhasmana, Dr Jordan and Dr Joffe wrote a letter to Dr Chamberlain concerning the Cardiology Group of the Royal College of Physicians' report on the development of cardiological services in Wales.
22 December 1987	Legal proceedings for defamation against the Heart Circle under consideration. Mr Wisheart wrote to Mr Gray in relation to this.
1987–1989	District General Managers (DGMs) informed Region both formally and informally at the District Reviews that they had cardiologists who were not happy with referring to the Bristol Unit. (NB This probably relates to adult rather than paediatric surgery.)
1987	Exeter's reluctance to refer to Bristol made known to Region.
1987	Miss Hawkins related her concerns to Dr Roylance.
1987	Bristol Unit's return to the UKCSR for the year ending 31 December 1987 showed 25 procedures on under-1-year-olds, with 7 deaths.

Date	**Event**
1987	The Bristol Unit produced its first Paediatric Cardiology and Cardiac Surgery Annual Report.
1 September 1988	Dr Bolsin commenced his employment and immediately had concern over the length of operation and bypass times.
1988	The Bristol Unit's 1988 Paediatric Cardiology and Cardiac Surgery Annual Report listed 29 operations on under-1-year-olds, with 11 deaths (over one third).
1989	Dr Bolsin approached Professor Prys-Roberts about his developing concerns about mortality. Professor Prys-Roberts advised him to collect evidence to create a clear picture of what was going on.
18 September 1989	Dr Bolsin issued a report of his first year in his post at the BRI.
27 September 1989	Dr Johnson acknowledged the report and offered support in a letter to Dr Bolsin.
1989	The Bristol Unit's 1989/90 Paediatric Cardiology and Cardiac Surgery Annual Report showed 40 open-heart operations on children under 1 year old, with 15 deaths.
1990	Cheltenham's reluctance to refer to Bristol made known to Region.
7 August 1990	Dr Bolsin sent a letter to Dr Roylance dealing with the appendix to the Application for Trust Status, and asking that the mortality for open-heart surgery on patients under 1 year of age should be addressed.
After 7 August 1990	Dr Bolsin met Mr Dean Hart at the latter's request, in response to the letter he had sent to Dr Roylance.
After 7 August 1990	Dr Roylance telephoned Dr Bolsin in response to the letter addressed to him.
After 7 August 1990	Dr Bolsin's evidence was that he met Mr Wisheart at the latter's request, in response to the letter sent to Dr Roylance. Mr Wisheart denied this.
After 7 August 1990	Dr Bolsin met Dr Williams in response to the letter sent to Dr Roylance. It was Dr Williams' evidence that he also spoke to Mr Wisheart about the letter. Mr Wisheart does not recall this.
October 1990	Miss Hawkins had a meeting with colleagues from Exeter concerning their dissatisfaction with the process of contracting, and their wish to move contracts to other areas.
November 1990	Miss Hawkins spoke to DGMs about concerns which they had with the Bristol Service.
December 1990	Miss Hawkins conveyed this dissatisfaction to the Department of Health.
1990	Report of the Cardiac Surgical Unit gave figures for open-heart operations in 1990 for under 1 year as 39 operations with 5 deaths. Good results when compared to the UKCSR.
1991	Dr Bolsin was advised at an anaesthetists' meeting to keep a low profile in the aftermath of his letter to Dr Roylance.
7 January 1991	Dr Shinebourne visited the BRHSC as Joint Committee on Higher Medical Training of the Medical Royal Colleges (JCHMT) representative in order to assess the establishment of a Senior Registrar post in paediatric cardiology, which he did not recommend.
28 July 1991	Meeting of the Paediatric Cardiac Surgical and Anaesthetic Group to discuss Unit performance and treatment protocols. Dr Bolsin took the minutes of this meeting, and was subsequently told not to do so again. The minutes refer to there having been a sense that outcomes had 'been reaching crisis proportions'.
October 1991	Professor Prys-Roberts again met Dr Bolsin to discuss his preliminary data on mortality. He suggested that Dr Bolsin continue to keep accurate records of outcomes.
11 October 1991	Professor John Norman wrote to Professor Prys-Roberts about the approach of three cardiac anaesthetists to one of his cardiac team with their concerns over the results of cardiac surgery in Bristol. A discussion between the two of them followed.

Date	**Event**
October 1991	Bristol Heart Circle started to keep a notebook of patients' details, which included details of bypass time and of outcome.
Autumn 1991	Dr Bolsin spoke to Dr John Zorab about his concerns. Dr Zorab said that he would appraise Sir Terence English informally of the problems.
20 November 1991	Miss Hawkins wrote to Dr Roylance about the dissatisfaction Region-wide with the rate and 'quality of performance' of the Cardiac Unit, having spoken to him prior to sending the letter to ensure that he understood its content.
Late 1991	Mr Martin Elliott was invited to apply for the Chair of Cardiac Surgery at the University of Bristol.
1991	The Unit's Annual Report showed that there had been 46 open-heart operations on children aged under 1 year in 1991, of whom 14 had died.
3 January 1992	Dr Roylance replied to Miss Hawkins' letter. Reply drafted by Mr Wisheart, 12 December 1991.
3 January 1992	Mr Elliott wrote to Mr Wisheart indicating that he had decided not to apply for the Chair of Cardiac Surgery at Bristol.
The week following 3 January 1992	Miss Hawkins spoke to Mr Wisheart about cardiologists' concerns.
Early 1992	Dr Bolsin visited Professor Prys-Roberts to express his concerns again, following which the latter said he would speak informally to Dr Roylance.
6 February 1992	Mr Steven Owen, Administrative Secretary to the Supra Regional Services Advisory Group (SRSAG), visited Bristol. He received data on mortality during his visit, indicating 30% mortality in the under-1s, which he passed to Dr Halliday.
14 February 1992	First article published in '*Private Eye*' which referred to cardiology and cardiac surgery in Bristol.
5 March 1992	Professor Prys-Roberts met Dr Roylance and probably on this occasion discussed the Bolsin data.
27 March 1992	Second article published in '*Private Eye*' which referred to cardiology and cardiac surgery in Bristol.
Spring 1992	Dr Bolsin met Kathleen Orchard and discussed comparative performance of the Bristol Unit.
29 April 1992	Dr Hammond met Dr Bolsin to show him the figures he had received from his source to check their accuracy.
8 May 1992	A meeting of the working party of the SRSAG was held at the Royal College of Surgeons, which discussed the need to maintain the number of supra regional funded units at nine.
8 May 1992	Further article in *'Private Eye'* about paediatric cardiac surgery (PCS) at the UBHT.
After 8 May 1992	Mr Peter Durie discussed the *'Private Eye'* articles informally with members of the UBHT Board.
May/June 1992	Mr Dhasmana's secretary gave him a copy of the *'Private Eye'* article that had been passed to her. Mr Dhasmana subsequently questioned all those present at the meeting of 3 June 1992 to seek to find out who was responsible for passing information from the meeting to *'Private Eye'*.
3 June 1992	The Bristol paediatric cardiac clinicians held a meeting to review the results of the Arterial Switch operation.

Date	Event
19 June 1992	Working Party Report commissioned by the SRSAG was delivered by Professor Hamilton to Sir Terence English. Supported continuing designation of Bristol.
22 June 1992	Letter sent to Dr Roylance by Ms J Binding, Corporate Affairs, NHS Management Executive, enclosing a letter dated 24 May 1992 written to the Secretary of State by a parent whose child was about to have surgery at the BRI.
22 June 1992	Dr Bolsin met Professor Prys-Roberts and discussed concerns and data collection.
2 July 1992	Sir Terence English, as President of the Royal College of Surgeons of England (RCSE), wrote a letter to Dr Halliday, enclosing the Hamilton Working Party Report and supporting its conclusions.
2 July 1992	Sir Terence English wrote to Professor Hamilton to thank him for the report and to express the full support of the RCSE for it.
2 July 1992	Sir Keith Ross wrote to Mr Wisheart to deny that comments in *'Private Eye'* suggesting concern about Bristol standards were attributable to him.
3 July 1992	A further article appeared in *'Private Eye'* about the mortality statistics at the UBHT, drawing unfavourable comparison with results in the USA and in Birmingham, UK.
15 July 1992	Dr John Zorab wrote to Sir Terence English at the RCSE, enclosing a copy of the article from *'Private Eye'* reporting concern and raising the issue of mortality.
21 July 1992	Dr Zorab's letter was forwarded to Sir Terence English by Sir Norman Browse, who had taken over from Sir Terence as President of the RCSE. Sir Terence subsequently went back to look at the Working Party Report data. He reconsidered his view as to Bristol's continued designation.
23 July 1992	Dr Roylance replied to Ms Binding in a letter dictated by Mr Wisheart and signed by Dr Roylance.
23 and 24 July 1992	Sir Terence spoke to Professor Hamilton twice by telephone and discussed the mortality rates at Bristol, and agreed that it should be recommended to the SRSAG that Bristol be de-designated. It was also agreed that Sir Terence should telephone Dr Halliday, which he did. Evidence as to what was said about the substance of the reservations was in conflict.
25 July 1992	Sir Terence dictated a reply to Sir Norman.
25 July 1992	Sir Terence dictated a letter to Dr Zorab.
28 July 1992	Meeting of the SRSAG. Dr Halliday communicated the fact of Sir Terence's reservations about the continuing designation of the Bristol Unit to the meeting, but gave no reason for his having such reservations.
July 1992	A decision was taken to de-designate NICS with effect from April 1994 as a supra regional service.
July 1992	Dr Black's daughter began a tabulation of data which had been collected by Dr Black and Dr Bolsin.
3 August 1992	Professor Hamilton wrote to Sir Terence English saying that the Working Party could be requested by the Advisory Committee on supra regional funding (SRSAG) to reconsider the mortality figures and possibly amend its findings.
29 September 1992	Next meeting of the SRSAG after July. Sir Terence attended and addressed the matter of his concerns over de-designation of the service as a whole. He did not refer to any specific concerns over Bristol.
9 October 1992	*'Private Eye'* published an article claiming that the concerns over PCS at the UBHT had been confirmed by an internal audit of the preceding two years' operations.
1992	Cardiac theatre nurses expressed concerns over the outcome of PCS operations.

Date	Event
October 1992	Professor Gianni Angelini was appointed Professor of Cardiac Surgery. Shortly afterwards Dr Black and Dr Bolsin presented him with the results of their collection and analysis of data.
19 November 1992	The Regional Advisor of the Royal College of Physicians, K R Hunter, wrote a report *'Regional Adviser's Visit'* to the BRI.
7 December 1992	The UBHT Management Board Meeting noted that a Regional Working Party had been examining cardiac services in the Region and their dissatisfaction with quality and costs in Bristol.
December 1992	Mr Dhasmana visited Birmingham with Dr Masey in order to observe Mr William Brawn at the Birmingham Children's Hospital performing a neonatal Arterial Switch.
5 January 1993	Mr Wisheart met with Professor Dieppe to discuss the AVSD results.
Early 1993	Professor Farndon became aware of concerns over PCS when Dr Bolsin came to see him. Dr Bolsin left hard copies of his data.
Spring 1993	Dr Masey became aware of the Bolsin/Black data. She subsequently asked for, and was shown, the most recent set of his figures by Mr Dhasmana.
1993	Dr Sheila Willatts had prolonged discussions with Dr Bolsin regarding outcomes and the course of action he might reasonably take. Dr Willatts spoke to others and Professor Farndon offered to chair a meeting.
1993	Mrs Mona Herborn expressed to Dr Masey her view that Mr Dhasmana was not capable of performing the Switch operation.
July 1993	Mr Dhasmana visited Birmingham Children's Hospital to observe Mr Brawn operating for a second time. He was accompanied this time by Dr Underwood.
1 July 1993	Mr Alan Bryan, consultant cardiac surgeon specialising in adult cardiac surgery, took up his post as Senior Lecturer in cardiac surgery at the University of Bristol. Shortly after (in the autumn of 1993), Dr Bolsin presented to him outcome statistics in relation to PCS. Dr Bryan subsequently talked to other clinicians about concerns.
September 1993	Dr Bolsin spoke to Professor Angelini regarding data which had been collected.
October 1993	Dr Bolsin took his data to show Dr Monk, at the latter's request.
November 1993	Professor Angelini talked to Mr Jaroslav Stark, consultant cardiothoracic surgeon at Great Ormond Street Hospital, (amongst others) about the data which Dr Bolsin had given him. At about the same time Professor Keen expressed his concerns to Professor Angelini, who also spoke to Professor Farndon.
16 November 1993	Dr Bolsin attended an appointment to see Professor Vann Jones, who had become the first Clinical Director of the newly created Directorate of Cardiac Services in the preceding month. Dr Bolsin showed him data for the BRI surgery on children and comparative UK data.
17 or 18 November 1993	Mr Wisheart went to visit Professor Vann Jones with a different set of figures for these procedures.
December 1993	Dr Jane Ashwell, a Senior Medical Officer at the Department of Health, met with Dr Bolsin at the Royal College of Anaesthetists and discussed outcomes.
13 December 1993	Dr Ashwell wrote to Dr Bolsin to say that she had spoken to Professor Farndon and had raised the issues discussed.
23 December 1993	Professor Angelini and Professor Farndon went to see Mr Wisheart to express concerns and to urge the appointment of a new consultant paediatric cardiac surgeon.
Latter part of 1993	Dr Alison Hayes was asked to collate the figures for the Arterial Switch operation.

Date	Event
Latter part of 1993	Dr Stephen Pryn was asked to prepare figures on paediatric cardiac outcome data for the chronological year ending 31 December 1993.
Latter part of 1993	Dr Bolsin showed Dr Davies the data he had collected and Dr Davies encouraged him to show the data to someone in authority.
1993	The Unit's return to the UKCSR showed figures for open-heart surgery on the under-1s as 53 procedures with 8 deaths.
20 January 1994	Audit meeting of surgeons, anaesthetists and cardiologists at which Dr Pryn presented some figures, as did Mr Wisheart from memory. Dr Hayes did not produce her data as planned.
10 February 1994	Dr Bolsin replied to Dr Ashwell's letter, thanking her for what she had done.
February 1994	Professor Angelini began to raise concerns with Dr Roylance. They had at least two meetings between the end of 1993 and March 1994.
March 1994	Professor Angelini and Dr Monk met Dr Roylance. Professor Angelini thought that Dr Roylance had data from Dr Bolsin but did not specifically refer to it.
April 1994	Professor Vann Jones met with Dr Bolsin and Dr Laszlo to discuss Dr Bolsin's revised figures and was persuaded that there was a problem with PCS.
5 April 1994	Dr Monk, Mr Wisheart, Dr Bolsin and Professor Angelini went to dinner at Bistro 21, to discuss possible concerns. Despite the invitation to do so, neither Professor Angelini nor Dr Bolsin expressed any concerns.
18 April 1994	Dr Bolsin attended an appointment with Ms Janet Maher, as General Manager of the Directorate of Surgery at the UBHT, and discussed his data and concerns.
Week following 18 April 1994	Ms Janet Maher spoke to Dr Monk and also to Dr Roylance, and repeated to each what Dr Bolsin had said to her.
April 1994	Professor Vann Jones was asked by Miss Lesley Salmon to convene a meeting of the non-medical staff to inform and reassure the departmental staff, which he did.
April 1994	Mr Wisheart completed his two-year term as Chairman of the Hospital Medical Committee.
May 1994	Professor Angelini was visited by Mr Durie and Mrs Maisey to discuss PCS problems.
May 1994	Professor Angelini spoke to Professor Vann Jones about his concerns.
12 May 1994	Professor Angelini and Professor Vann Jones wrote to Mr Durie about the appointment of a new paediatric cardiac surgeon, commenting that, without this, PCS at Bristol would collapse.
May 1994	Mr Durie raised the Professors' concerns orally with Dr Roylance and asked him to look into them. He subsequently regretted not pressing Dr Roylance as to what he had done about them.
12 May 1994	The Cardiac Expansion Working Party of the UBHT reported a perception that the quality of paediatric cardiac services at Bristol did not match that of 'competitors'.
June 1994	Anaesthetists discussed a letter expressing concerns about the Switch operation, and decided to address it to Dr Monk, for him to take forward with Dr Roylance.
21 June 1994	Letter signed by six anaesthetists at the UBHT expressing concern about the Arterial Switch programme being undertaken at the BRI.
30 June 1994	Dr Underwood anaesthetised a patient undergoing a non-neonatal Switch operation.
1 (or 12) July 1994	Dr Monk spoke to Dr Roylance and informed him that there was a problem in PCS regarding outcomes. He says that he offered Dr Roylance a copy of the anaesthetists' letter, but that Dr Roylance refused to accept it since it was addressed to Dr Monk. Dr Roylance denies being shown the letter at all.

Date	Event
July 1994	The anaesthetists' concerns about the Arterial Switch programme were brought to Mr Dhasmana's attention by Dr Monk.
19 July 1994	Dr Peter Doyle attended a meeting in Bristol. Dr Bolsin accompanied him back to the station. During the journey, he handed Dr Doyle a copy of his data in an envelope (which Dr Doyle subsequently did not read), and outlined concerns.
21 July 1994	Dr Doyle wrote to Professor Angelini, and stated that concerns over mortality rates in NICS at the BRI had been brought to his attention.
19 August 1994	Professor Angelini replied to Dr Doyle's letter.
30 August 1994	Dr Doyle replied to Professor Angelini's letter.
4 September 1994	Mr Wisheart wrote to Dr Roylance, commenting on Professor Angelini's letter of 19 August 1994 and referring to 'the limited nature of the problem'.
12 September 1994	Dr Roylance wrote to Dr Doyle, having been made aware that correspondence had passed between Dr Doyle and Professor Angelini stating that the Trust Board were 'aware of the problem'. (There was no evidence to this effect given to the Inquiry.)
September 1994	Professor Farndon, Mr McKinlay and Professor Angelini had a meeting to ensure there would be no administrative problems associated with the appointment of the new paediatric cardiac surgeon.
22 September 1994	Dr Roylance wrote to Dr Doyle to inform him that a new paediatric cardiac surgeon had been appointed and of the progress in moving PCS to the BRHSC.
3 October 1994	Dr Doyle replied, thanking Dr Roylance for keeping him up to date.
October 1994	Mr McKinlay began to hear for the first time from Dr Roylance about Dr Bolsin and Dr Doyle.
10 November 1994	A consultants' meeting was held, attended by Mr Dhasmana, Mr Hutter, Mr Bryan and Professor Angelini, immediately after the monthly audit meeting. The meeting ended in acrimony, with Mr Dhasmana accusing Professor Angelini of raising concerns about his clinical performance outside Bristol, and the Professor seeking to rationalise the paediatric cardiac service.
17 November 1994	Professor Farndon discussed the concerns being expressed about PCS with Mr Wisheart. The latter agreed that the outcomes of some procedures were 'not good'.
18 November 1994	Professor Farndon set out the previous day's discussion and the agreed way forward in a letter to Mr Wisheart.
21 November 1994	At one of his clinics, Dr Martin saw Joshua Loveday for the last time before his operation on 12 January 1995.
8 December 1994	A meeting of the 'Paediatric Heart Club' took place in the evening at Dr Joffe's house to discuss Mr Dhasmana performing non-neonatal Switch operations.
15 December 1994	Professor Vann Jones wrote to Mr Wisheart acknowledging receipt of data Mr Wisheart had sent him.
By Christmas 1994	Mr McKinlay said he had reached the point where he told Dr Roylance that he wanted an independent inquiry and Dr Roylance agreed to it. Dr Roylance said that this decision was not reached until after the Loveday operation.
After Christmas 1994	Joshua Loveday's parents received a letter from the BRI advising them that if they wished the operation to go ahead Joshua could be admitted to the BRI on 10 January 1995.
December 1994	Dr Bolsin contacted Dr Doyle at the Department of Health in the light of the proposed operation.

Date	Event
1994	Figures submitted to the UKCSR showed that there had been 50 open-heart operations in those under 1 year of age, with 14 deaths.
January 1995	Mrs Herborn pointed out the listing of Joshua Loveday to Dr Bolsin, who told her the operation would not take place. By 11 January she said she had spoken to Dr Bolsin again and also to Professor Angelini.
6 January 1995	Professor Angelini went to see Mr Wisheart to persuade him that the Loveday operation should not proceed.
6 January 1995	Immediately after the meeting with Professor Angelini, Mr Wisheart telephoned Dr Bolsin and agreed that data was to be urgently gathered and that there would be a meeting of the whole Paediatric Group on 11 January 1995 to review the decision to operate on Joshua Loveday.
10 January 1995	Professor Angelini wrote to Mr Wisheart in order to put his concern in writing.
10 January 1995	Joshua Loveday was admitted to the BRI. Dr Martin did not see Joshua upon admission.
11 January 1995	Dr Doyle telephoned Dr Roylance to advise him of the fact that concerns over the operation had been expressed to him by Professor Angelini.
11 January 1995	Dr Monk spoke to Mr Wisheart expressing his view of the risks of going ahead with the proposed operation.
11 January 1995	At 5.30 pm a meeting of clinicians was held in the Catheter Laboratory at the BRHSC to discuss the outcomes at Bristol of Arterial Switch surgery and whether to proceed with the planned surgery on Joshua Loveday. Dr Martin, Mr Wisheart and Mr Dhasmana convened a side-meeting, which took place after the discussions in the main clinicians' meeting. The need for the operation was expressed as urgent. The decision of the meeting was to proceed. That of the side-meeting was to the effect that Mr Dhasmana felt able to do so.
11 January 1995	Joshua's parents gave consent to the operation. They had not been told of the (extraordinary) meeting which had just been held to discuss the advisability of the operation.
12 January 1995	Mr Wisheart telephoned Dr Doyle to inform him that the outcome of the meeting had been to proceed with the planned operation.
12 January 1995	Operation on, and death of, Joshua Loveday.
12 January 1995	Dr Doyle spoke to Dr Roylance and Mr Wisheart and advised that an outside independent inquiry into the PCS service was now essential.
13 January 1995	A coroner's post-mortem was carried out on Joshua Loveday.
16 January 1995	Professor Angelini wrote to Dr Roylance stating that an inquiry should be held on the paediatric work carried out in the Department of Cardiac Surgery.
19 January 1995	Professor Vann Jones wrote to all the cardiac surgeons, stating that Dr Roylance had requested him to call a meeting between all the cardiac surgeons, himself and Dr Roylance to discuss the situation with regard to the Switch operations.
23 January 1995	Professor Vann Jones wrote to the members of the cardiac surgery associate directorate expressing his dismay at how divided and acrimonious the atmosphere was in cardiac surgery at the most recent meeting.
24 January 1995	Dr Doyle wrote an internal memorandum addressed to Dr Winyard and Dr Scally, updating his colleagues on the situation developing in Bristol.
25 January 1995	Dr Doyle wrote to Dr Roylance saying that it would be extremely inadvisable to undertake any further neonatal or infant cardiac surgery.
26 January 1995	Dr Roylance replied to Dr Doyle's letter, confirming that the UBHT had ceased to perform complex neonatal and infant cardiac surgery.

Date	**Event**
3 February 1995	Dr Doyle wrote to Dr Roylance confirming the way forward for the inquiry.
10 February 1995	Professor de Leval and Dr Hunter visited the UBHT.
24 February 1995	Dr Roylance told the UBHT Board that Mr Wisheart would review the contents of the report together with Professor Vann Jones and Dr Joffe.
24 February 1995	Dr Roylance went on annual leave.
During the week of 27 February 1995	The faxed report became known to Mr Nix following press interest. Mr Nix stated that he consulted Mr McKinlay about the appropriate response to be made by the UBHT.
3 March 1995	Mr McKinlay wrote to Ms Rennie Fritchie that he had requested Mr Wisheart not to deal with the media queries and to leave the internal action in the hands of Dr Laszlo.
3 March 1995	The report was considered by Dr Laszlo, Dr Joffe, Dr Monk and Professor Vann Jones. This led to a report of their combined views, which was produced to assist Mr McKinlay and Mr Nix.
3 March 1995	Mr McKinlay wrote to Ms Rennie Fritchie confirming the UBHT's intention to act on the report's recommendations.
6 March 1995	The UBHT's first press statement in relation to the performance of the PCS team was made.
6 March 1995	NHS Executive arranged a meeting between the Regional Health Authority, the UBHT and NHS Executive representatives.
9 March 1995	The above meeting took place and the report was considered. It was agreed at the meeting that the approach would be as set out in Dr Roylance's letter to Dr Doyle of 26 January 1995.
13 and 14 March 1995	Two meetings were held of all relevant consultants to discuss the report.
15 March 1995	Mr Nix and Mr McKinlay set out what they believed was the consensus view of the way forward in the department in a draft protocol.
15 March 1995	The draft protocol was circulated to the clinicians and to Professor de Leval and Dr Hunter for their approval. A copy of the protocol was sent to Ms Fritchie inviting comment.
21 March 1995	Professor de Leval indicated his satisfaction in a letter.
27 March 1995	Dr Hunter indicated his satisfaction in a letter.
4 April 1995	The media broadcast the story surrounding the UBHT. A helpline was set up by the Trust.
5 April 1995	*'Daily Telegraph'* article was published.
6 April 1995	Dr Bolsin appeared on the BBC regional news programme.
16 April 1995	A letter written on behalf of Dr Joffe, Dr Martin, Dr Hayes, Mr Wisheart and Mr Dhasmana was addressed to the medical staff, setting out the UBHT's position.
1995	Meeting between Dr Bolsin and Dr Roylance in respect of the investigation in relation to an incompatible blood transfusion. Dr Bolsin described being threatened with the sack. Dr Roylance denied that this was what was intended by an analogy he used in conversation.
April 1995	A similar analogy was used to Dr Bolsin's union representative, and was similarly interpreted.
April 1995	Dr Bolsin's anaesthetising rota was altered.
24 April 1995	Dr Bolsin wrote to Dr Monk expressing his concerns about the unofficial change to his contract that had occurred in the previous two weeks.
25 April 1995	At a clinic, Dr Martin met Mrs Peacock, mother of Andrew.
25 April 1995	A meeting was held to discuss changes in Dr Bolsin's cardiac commitments, attended by Dr Bolsin, Dr Monk, Dr Trevor Thomas and Professor Prys-Roberts.

Date	**Event**
26 April 1995	Dr Monk replied to Dr Bolsin's letter, asking him to agree to flexibility in his work pattern, in order to avoid interpersonal conflict.
1 May 1995	Mr Pawade took up his position as paediatric cardiac surgeon at the BRI.
1 May 1995	Surgery took place on Andrew Peacock, performed by Mr Wisheart.
6 May 1995	Dr Joffe's reply to the article of 15 April was published in the *'British Medical Journal'* concerning the audit figures.
23 May 1995	Dr Black responded to Dr Joffe by letter.
25 May 1995	A letter was written by Dr Bolsin to the *'British Medical Journal'*.
30 May 1995	Andrew Peacock died.
June 1995	A meeting took place to discuss the audit figures involving Dr Joffe, Mr Wisheart, Mr Dhasmana, Dr Bolsin and Dr Black, chaired by Dr Roylance.
June–August 1995	Arrangements for counselling were made by the UBHT to mediate between the cardiac surgeons and Dr Bolsin.
Autumn 1995	Dr Bolsin withdrew from the counselling process.
1 September 1995	Professor Vann Jones wrote to Dr Roylance to express his dismay that the recommendation that all the operations on children should be done by Mr Pawade had not been implemented.
13 September 1995	Professor de Leval wrote to Dr Roylance concerning the quality of Mr Dhasmana's work and his withdrawal from PCS.
September 1995	Dr Bolsin wrote to Dr Roylance indicating that he and Dr Black were dismayed to have made a mistake in relation to the VSD operations.
12 October 1995	Professor de Leval sent another letter to Dr Roylance reiterating the points made in his first letter.
17 October 1995	Dr Roylance responded to Professor de Leval.
November 1995	Professor de Leval was invited to write a report on the updated PCS results of the UBHT.
23 January 1996	Mr Ross sent the second de Leval report to the Regional Director of the NHSE.
26 January 1996	The UBHT's final report on PCS was presented to, and approved by, the UBHT Board.
31 January 1996	The UBHT's final report was presented at a public meeting.
February 1996	Dr Bolsin left the Trust's employment to take up an appointment in Australia.
27 March 1996	Sir Terence English commented on the mortality levels at Bristol as having been disturbingly high during an interview for the television programme *'Dispatches'*.
3 June 1996	Mr Wisheart prepared a statement for the Clinical Directors, in which he sought to answer questions or allegations raised against him.
June–July 1996	The Hospital Medical Committee passed a motion of support for Mr Wisheart.
24 July 1996	Professor Farndon wrote to Dr Black expressing his attitude towards the concerns over PCS.