

BHCAG RESPONSE TO THE
CLOSING SUBMISSIONS MADE ON
BEHALF OF DR ROYLANCE

PRELIMINARY

This document is the written response of the Bristol Heart Children's Action Group to the Closing Submissions of Dr Roylance's legal team.

1. INTRODUCTION

Para 5 Page 2

'There is no evidence that the system of managing the organisation provoked contemporaneous demands for change in it ...'

- We reject this submission. The Medical Director was accountable for the quality of his clinical practice to no one but himself – what we term in our Written Submissions a 'managerial loophole'.
- It should have been apparent to Dr Roylance that this 'system' needed changing so that concerns about Mr Wisheart's performance needed could be investigated by an independent senior clinician.

2. DR ROYLANCE'S STANDING IN THIS INQUIRY

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'... to make specific adverse judgments of any individual would be unjust ...'

- In our view, while there were times when we would have preferred a more combative and tendentious approach to examination, we accept that the questioning of witnesses by Inquiry Counsel was comprehensive and rigorous.

- Indeed, adversarial questions formulated by the legal representatives of interested participants were routinely put to witnesses by Inquiry Counsel and opportunities were repeatedly given to revisit areas of evidence which were significant and required greater clarification.
- We therefore believe that the evidence elicited by the Inquiry was sufficiently probing and balanced to support findings of fact on which adverse judgments of individuals or organisations may be made.

3. DR ROYLANCE THE MAN AND THE DOCTOR

- The Inquiry panel is not a jury, who must assess a defendant's 'good character' when deciding whether or not it is likely that he or she has committed an offence.
- Dr Roylance is not accused of any criminal acts, but of serious failures of management.
- His exemplary medical record is of no relevance to the Inquiry when assessing the 'probability' that he did or did not take sufficient heed of concerns raised about paediatric cardiac surgery.

4. DR ROYLANCE THE WITNESS

- In our view, Dr Roylance was impressive in the level of detail which he was able to recollect and the authoritative manner in which he maintained that his description of disputed events was the only account of any accuracy.
- The Inquiry panel will have its own view of Dr Roylance's demeanour as a witness.
- We submit that his characteristic gruff dismissals of Inquiry Counsel's suggestions of mismanagement – however minor – were vivid illustrations of his managerial style and his unwillingness to address the concerns which were raised about paediatric cardiac surgery whilst he was Chief Executive.

5. ROYLANCE MANAGEMENT METHOD

- We ask the Inquiry to bear in mind:
 - (1) Ms Hawkins' criticism of Dr Roylance (56/71/18):

'I believe his weakness was that he did not fully appreciate the politics in a teaching hospital with a big and a small 'p' and that, because he always tried to be so even-handed, he was not always seen to be in charge. And his style cascaded down through some of the senior management. That meant there were some loose cannons.'
 - (2) Professor Stirrat's comment (69/17/21) that Dr Roylance:

'tended to stand back in management a bit. He did not interfere with the work of clinicians. He was in a sense a bit laid back.'
 - (3) Mr Ross's belief that Dr Roylance had been a dominant figure within the Trust (19/56/4) at that at the time he took over from him as Chief Executive the system of promotion favoured fitting in rather than more objective measures such as individual and performance reviews (19/53/5).
 - (4) Professor Vann Jones' assertion that Dr Roylance was 'not very approachable' and 'somewhat inflexible' (59/140/7).

Para h Page 14: The consequence of delegation

'There is no doubt that Clinical Directors were expected to assume total responsibility for their departments. More senior management were to be brought in to help only when considered necessary by the Clinical Directors, and clinical responsibility and competence were to be overseen by professional colleagues, not by central management, unless the latter were advised in specific terms of the need to intervene.'

- In our view, Dr Monk's meeting with Dr Roylance in June 1994 was an instance where a senior manager was being asked to intervene in the management of clinical responsibility and competence.

- Dr Roylance did not do so and the anaesthetists' concerns about the paediatric cardiac unit remained unresolved.

Para i Page 16: Whether it was within the normal range of management techniques

'There is no evidence that the management at Bristol was unique in the NHS or elsewhere ...'

- While the structure of delegated clinical management at Bristol was not unique, the problem which needed to be managed within that structure was.
- Senior management at Bristol were faced with:
 - (1) continually resurfacing expressions of concern about the quality of the paediatric cardiac care;
 - (2) the fact that the clinician at the centre of the concerns was the Medical Director of the Trust; and
 - (3) a significant unresolved rift between anaesthetic and surgical staff following the completion of a secret performance audit.
- Dr Roylance failed to recognise that if key senior clinicians denied the existence of a problem within a particular unit, autonomous clinical management would not function.
- In such circumstances, the only means to impose clinical accountability was managerial intervention.

6. THE CONTEXT IN WHICH MANAGEMENT HAD TO WORK

Para b.iii. Page 20

'Continual reassurance from those professionals charged with the management and running of the paediatric cardiac service that there was no cause for concern.'

- These 'reassurances' were repeatedly given by one professional, Mr Wisheart.
- It should have been obvious that Mr Wisheart would be unwilling to admit that the quality of his judgment and surgical skills was inadequate and had led to the death of children under his care.

- Dr Roylance therefore needed objective clinical evidence. He failed to recognise this until January 1995.

Para b.iv. Page 20

'The general view that the solutions to any problems in the service were the appointment of a new specialised surgeon and the move of the service to the Children's Hospital, both of which were in hand.'

- The premise of this view is that there were problems but that these problems were temporarily acceptable.
- In our view the fact that the quality of paediatric cardiac care may determine whether a child lives or dies, renders any remediable problems unacceptable.
- It was not sufficient to acknowledge the existence of problems which may have resulted in loss of life and then to wait several years for the implementation of the perceived solutions.
- Action should have been taken immediately to assess the exact nature of the problems and – if there was no immediate remedy – to cease treating those children who were being put at risk.

7. DR ROYLANCE'S KNOWLEDGE AND UNDERSTANDING OF CONCERNS – GENERAL

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'He did not understand that anyone thought that the service was of such a low standard that it should be stopped or curtailed until the changes had been implemented. It is inconceivable that he would have stood by ...'

- Dr Roylance never asked anyone whether this was the case.
- Until January 1995, he never sought objective information which would have allowed him to decide whether any aspect of paediatric cardiac care was unacceptable.

- He did know that the problem was partly with the quality of surgery – since he knew that it was to be solved by the appointment of a new surgeon.
- Knowing this, he should have implemented a review of the service to identify aspects of the service – i.e. which conditions and/or which age groups – were receiving sub-standard care.
- Without actively seeking the fullest information from an impartial source, Dr Roylance was never in a position where he could reasonably ignore expressions of concern.

8. THE EXPRESSION AND COMMUNICATION OF CONCERNS TO DR ROYLANCE

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'The paucity of even claimed communications ... is eloquent testimony that the vast majority of clinicians were either unaware that there were serious concerns, or rejected the credibility of them.'

- As we argue in our Written Submissions, following the completion of the Bolsin / Black audit in July 1992, the number of clinicians who were aware of serious concerns about the quality of paediatric cardiac surgery was significant and grew rapidly.
- Only a few clinicians, such as Dr Bolsin and Professor Angelini, were able to specify the operations which appeared to result in poor outcomes.
- Others, such as Professor Vann Jones were aware of concerns but rejected their credibility without proper analysis and discussion.
- Of the many clinicians who became aware of concerns between 1992 and 1995, very few addressed the key implication that the unit was endangering lives and very few took proactive steps to achieve a review of the service.
- The rejection of Dr Bolsin's concerns by the clinicians at Bristol was ill-considered and a serious failure of management.
- As the Clinical Case Note Review has demonstrated, a significant proportion of the paediatric cardiac service was of substandard quality and resulted in poor outcomes.

- This was recognised by some contemporaneously. It could and should have been remedied.
- The treatment of concerns at Bristol is eloquent testimony that clinical autonomy does not equate to good health care.

Para a.i. Page 25: Medical Director

- It cannot be over-emphasised that it should have been obvious to Dr Roylance that Mr Wisheart was the wrong person to ask for an objective opinion as to whether he was responsible for a sub-standard service.

CONCLUSION

It is notable that Dr Roylance does not even now accept – as Mr Ross did before the Inquiry – that a substantial number of parents and children did not receive the standard of care at Bristol which they were entitled to expect.

Throughout his evidence to the Inquiry, Dr Roylance repeated the mantra that he was never told that the paediatric cardiac service was thought to be unacceptable. This expression is echoed within his Closing Submissions.

It is no excuse for providing substandard medical care.

‘Acceptability’ is a legal test used when assessing clinical negligence. It is not the threshold which should determine managerial intervention within the National Health Service.

Whenever concerns are expressed that treatment within a particular unit may result in higher than expected mortality, it is the duty of senior management to investigate the source of those concerns and to ask for objective evidence of that unit’s performance.

Only then can managers make a judgment as to whether their service is unacceptable.

Dr Roylance did know that clinicians, managers and the press (in the form of *Private Eye*) were concerned that the results for paediatric cardiac surgery at Bristol were poorer than at other centres. Such concerns were insufficient information for him from the view that the service was unacceptable, but they should have alerted him to that possibility.

He should have taken independent advice.

By consistently relying on Mr Wisheart, Dr Roylance was never in a position to refute with any certainty the suggestion that children in his hospital were dying unnecessarily.