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.'

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.

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

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

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,

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?

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.

[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

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]

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]

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]

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]

[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.

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]

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]

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".

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.

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.

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.

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

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]

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.

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.

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.

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.

[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:

[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]

[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%.

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.

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

[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

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".

[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]

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.

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]

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]

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.

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

[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]

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]

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

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.

[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

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

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?

[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.

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

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 …

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]

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

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]

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

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

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]

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.

[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

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

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

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

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