Bristol Royal infirmary inquiry

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'There's no incentive to admit error, only to cover up'

In an exclusive newspaper interview, Clare Dyer talks to Ian Kennedy, the law professor who headed the inquiry into the heart-surgery baby scandal at Bristol Royal Infirmary

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The photographer poses Ian Kennedy in front of a patch of north London graffiti - a metaphor, perhaps, for the bombed-out NHS, the backdrop against which the events at Bristol Royal Infirmary so tragically unfolded.

Between 30 and 35 babies died needlessly from 1991 to 1995, according to a review carried out for Kennedy's inquiry, which delivered its report last week. Others were left brain-damaged. Bristol was at the bottom of the league table for specialist units doing open-heart surgery on babies, its death rate twice as high as elsewhere. The system of caring for sick and vulnerable children was shot through with flaws.

The disaster was not just down to surgeons with too little skill who were unwilling or unable to recognise their shortcomings and stop operating. The chief executive refused to intervene in clinical matters, and teamwork was lacking between the various professionals involved in children's care. From referral to diagnosis to surgery to intensive care, parents were delivering their sick children into a system that was inherently unsafe. Even the very set-up of the buildings was dangerous.

With hindsight, it was doubtful that Bristol should ever have been designated as a specialist centre for open-heart surgery on babies. The hospital never did enough operations on children for the surgeons, trained and experienced in adult heart surgery, to become really skilled. The surgeons thought they were on a "learning curve" and their figures would improve, but they never did.

Kennedy, 59, admits that the chapter on children's healthcare services was written in some anger. An academic lawyer who deploys words precisely, he twice describes the experience of hearing the evidence about the procession of dead and damaged children as "lacerating". It was, he says, "very hard to listen to such a litany of sadness".

A father himself, with two sons aged 14 and 12, he decided to commute for nine months from his north London home to Bristol and back because "I wanted to remain grounded in my own family. I have young children and I didn't want to be an absentee father to them."

The task was onerous, consuming nearly three years of his

under standing. There was an intellectual challenge in devising a process which was informative and instructive for the panel without being too destructive to witnesses. And there was the challenge of the broad sweep of the NHS - trying to work out how to slowly reconfigure it, knowing that you don't have a clean sheet of paper."

The panel's terms of reference took it way beyond Bristol; it was asked to apply the lessons learned there to produce, in effect, a blueprint for high-quality healthcare across the NHS. Chillingly, despite a raft of recent initiatives, the report notes: "Even today, it is not possible to say, categorically, that events similar to those which happened at Bristol could not happen again in the UK; indeed, are not happening at this moment."

Kennedy says: "To a degree, I had a strong feeling that what we were witnessing in Bristol was not particularly unique to Bristol at all, or to children's heart surgery, or indeed any other corner of the health service. I always felt it could be anywhere and any one of a range of services.

"That said, the important question is whether you can extrapolate from one particular set of circumstances to a whole set of wider observations. I happen to think that if you were careful enough to identify and separate the Bristol specific from the NHS general, you could generalise from Bristol and use it for making wide-ranging observations."

Among the inquiry's nearly 200 recommendations, key themes include setting standards which the public can expect from healthcare and monitoring to ensure the NHS lives up to those standards. The need for openness is one of the strongest messages. The report calls for a non-punitive reporting system like those used by airlines, with incentives for staff to report errors so that lessons can be learned, and possible disciplinary action for those who cover up. One of the most sweeping recommendations is for the abolition of the whole system of suing through the courts for compensation for medical mistakes.

Kennedy, professor of health law, ethics and policy at University College, London, believes the litigation process contributes much to the culture of secrecy and blame which allowed the lid to be kept on the Bristol tragedy for so long. "We take the view that clinical negligence litigation is one of the most significant barriers to open reporting and therefore to learning. There's no incentive to admit error, to investigate er ror, to change practices. There's every incentive to deny and cover up, not least because your career is on the line or your budget may be on the line.

"I don't think we'll ever get to the position where we can properly identify and deal with near misses in an environment where everyone feels safe to talk about it and admit it, unless we get rid of the blame culture which so inhibits everyone. If doctors and nurses feel they can talk about things that are going wrong, then we'll begin the long haul towards safer care, rather than have a profession that feels beleaguered by the media and the clinical negligence system which is looking for someone to take outside and beat up."

The government is studying a range of alternatives, including no-fault compensation, and a system of fixed payments which still leaves patients the option to sue. Kennedy would like to see a new administrative system for allocating compensation, focusing on the patient's needs, and leaving questions of whether any professional acted wrongly to be dealt with under the employment contract or by regulatory bodies such as the GMC.

smaller cases, often more than the patient receives in damages. But many patients who could sue are deterred by the hurdles that the litigation system puts up. Wouldn't a system along the lines Kennedy proposes lead to many more claims? After all, going into hospital is much more dangerous than boarding a plane. The report suggests that up to 25,000 people could be dying each year from avoidable events in UK hospitals, the equivalent of one jumbo jet crash a week. "The current system costs, but it isn't cost-effective," says Kennedy. "A new system will cost, but if it induces a new attitude of trust, I think it will be cost-effective."

A central message from Bristol, says the report, is that if the NHS is to learn from mistakes and reduce the risks to patients, staff "must feel able to be open about their work and the work of colleagues". Bristol was "awash with data" which could have prompted questions about death rates from the late 1980s, had the mindset to ask those questions existed. But James Wisheart, the powerful senior surgeon and medical director, refused to acknowledge that there was a problem. A "club culture" prevailed, with "too much power in too few hands".

Stephen Bolsin, the anaesthetist who eventually brought the scandal to light, sacrificed his UK career in the process and had to start again with his family in Australia. The report notes that the Public Interest Disclosure Act, the legislation passed in 1998 to protect whistleblowers, would not in fact have safeguarded Bolsin in releasing figures to Private Eye, if it had been in force at the time, because he had not first taken the steps laid down by the act. The panel recommends that the law should be changed to protect healthcare professionals who report concerns to the proposed new National Patient Safety Agency.

Many of the recommendations will require legislation, and some will need substantial extra resources. Is Kennedy hopeful that most will be implemented? "There is an important sentence in the report which says that the public is watching, and there are a number of proposals which we regard as important. If they are regarded as bad, we would like to hear the reasons. If not, we'd like to see the action."

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