The Bristol Royal Infirmary Inquiry

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Ministerial statement

THE SECRETARY OF STATE FOR HEALTH'S ANNOUNCEMENT OF A PUBLIC INQUIRY INTO PAEDIATRIC CARDIAC SURGERY SERVICES AT BRISTOL ROYAL INFIRMARY

Frank Dobson, Secretary of State for Health, made the following statement to the House of Commons on Thursday 18 June 1998:

"I promised that once the General Medical Council had completed its disciplinary proceedings against the three doctors concerned, the Government would establish an independent inquiry into children's heart surgery at the Bristol Royal Infirmary. On 29 May, the GMC announced that it had concluded that many of the charges against the doctors were proved. It has taken further time to consider what action to take against the doctors concerned. Today, it has struck off two of them, Mr Wisheart and Dr Roylance, and censured Dr Dhasmana.

The inquiry will be chaired by Professor Ian Kennedy, professor of health law, ethics and policy at University College London. He is an eminent lawyer and an expert in medical, legal and ethical issues. He has written extensively on problems arising from the care of severely disabled new-born babies. He has chaired the Expert Advisory Group on ethics of xenotransplantation and the Advisory Group on rabies and quarantine. He was a member of the Expert Advisory Group on AIDS.

Under the National Health Service Act 1977, as Chairman of the Public Inquiry Professor Kennedy will have the power to require witnesses to attend the Inquiry; to give evidence on oath and to produce documents. Criminal penalties are available against any who refuse to do so.

I intend to announce the other members of the inquiry and its detailed terms of reference very soon. Today I can make it clear that the inquiry will examine all aspects of what went wrong at Bristol. It will identify any professional, management and organisational failures and make recommendations to safeguard patients and their families in the future.

I have had three meetings with the representatives of parents of children who died or suffered brain damage following heart surgery at Bristol Royal Infirmary. I was deeply impressed by their grief at what had happened to their children, by their dissatisfaction with how they - the parents - has been treated since, and by their disillusion with the clinical, professional and management arrangements which failed to deliver the standards of treatment and care that everyone has come to expect from the national health service. We owe it to them to get to the bottom of what went wrong in Bristol - that all the facts are exposed and

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responsibility is identified. We also owe it to them to try to complete the inquiry within a reasonable period so that they can make a new start in their lives. We owe it to them and everyone else in our country to make sure that lessons are learned so that such a tragedy never occurs again.

The Government are not going to wait for the outcome of the inquiry before taking action to in place new machinery for setting and maintaining clinical standards in the national service. As we spelled out in December in our White Paper, "The New NHS", we are introducing a whole range of measures.

We will establish a national institute for clinical excellence to set national standards. No such organisation exists at present. We will place a duty of clinical governance on NHS trusts. They do not have such a duty at present. To make sure that the new national standards are being met, we will establish a commission for health improvement. There is no such organisation at present. We will require all hospital doctors to participate in national external audit. There is no such requirement at present.

We will enable all patients and their GPs to get information on treatment success rates at their local hospital. They have no such right at the moment. All those measures have been welcomed by the Bristol parents. They have been welcomed by the medical nursing and midwifery professions. They will be included in our forthcoming national health service Bill. Where legally possible, we will proceed with some changes even before the Bill becomes law.

As I said when I met them last Friday to the representatives of the Bristol parents, the measures already in train and any further changes which result from the public inquiry will be too late to save their children; but I think I was speaking on behalf of us all when I expressed to the parents my hope that they would gain at least some consolation from the knowledge that the lessons learned from what their children has suffered should mean that nothing like it ever happens again."

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Terms of Reference

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

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Who's who

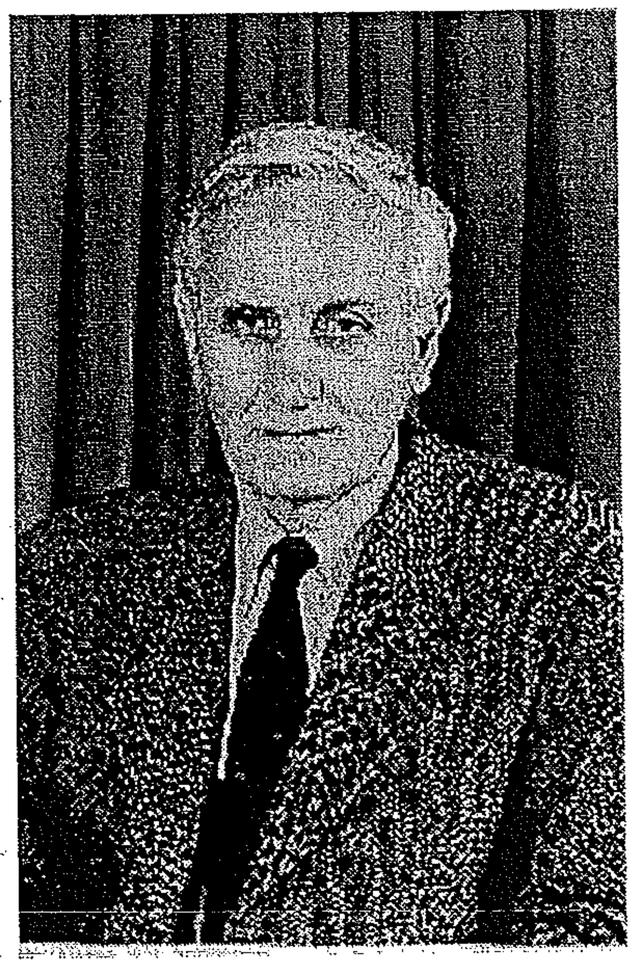
Chairman

Professor Ian Kennedy is Professor of Health Law, Ethics and Policy at the School of Public Policy, University College, London. He holds degrees in law from universities in the UK and USA and is a Barrister and Honorary Bencher of the Inner Temple. Until December 1996, he had been Dean of the Law School at King's College London for ten years and was Director and then President of the Centre of Medical Law and Ethics which he founded in 1978.

He has a long involvement in public service including membership of the Medicines Commission and the Department of Health's Expert Advisory Group on AIDS. He Chaired the Secretary of State for Health's Advisory Group on Xenotransplantation and the Minister of Agriculture's Advisory Group on Quarantine. He is Chairman of the Nuffield Council on Bioethics and serves on the Archbishop of Canterbury's Advisory Group on Medical Ethics and the International Forum on Transplant Ethics.

The Reith Lecturer in 1980, Professor Kennedy has taught and lectured throughout the world. He is the author of texts on medical law and ethics, co-editor of the leading journal on medical law and a member of the editorial board of ten national and international journals.

Panel Members



Professor Sir Brian Jarman OBE is Emeritus Professor at Imperial College School of Medicine at St. Mary's Hospital, London W2 and a member of the Standing Medical Advisory Committee to the Government. He is a locum GP at Lisson Grove Health Centre in London NW8 and was previously Head of Division, Primary Care and Population Health Sciences, at Imperial College School of Medicine. He is a Fellow of the Royal College of Physicians, a Fellow of the Royal College of General Practitioners and a Member of the Faculty of Public Health Medicine.

Rebecca Howard is the Executive Director of Nursing at the Royal Liverpool Children's NHS Trust. A registered sick children's nurse with over 20 years' NHS experience, she has contributed to the development of national policy in the area of children's services, and has a special interest in paediatric intensive care.

THE SHIPMAN INQUIRY

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Background to the Inquiry

Harold Fredrick Shipman was convicted at Preston Crown Court on 31 January 2000 of the murder of 15 of his patients while he was a General Practitioner at Market Street, Hyde, near Manchester and of one count of forging a will. He was sentenced to life imprisonment.

Police have also investigated allegations that he may have murdered many more patients while he was a GP in Hyde and Todmorden.

On 1 February 2000, the Secretary of State for Health announced that an independent private inquiry would take place to establish what changes to current systems should be made in order to safeguard patients in the future. Although it would be held in private its report would be made public. The private inquiry, under the chairmanship of Lord Laming of Tewin, began work on 10 March and was charged with reporting its findings and recommendations to the Secretary of State for Health and the Home Secretary by September 2000.

Many of the families and sections of the British media sought a Judicial Review in the High Court, which found in their favour and recommended that the Secretary of State for Health reconsider his decision that the Inquiry should be held in private.

In September 2000, the Secretary of State for Health announced that the Inquiry would be held in public under the terms of the Tribunals of Inquiry (Evidence) Act 1921. Both Houses of Parliament ratified this decision in January 2001.

Dame Janet Smith DBE, a High Court judge, was appointed Chairman of The Shipman Inquiry and the work of the independent public inquiry began in February 2001. The public hearings into Phase 1 began on 20 June 2001. The public hearings into Phase 2 began on 7 May 2002.

The Inquiry's First Report was published on 19 July 2002

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