Dr Kim Holt, Baby P and Great Ormond Street Hospital

AFTER finally issuing an apology to whistleblower Dr Kim Holt last month, Great Ormond Street Hospital (GOSH – a foundation trust-in-waiting) and its Tellen-coated CEO Dr Jane Collins were doubtless hoping to draw a line under Baby P. But Lynne Featherstone MP is now calling for an investigation into Collins’ actions in withholding vital information – the Sibert report from the original serious case review into the death of baby Peter Connelly. Collins says this was on legal advice and her review into the death of baby Peter Connelly. The hospital has friends in high places: Ivan Cameron, the prime minister’s severely disabled son, was treated at GOSH; and its charity is wooing Samantha Cameron as a patron. Collins, who removed herself from the General Medical Council (GMC) register and can’t be referred over Baby P’s death, has survived persistent calls for a public inquiry and a vote of no-confidence from 50 consultants last year. But she needs to be held accountable for the audit trail of suppression that has protected one of Britain’s most cherished hospitals and deflected the blame for Baby P’s death disproportionately onto to standard social services and one under-qualified consultant, Dr Sabah Al-Zayyat, who missed the child abuse.

Peter Connelly was found dead in his cot on 3 August 2007. In January 2008, Dr Collins commissioned a report, written by Professor Jo Sibert and Dr Deborah Hodes, two renowned paediatricians, entitled Review of Child Protection Practice of Dr Sabah Al-Zayyat. Normally NHS trusts “own” these expert reports and can publish the favourable bits and miss out the bad bits, but you are expected to come clean for a serious case review. Collins didn’t.

The Sibert report exposes serious failings in the management at St Ann’s child development clinic in Haringey, where GOSH employed the clinical staff: “Dr Sukanta Banerjee (a consultant) told us the state of affairs at St Ann’s was a ‘clinically risky situation’. We agree with her and we believe the present arrangements for seeing child protection cases at St Ann’s cause grave concern. In particular, the lack of consultant staff.”

But GOSH already knew this. In 2003, it paid and gagged Professor Sam Lingham, who was then running the child development clinic single-handed. GOSH then hired four new consultants, who found the working environment very unsafe. They wrote a letter in 2006 highlighting their concerns about a “lack of unified records”, “missing records” and “no child protection follow-up”. To make safe decisions on the risk of child abuse, accurate and comprehensive notes are essential. Two of the consultants left. Kim Holt was put on special leave, having already written to management about the dangerous and poorly functioning clinic.

So GOSH hired Sabah Al-Zayyat into a consultant post that required two years’ child protection training. Dr Al-Zayyat’s CV made clear she had none. She was also to do a very difficult job with no notes. By the time Baby P presented at the clinic, he had already been to A&E three times previously, as the notes would have made clear.

At nine months, Peter had been admitted to the paediatric ward at the Whittington hospital with an unexplained haematoma. The hospital noticed bruising on Peter’s head, cheek and buttock describing it as classic non-accidental injury. At the time, Peter’s mother provided a variety of different explanations for the injury. At 13 months old, Peter arrived at A&E at North Middlesex University Hospital after a head injury. The CT scan was normal but Peter had bruising and scratching on his face, and his mother provided two different explanations for the injuries. At 16 months Baby P again presented at A&E, this time with a rash on his scalp, itchy left ear discharge and swelling in the ear lobe. He also had bloody scabs on his infected scalp, itchy hives and head lice. His mother again gave two different versions of events, blaming it on an “allergic reaction to Red Leicester cheese”. A diagnosis of child abuse had already been made, but Dr Al-Zayyat knew nothing of this.

The Sibert report makes it clear three times in bold that “This information was not in the St Ann’s notes.” This was hardly what Collins wanted to hear, as she could no longer blame Baby P’s death on one doctor – who made serious clinical errors - when there was also a convincing written audit trail implicating GOSH and her leadership.

So what did Collins do? She tried to manage the problem. Immediately after Baby P’s death, Kim Holt was offered a year’s salary in November 2007 to leave. In December 2008, when Baby P’s death had become a tabloid sensation, Dr Holt was offered £120,000 to sign a compromise agreement with a “super-gag” clause. But there was one catch. Lawyers for Great Ormond Street, Beachcroft, wrote to Dr Holt claiming: “Our client is not aware that Dr Holt has ever raised concerns over the management of child protection issues.” This one sentence sought to rewrite the audit trail and ensure GOSH could escape blame. The offer of £120,000 was then made expressly

’Tif our concerns had been taken seriously at the time we raised them, we could have prevented the death of Baby Peter’

Whistleblower Dr Kim Holt

THE NHS will always need whistleblowers. Healthcare is complex, rapidly changing and dangerous; staff are fallible, variably trained and widely spaced; and demands are huge and resources limited. No matter how much is spent on regulation and risk management, shit will always happen – mistakes, incompetence, inhumane treatment and corruption.

The system doesn’t need to keep on happening. If it’s picked up and acted on, many lives and much money can be saved. If staff, patients and carers are encouraged to speak up, you can even stop mistakes in their tracks before harm is done.

As this special report highlights, however, the shocking treatment of NHS whistleblowers persists as the body that is trusted to care for us from cradle to grave systematically covers up scandals, crushes dissent and kills patients unnecessarily...
subject to these allegations being withdrawn. Kim Holt bravely refused. GOSH also failed to tell the Treasury that the £120,000 “off fee”, at taxpayers’ expense, would be tied to a silencing agreement. Faced with Dr Holt sticking to her principles, the strategic health authority sprang into action. NHS London’s GOSH, on a report from a firm of solicitors, which appears to exonerate NHS managers. GOSH spent £286,797.41 on Verita management consultants who also seemed to find no fault with management (and did not even interview the four consultants who signed the 2006 letter).

Dr Holt, meanwhile, remained on special leave at a cost of £95,000 a year, and GOSH had spent £82,218 on legal advice to date in her case. No manager has faced any sanction as a result of their failings in running the child protection clinic.

And what of the Care Quality Commission? In February 2009 Dr Holt sent it the letter written by all four consultants, and her letter to Cyril Chantler, GOSH chairman, and Jane Collins from November 2006. In May 2009, the CQC responded by releasing a report in which the problems at the child protection clinic were all put down to “communication”. No blame was levelled at any manager and the whistleblowing letter of the four paediatric consultants was ignored.

When Dr Holt contacted the CQC to make it aware of previous whistleblowing disclosures, she was told that the CQC had considered her information. However, recently the CQC has “lost” all communications with Great Ormond Street. It paid over £6,200 to give details of any information may have been used for “horizon scanning” or to contact people with concerns.

Were people contacted? Not that the Eye could ascertain. And certainly not the CQC. If GOSH is absolutely marvellous, as The Lancet observed: “If GOSH’s management team had been in Wigan they would be gone by now.”

In the meantime, health secretary Andrew Barclay MP, Chair of the GOSH Foundation Trust, had decided to meet Dr Holt and has resisted calls for a public inquiry. Someone at GOSH has been protected; but it certainly wasn’t Peter Connelly.

Gagging clauses can apply to whistleblowers, whatever their rank, and to incompetent staff who’ve been paid to move on. Either way, safety concerns are hidden and there’s no guarantee lessons are learned or that harm will be prevented.

In November 2009 the Information Commissioner forced Liverpool Women’s NHS Foundation Trust to hand over all its compromise agreements and their cost to the public purse. Thirteen members of staff had signed agreements at value of £440,000, all containing “gagging” clauses. Of those 13 silenced were “individuals may be subject to inquiry, comment or criticism”. Dudley NHS Foundation Trust wanted £10,412.50 to provide the information; and University Hospital Birmingham NHS Foundation Trust wanted £2,408,026 so far in 2010-11. The top five FTs for pay-offs are: Alder Hey Children’s Hospital Trust £2,408,026 so far in 2010-11. The top five FTs for pay-offs are: Dudley NHS Foundation Trust £177,388

Pay off, shell out, shut up

THE Treasury made 2008-09 a bumper year for non-foundation trust pay-offs, approving 192 at a cost of £5,990,504. Foundation trusts now hold the bacon with 105 pay-offs worth £2,408,026 so far in 2010-11. The top five FTs for pay-offs are:

South Staffordshire and Worcestershire (10/11) £330,850
Sherwood Forest Hospitals (09/10) £230,000
Central Manchester University Hospitals (10/11) £224,253
Alder Hey Children’s (09/09) £198,726
University College London Hospitals (10/11) £177,388

For figures for all NHS trusts see www.medicalmalpractice.org.

Behind the gag

NONE of the NHS trusts would provide names for the staff they had paid off and gagged, or the reasons why.

When the Eye contacted Alder Hey Hospital to ask about gagging orders, the answer was very firm: “Alder Hey has never placed gagging orders on any member of staff.” But the Eye already had in its possession the compromise agreement relating to a senior child heart surgeon, Mr Marco Pozzi, and the amount he was paid, namely £516,000. That agreement prevents Mr Pozzi making any adverse or derogatory statement about the trust and communicating with any media. When we put this to the trust, it apologised for the “misunderstanding” but wouldn’t say what it wanted to keep quiet.

Marco Pozzi gave evidence to the Bristol Inquiry and became the lead surgeon in children’s heart surgery at Alder Hey. From 2003 to 2008, a freedom of information request reveals, his mortality rate for 80 arterial switch operations was an enviable zero. Not a surgeon one would want to lose. From a local MP, however, we have learned that Mr Pozzi had been instrumental in limiting the practice of an underperforming surgeon and had concerns about
Lansley's broken promises

HEALTH secretary Andrew Lansley hasn’t had a great year.

Having pledged to depoliticise the NHS, he’s managed to turn it into a massive political bun-fight; and having promised to reduce top-down control, he’s somehow increased it, junking two levels of bureaucracy to create four. Out go strategic health authorities and primary care trusts (SHAs and PCTs), in come a National Commissioning Board, Regional Branches of the Board, Clinical Senates and Clinical Commissioning Consortia.

But easily the most important pledge he made before the House of Commons on 9 June 2010 has been quietly shelved.

Then, the new health secretary announced a public inquiry into “events” at the Mid Staffordshire NHS Trust, where up to 1,200 patients may have died due to appalling standards of care. Three previous inquiries had unearthed a culture of fear, secrecy and bullying, where whistleblowers were being punished and silenced. Lansley pledged “a range of measures to build on and give teeth to the current safeguards in the public interest disclosure act 1998 (PIDA)”. Thirteen months later, we’re still waiting.

alleged manipulation of statistical outcomes. He approached the Department of Health for advice but was told — as all whistleblowers are — it was a local matter that needed to be sorted out locally.

Since Mr Pozzi has now been paid off at public expense, these problems will never be independently scrutinized. The gagging clause was negotiated by Louise Shepherd, the chief executive of Alder Hey. At her former hospital, the Liverpool Women’s NHS Trust, she was also fond of gagging (see Gagging for it, above).

Even GPs are gagged. Dr Louis d’Arcy was a single-handed GP at Hanson Place surgery in Wyke, near Bradford, where he had practised for more than 25 years.

In 2004, Bradford primary care trust (PCT) sent in a nurse practitioner to his surgery to help manage his diabetic patients in a nurse-led clinic. Over a few years, d’Arcy became concerned that some might be testing “false positive” for diabetes and be wrongly diagnosed and treated for life. A consultant endocrinologist saw one patient and confirmed the diagnosis. Lansley pledged “a duty of candour to ensure patients and their relatives are told when they have been harmed by the care they’ve received”. But he has been gagged.

The National Harm Service

HEALTHCARE is an industry that causes significant harm while bringing enormous benefits. One million people are injured or killed each year due to errors in care. Any other industry would be shut down with such an appalling safety record; but healthcare has an ingrained culture of denial. Errors are hidden, rather than owned up to; and many more pass unnoticed because nobody bothers to pick them up.

The NHS has tried to write off its worst excesses until the heart scandal at the Bristol Royal Infirmary (BRI). The avoidable death and brain damage of a large number of babies there was too much even for the NHS to hide. Even worse, the whistle was blown from 1988, the Department of Health knew it had a problem in 1989, the Eye broke the story repeatedly in 1992 and yet the deaths and brain damage continued until 1995.

In 1997 Labour inherited a whole host of scandals from the Tories. In 1998 it introduced PIDA to try to outlaw the gagging of whistleblowers and to offer unlimited damages for those were punished for raising genuine concerns.

The Bristol Inquiry acknowledged that the heart scandal was the tip of a very unpleasant iceberg. It estimated that 25,000 patients a year die in the NHS in England and Wales “from adverse events that may be preventable from the exercise of ordinary standards of care”.

Inquiry chairman Ian Kennedy said he could not be confident that other systemic failures of care were not hiding in the NHS, and that radical change was needed to stop and prevent them. The report made 198 recommendations to enshrine transparency and patient safety as the organising principles of the NHS. These included:

- The creation of an open and non-punitive environment in the NHS in which it is safe to report and admit to “near misses” and patient harm.
- A compulsory analysis of all such events, taking into account both the conduct of individuals and wider contributing factors within the organisation.
- Disciplinary action against any member of staff in the NHS who covers up or does not report an adverse event.
- A duty of candour to ensure patients and relatives are told when they have been harmed by the care they’ve received.
- An acknowledgement, explanation and apology to those harmed.
- A prompt system for providing compensation for those who suffer harm arising out of medical care based on patients’ needs.
- An urgent investigation to ensure child heart surgery is not currently being carried out where the low volume of patients or other factors make it unsafe to perform such surgery.

Ten years on, none of these key reforms has been properly enforced. Labour tried to manage patient safety from the centre and it didn’t work. The risks of healthcare change by the second and regulators haven’t got a clue what’s happening on the frontline. Hospitals learn how to pass checklist assessments and patients are conned into thinking a hospital is safe because it’s passed an annual healthcheck.

A review in 2009 showed that NHS organisations were subject to 35 different regulators, auditors, inspectors and accreditation agencies that demanded information from the various parts of the system. Not one of them can prove the NHS is getting safer, and none of them prevented the scandals at Stoke Mandeville, Maidstone and Tunbridge Wells, Basildon and Thurrock, Colchester or Mid Staffs.

The black box of general practice

GENERAL practice remained hidden away until the horrors committed by Dr Harold Shipman emerged. Whether he’d killed more than 200 people by murder or incompetence, the real shock was that no one had picked it up. He wasn’t even offered retraining.

A decade ago, Dame Janet Smith called for reforms of death certification, coroners, controlled drugs and the regulation of doctors.
Her recommendations have been watered down or ignored to the point that she has been told in no uncertain terms by the Department of Health and national leaders that her work was not required. When she knocked back the collected figures to show how awful the results were for a whole range of complex child heart operations, supported parents who were fighting their own cases of negligence by their cardiac surgeons and the chief executive to the General Medical Council (GMC). He was a hero; yet the medical and managerial establishments hated him for exposing how dangerous and self-destructive the system was.

The further tragedy of Bristol was that it was avoidable. Had those in authority acted promptly on Bolsin’s concerns, the scandal would never have happened. Many more babies’ lives would have been saved, many children and young adults would be living without brain damage and many more families would still be intact. After the inquiry, parents realised that everyone seemed to know about Bristol but no one did anything about it. The preventative was too little, too late. Marriages split up, lives were totally inadequate. They also employed a “nurse” who was not qualified.

The process of removing dangerous doctors in Tower Hamlets took great effort and cooperation between those raising concerns and those acting on them. It’s a beacon of how the system works against whistleblowers to suppress scandals that might be politically or commercially damaging.

Steve Bolsin and Ash Pawade

POLITICAL reforms often court disaster. Twenty years ago, the Bristol Royal Infirmary was keen to become a trust hospital under the Tories, just as Mid Staffs wanted to become a foundation trust under Labour and GOSH do today. This was because the process of removing dangerous doctors in Tower Hamlets took great effort and cooperation between those raising concerns and those acting on them. It’s a beacon of how the system works against whistleblowers to suppress scandals that might be politically or commercially damaging.

The DoH deliberately and systematically suppresses sound evidence from reliable sources which they would prefer not to hear...
Birmingham and The Black Country SHA and in August 2005 became chief executive of Shropshire and Staffordshire SHA and West Midlands South SHA. Mid Staffs started on his watch and his evidence to the public inquiry is likely to be equally revealing. Or at least it would have been if the DoH hadn’t delayed producing key documents and postponed his appearance.

Nicholson has now been appointed – without any apparent competition – as chief executive of the coalition’s new NHS Commissioning Board. The combination of rapid structural reform and impossible efficiency savings is a perfect storm for more scandals, particularly if the same leaders are enforcing the same culture of denial and blame. At Mid Staffs staff have even been blamed for not blowing the whistle. In fact there is evidence that plenty of concerns were raised over a period of years. The problem is that they were not acted upon.

**Raj Mattu**

IN 1999, managers at University Hospitals Coventry and Warwickshire NHS Trust (UHCW) – a neighbour of Mid Staffs – came up with a clever policy to hit Labour’s waiting time targets. They decided to stuff five beds into wards designed for four, so three beds had no easy access to suction or oxygen sockets and there was very little space to move between them.

In December, a 35-year-old man was admitted to the cardiology ward having arrived at A&E the night before and had a cardiac arrest. Unfortunately he was put in one of the beds with no suction or oxygen supply nearby.

With the patient blue and choking, Dr Raj Mattu – a consultant cardiologist and world-renowned researcher – looked down his throat and found a large blood clot. This could have been removed by suction, but there was none available and the crash trolley could not get to the side of the bed. Dr Mattu could not remove the clot as the crash team looked on helplessly. The patient died soon after.

Mattu filled out a clinical incident form, also signed by two of the emergency nurses. There were other alleged deaths implicating the 5-in-4 beds policy, one just three weeks later. Mattu received no response to his clinical incident form and wrote to CEO David Loughton chasing a response. None came. Sixteen months later, 80 clinical incident forms had been filled in by doctors and the trust had still not acknowledged Mattu’s letters. Mattu was twice voted in by his colleagues as clinical director and twice vetoed by management.

In September 2001, the Commission for Health Improvement (CHI) visited the site. It issued a damning report, saying the practice of 5-in-4 was “wholly unacceptable” and “must stop and cease immediately”. To add to the trust’s woes, the mortality ratio was higher than even Mid Staffs. Loughton went on local TV and claimed that there had been no deaths he knew of as a result of the “5 in 4 policy”. In consultation with his union, Mattu went on TV a week later and described the death he had witnessed.

Loughton then commissioned a secret review of the death from an anaesthetist, Dr Mark Porter, now the BMA’s lead spokesperson on whistleblowing. Dr Porter’s report declared “this is a failing that should not have happened”, but adds: “There are records of medical problems sufficient to conclude that his death may have been unavoidable, or was not avoided by medical management that could have been taken.” The report was a godsend to Loughton.

Mattu’s representative, Stephen Campion, was called to an off-the-record meeting with Loughton at a local hotel. At that meeting, Campion claims Loughton said: “I’m not interested in giving Dr Mattu a parking ticket, I want him off the road.” Two months later, Mattu was suspended on an allegation of bullying. He remained suspended for six years. Loughton left the trust in 2002.

An independent QC was employed by the trust to conduct an internal review at a cost of more than £1m in 2005. He recommended that Mattu be reinstated. After the suspension was finally lifted in 2007, the trust sent more than 200 allegations about Mattu to the GMC.

Every allegation was dismissed by the GMC, but the stress was huge. Finally in November 2010, the hospital sacked Mattu for becoming ill during the process. Mattu suffers with a multisystem autoimmune disease which comprises sarcoidosis, pancreatitis and lung disease, and is known to be exacerbated by stress. The trust had been fully aware of his condition since 1999.

Throughout Dr Mattu was offered pay-offs with gag clauses that he courageously refused. The entire episode has cost the trust £5m; it has destroyed the career of one of the finest consultants it ever had; and staff at nearby Mid Staffs were left in no doubt about the dangers of whistleblowing.

UHCW told the *Eye* it had conducted an independent review into deaths from 5-in-4 wards. However, the trust was unable to provide the name of the reviewer or the text of the independent review. The review therefore remains secret and we have no evidence that it took place. UHCW denied that 200 complaints had been made to the GMC about Dr Mattu but did not provide the real number.

**Gary Walker**

THE United Lincolnshire Hospitals Trust was in trouble, with seven CEOs between 2000-2006, each lasting on average only nine months. During that time, seven doctors were on the receiving end of compromise agreements, all with gag clauses.

In 2006, the trust appointed Gary Walker, a turnaround chief executive who would stay. One of the first things Walker did was to abolish a middle manager fix which had seen A&E beds being pushed into corridors and cupboards without an oxygen supply to ensure that waiting time targets were achieved.

Within two years financial deficits had been paid off and targets were met. In the winter of 2008, the trust experienced a dramatic rise in A&E admissions, sustained for eight months. Clinicians approached Mr Walker about the increased risk of hospital acquired infections...
and avoidable mortality in the overstretched department. The overwhelming view was that targets could not be met without compromising patient care.

Mr Walker wrote a letter to his SHA: “I believe the health system is in distress. I am extremely concerned about safety and have asked for a series of reports on safety issues including mortality.” The chief executive of the SHA, Barbara Hakin, wrote on an internal email seen by the Eye: “You need to meet targets whatever the demand.” Two months later Hakin took to the local media to voice her “considerable concerns as to whether governance arrangements in the trust were right”.

In internal board documents seen by the Eye, it is claimed that at a meeting with Walker the SHA suggested Walker should leave and construct a story for the hospital board, and that he was told if he did not leave, “his career would be in ruins”. Mr Walker was offered £43,000 to sign a compromise agreement with a gag clause and leave. He refused. He was then summarily sacked, in February 2010, for the gross misconduct of allegedly using the “f-word” nine times at three meetings over a two-year period, not directed at any one individual but in general. He is now claiming unfair dismissal.

Since Walker was sacked, mortality rates and debt at the trust have risen and safety concerns have continued. Recently, after a road traffic accident, it is claimed that an experienced surgeon was pulled out of theatre to operate on an 18-week target patient. A staff grade surgeon took over but ran into difficulties and it is claimed the patient has since had a leg amputated. Another patient died unexpectedly after a prostatectomy.

In May 2010, the CQC undertook an unannounced site visit but did not contact or speak to any doctors with concerns. The regulator says it checked the notes of six patients but did not contact or speak to any doctors with concerns. The CQC report stated: “It is claimed the patient has since had a leg amputated. Another patient died unexpectedly after a prostatectomy.”

Barbara Hakin, meanwhile, has been promoted to the DoH’s director of commissioning, slotting in beside David Nicholson. In a statement, the DoH denied the commissioning, slotting in beside David

SUPER SEXTET. From top left, Dr Kim Holt, sent on ‘special leave’ for four years after whistleblowing at Great Ormond Street; cardiac anaesthetist Steve Bolsin and cardiac surgeon Ash Pawade, whose outspoken but valid criticisms led to their parting company from the Bristol Royal Infirmary; Raj Mattu, the consultant cardiologist in Coventry who knew that five beds into four simply won’t go; Gary Walker, a ‘turnaround chief executive’ at the United Lincolnshire Hospital Trust, who said government targets were putting patients at risk and was duly sacked for using the f-word; and Dr Peter Wilmshurst, godfather of whistleblowers, whose outspoken campaigning means he faces bankruptcy. Again.

John Watkinson

ONE of John Watkinson’s first actions as CEO of Royal Cornwall Hospitals NHS Trust (RCHT) in January 2007 was to bring back to work two employees who had blown the whistle on the trust for making false declarations. Eighteen months later, Watkinson was suspended and subsequently dismissed for whistleblowing plans to move cancer services without the legally-required public consultation.

RCHT was the worst performing trust in England, with a £35m debt and staff utterly demoralised. Within a year, Watkinson delivered a £1.2m surplus and RCHT was in the top four A&E performers in the country. Then NHS South West, the SHA, decided to concentrate upper gastro-intestinal services in Plymouth, with Cornwall and Exeter forming a centre of excellence. Two statutes say that such major service changes require formal public consultation – “no decision about me without me” – but neither the SHA nor the PCT wanted delay. Watkinson’s chairman, Peter Davies, resigned over the issue and when Watkinson sought legal advice confirming the obligation to consult publicly, his days were numbered. He was sacked six months later.

An employment tribunal found Watkinson had been “got rid of” because of his support for doing what the law requires. The findings were damning of RCHT and the SHA and it awarded him £1.2m compensation, now reduced to £900,000. The trust admitted he had been unfairly dismissed, but appealed the finding of whistleblowing, the outcome of which is awaited.

An Eye freedom of information inquiry revealed that RCHT has already spent £400,000 on legal costs. Watkinson has spent a similar, non-recoverable, amount of his own; and if the trust keeps throwing public money at appeals he may never get any compensation.

In doing the right thing, Watkinson lost a 35-year career, any prospect of employment and a £150,000 a year salary. Suspension required him not to talk with former colleagues, while not a single NHS chief executive – of whom he knows dozens – has been in contact since his case began. Worst of all, RCHT – like ULHT – has lost an excellent NHS manager who had the balls to stand up to the bullies at the centre on behalf of patients.

Be a fraud…

NATIONALLY renowned cancer expert Dr K had a brilliant career both academically and as a caring and much-loved doctor to his patients. In 1990 he began training in clinical oncology at Christie Hospital, Manchester – the largest single-site cancer centre in the UK – and became a consultant in 1996.

Dr K became concerned that the trust was not treating a sufficient number of cancer patients with radiotherapy. He was also worried that pathology results were missing
from patients’ notes and that the medical cover for patients on a private ward called Nathan House was insufficient.

Dr Foe has seen an unrelated four-page letter from a patient who wrote “to demonstrate a remarkable, disappointing and very alarming drop in the quality of care” at Nathan House. Chemotherapy tablets were allegedly not prescribed; a dose of erythropoietin was lost; a nurse didn’t know where vital equipment was and couldn’t take blood; urine collectors were removed without gloves; a patient was told to swallow a tablet that was meant to be chewed; and a diagnosis of septicaemia was delayed because a thermometer wasn’t working.

The trust investigated Dr K’s concerns and found no substance to them. However, it did launch an investigation into his conduct and referred him to the GMC for fraud.

Dr K’s BMA rep said the charges were “completely incredible” (sic) but they placed him under enormous stress. The GMC summoned him to an interim orders panel, where he collapsed and died of a brain haemorrhage at the age of 46.

When Private Eye contacted the Christie to ask about the concerns on pathology notes and radiotherapy treatment, the trust said a “serious untoward incident” process had been completed, and that a “senior oncologist” investigated the concerns and found no substance to them. The trust was unable to say whether the oncologist was from within the trust, nor to provide any details of the investigation.

Gideon’s libel

IN JULY 2010, the GMC suspended surgeon Gideon Lauffer for six months. He’d previously been banned by Barking, Havering and Redbridge University Hospitals NHS Trust in Essex from carrying out laparoscopic and varicose vein surgery, but neglected to tell three private hospitals because he was too “embarrassed”.

The GMC also declared that he operated on his own competence and had failed to tell a patient that he had damaged the man’s left testicle during an inguinal hernia repair. In March 2008 he had failed to tell a patient who was due to undergo a laparoscopic cholecystectomy that he had damaged and found no substance to them. The trust was unable to say whether the oncologist was from within the trust, nor to provide any details of the investigation.

Criminal sanctions should be enforced against individuals and NHS bodies for the victimisation of whistleblowers and the corporate manslaughter of patients who are harmed as a result of their failure to act.

Dr Peter Gooderham, academic lawyer and whistleblowing expert

ended up in front of the GMC, Mr F received a letter from lawyers warning him to remain silent, King George Hospital told the Eye there was “nothing illegal” about gagging clauses and that they no longer held Mr F’s details on file. No one we asked has any idea where Mr Lauffer is working now, who is auditing his work and whether he is safe. The GMC is just hoping it all quietly goes away, Anne Harris will make sure it doesn’t.

Dr Peter Wilmshurst

DR PETER Wilmshurst is the godfather of healthcare whistleblowers. He has taken on corrupt colleagues and the pharmaceutical industry for more than 30 years, and is still holding down a job as consultant cardiologist at Royal Shrewsbury Hospital.

He is currently fighting three defamation actions against a win, not an American branded Swiss company, NMT Medical, which is suing him in the English high court after comments he made at a cardiology meeting in the US in October 2007 were published on an American cardiology website by a Canadian journalist. Neither the website nor the journalist is being sued (see Eyes passim).

Wilmshurst was the principal cardiologist in the team which was sponsored by NMT and aimed to see if closing a hole in the heart could reduce migraines. He and another researcher refused to be authors of an article about the trial in the cardiology journal, Circulation. They were concerned that the data submitted was inaccurate and incomplete. After publication, Wilmshurst sent the editor of Circulation hundreds of pages of documents, which led to a long correction, a four-page data supplement and an agreement by NMT and the principal investigator to refund Wilmshurst £125,000 and the agreement, which included a “gagging” clause. Mr F could only talk to his immediate family and could not, directly or indirectly, make any comments about the trust. When the Eye asked for details of compromise agreements from Barking, Havering and Redbridge University Hospitals Trust, Mr F’s agreement was omitted. His concerns, and the record of his gag, remained secret. Mr F has been unable to talk to Private Eye.

None of the surgeons recently involved in restricting Lauffer’s practice has heard of the concerns raised back in 1999. Whistleblower Mr F has since found NHS employment hard to come by. Mr F wrote to the GMC about Lauffer in 2000. On one occasion that Lauffer...
and speaking to regulators in other countries, he was able to prevent amrinone getting a European licence.

In 1984 Sterling-Winthrop announced it was withdrawing the drug worldwide because of its unacceptably high rate of life-threatening side effects. However, in 1986 Wilmshurst discovered that it was still selling amrinone over the counter in parts of Africa and Asia. Wilmshurst asked Oxfam to use its representatives in developing countries to collect evidence and the drug was finally withdrawn worldwide.

In 1996 Wilmshurst gave a seminar to 40 editors of UK medical journals, highlighting 16 cases of misconduct that were all well known in the medical profession, but in no case had the scientific record been corrected or the guilty punished. He has reported more than 20 doctors to the GMC for research fraud and other forms of misconduct. Usually the wrongdoing was known to individuals in authority for some time but Dr Wilmshurst was the only one to act. He deserves a medal.

**Something must be done**

**WHISTLEBLOWING** is bad for your health. Stress-related illnesses, relationship breakdown and financial hardship are very common. Even if you win it can feel like a defeat.

Consultant surgeon Ramon Niekrash was suspended from his job at Queen Elizabeth Hospital, Woolwich for 10 weeks after raising concerns about the impact of closing a urology ward was having on patient care. The tribunal found in his favour but left him with £160,000 legal bills. The trust used taxpayers’ money to pursue its vendetta. All the managers involved are still employed by the NHS and some have been promoted.

The GMC obliges doctors to raise concerns about patient harm or risk being struck off, but it then fails to support them and will even spend years investigating vexatious complaints against those who blow the whistle. Many surveys have found doctors and nurses are still too frightened of repercussions to report concerns about patient safety.

The BMA claims to support whistleblowers but the largest portion of compromise agreements with gag clauses are negotiated by... the BMA. Professor David Hands knows why: “Professional bodies frequently collude with managers to define the problem as an employment issue because the sacrifice of one employee (who will shortly no longer be paying subscriptions) is better than losing a cosy relationship with an employer.”

NHS whistleblowers are not always right, but are usually genuine in their concerns. They often end up leaving employment while those who suppress their concerns are promoted. Their dedication and altruism are lost forever, and the harm they’ve tried to expose is buried.

Lessons are not learned, dangerous care is repeated and thousands of patients die from avoidable harm.

America has its own National Whistleblower Centre and offers huge support to whistleblowers. Why? There is good evidence that whistleblowing is more effective than regulatory authorities, saves vast sums of public money and many lives. The UK should follow suit.

What’s needed is not just better statutory protections for NHS employees who raise concerns, but statutory enforcement of sanctions for any professional – managerial or clinical – who fails in their duty to investigate the concerns. And the investigation needs to be truly independent.

The NHS needs its own crash investigation team, free from the NHS brotherhood, that goes in fast and dirty in response to poor outcomes, an unexpected death or injury, serious patient complaint or whistleblowing concern, do a thorough analysis and publish it. This was proposed by Dr William Pickering in 1998 and endorsed by the **Eye**. The CQC cannot be both regulator and inspector.

The key Bristol Inquiry reforms must now be enforced to end the mindlessness, duplicity and transparency at the heart of the NHS. All gagging clauses in public services should be revoked. Junior staff must be properly trained, not left unsupervised and dangerously overworked. Managers must be free to serve patients, not ministers. Patients need to be given an independent voice, not hidden inside the CQC. The NHS needs an Outcomes Board not a Commissioning Board. Above all, patients, relatives and staff must be encouraged to speak up to stop shit happening. Patient harm must be monitored and displayed in real time, like a smoke alarm for the NHS.

There are still plenty of brave NHS whistleblowers out there, and they need to be recognised and rewarded. And those in authority must be held to account for ignoring them. Dr Peter Gooderham (see below) had no doubt what needs to be done: “Criminal sanctions should be enforced against individuals and NHS bodies for the victimization of whistleblowers and the corporate manslaughter of patients who are harmed as a result of the failure to act on the whistleblowers’ concerns.”

For more whistleblowers’ stories, references and supporting documents go to www.medicalharm.org.

**How to skin a whistleblower**

**PETER GOODERHAM (1965-2011)** was an academic lawyer and former doctor who devoted much of his life studying and supporting NHS whistleblowers. Before his death, he worked with the **Eye** to define the methods the NHS uses to shoot the messenger...

- **Inflict subtle sanctions beyond legal protection** – like cutting secretarial help and teaching budgets, blacklisting appointments and merit awards, “briefing against” informally.

  Whistleblowers are said to have “attitude problems” and to be obsessed with historic issues and not prepared to move on.

  - **Gather dirt on a whistleblower** and bring accusations of not raising concerns as the “official” reason for action against them. Allegations of mental illness are common and may be self-fulfilling as a whistleblower buckles under the stress.

  - **Refuse to disclose documents.**

  NHS trusts breach the data protection and freedom of information acts with impunity.

  - **Take or threaten reprisals** against colleagues who support a whistleblower.

  - **Threaten the whistleblower.** Dr Peter Brambleby, ex-director of public health for Norwich PCT, was told he might “end up in the woods like David Kelly”.

  - **Accuse a whistleblower of not raising concerns early enough.** This lays doctors and nurses open to censure by their professional bodies for delay.

  - **Claim it’s an employment conflict, argue that the public interest disclosure act does not apply and suspend the whistleblower.**

  - **Apply to the Treasury for public money to pay off and gag the whistleblower.** Some silencing agreements require whistleblowers to sign statements suggesting all concerns have been addressed even if they haven’t.

  - **Threaten whistleblowers and the media with libel suits if concerns that could affect the reputation of a trust are to go public.**

  - **Rely on the cowardice and apathy of the Department of Health.** It usually refuses to intervene, saying it’s a local employment matter.

  - **Make vexatious complaints to a professional regulatory body.** The General Medical Council’s “Duties of a Doctor” guidelines are so vague they allow trusts to concoct dozens of complaints.

  - **Throw public money at an employment tribunal (ET).** Trade unions rarely give adequate legal support to members, who are usually tribunal novices while NHS trusts are “frequent fliers” with unlimited public resources. Whistleblowers can be saddled with crippling legal bills even if they win.

  - **If the trust loses the ET – or any legal ruling – it can keep appealing, using public money, until the whistleblower is bankrupt.**

  - **Arrange an “in house” investigation.** Often this is a sham instigated by the trust’s own managers who are not impartial.

  - **If the press insists on an external investigation, the trust can still organise and pay for it, recruit the panel, agree the terms of reference, hold the inquiry in secret and control how much, if any, of the report reaches the public.**

  - **Don’t fear public inquiries.** They’re belated exercises in grief management that seldom change anything. They occur long after the event, when many of those in the dock have moved on and problems, like whistleblowers, are dismissed as “historical”.

- **Duties of a Doctor” guidelines** (1998 and endorsed by the **Eye**). The CQC