The Whistle

FREEDOM TO CARE
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Promoting public accountability - Protecting freedom of speech in the workplace

TEN YEARS OF *FREEDOM TO CARE*

Freedom to Care members celebrated ten years of promoting public accountability and assisting whistleblowers, following its AGM on 21st July 2001. In the Library at Conway Hall (Red Lion Square, London), meeting place of notable dissidents and reformers since the 19th century, an audience of over 50 people listed to Dr Keith Allen, FRCPath., deliver the 1st 'Dr Chris Chapman Memorial Lecture'; heard Prof. Geoff Hunt reminisce about the ten years since he founded the organisation; and witnessed the launch of the 'Charter for an Accountable Society'.

1st 'Dr Chris Chapman Memorial Lecture

The first of FtC's 'Dr Chris Chapman Memorial Lectures', which remembers the life and work of the Leeds scientist (and ex-FtC director) who blew the whistle on scientific fraud and paid a heavy personal price. Chris died on 4th November 1998 at the age of 56. Dr Allen, one of Chris's colleagues, commended Chris's courage for speaking up in an area of work that is still shrouded in secrecy and collegiate back-scratching. Many scientific reports were misleading or unethical in one way or another, but once published in journal a research report gained "gospel status". There was a great reluctance to report wrongdoing, for the whistleblower would lose support and funding, since the interests of wrongdoer and the institution were usually aligned.

Lessons learned from Chris' speaking up are that investigations should not be allowed to drag on for years & managers should have impressed upon them a duty to properly investigate allegations. Students need to be taught the ethics of research, and there should be random audits to deter the wrongdoing that "chips away at the moral authority of science". Looking back on the way the authorities had handled a simple case of telling the truth about wrongdoing Dr Allen was reminded of Einstein's words: "Two things are infinite: one is the universe, the other is human stupidity." Speaking from the floor, Rachel, also a researcher from Leeds, said that her contract was not renewed after she raised concerns - and this was *after* the post-Chapman probity policies were in place! How much had changed at Leeds University and Infirmary?

Sheila Chapman, wife of the late Chris Chapman, was presented with a bouquet of flowers at the end of lecture.

Founder reflects on ten years

Geoff Hunt opened his brief reflections by reminding everyone that "conscientious speaking up" is nothing new. Two and half thousand years ago Socrates lost his life for speaking the truth to the youth of Athens. The philosopher Bruno was burned at the stake in 1600 for his unconventional views on the nature of the universe, and during the Cold War years Soviet dissidents such as Andre Sakharov were persecuted. 'Whistleblowing' is a new word for something the human race has long been familiar with, but in this case it is conscientious workers and professionals who are speaking up about the public damage their employing organisations sometimes cause. Geoff said he returned from 11 years in Africa to find that academic standards had slipped and professional integrity eroded. At Swansea University degrees were awarded in his department when work had not been done. He ended up resigning in protest, and there were two public inquiries. Since then universities have become more implicated in the corrosive effects of commercialisation, Nottingham University's involvement with tobacco industry money being one recent example. Geoff moved to the Hammersmith Hospital, London to set up an ethics centre, and in 1991 organised the UK's first national conference on whistleblowing. In November 1992 Freedom to Care was launched at the House of Commons, with assistance from Derek Fatchett MP. Tony Wedgwood Benn was

one of the people present. This was the period when NHS managers were paranoid about resistance to their public expenditure cuts and 'new managerialism' and Geoff was sacked on the spot a few days later. He was lucky to find a post at the University of East London, and published the book *Whistleblowing in the Health Services* (Arnold). He and three other Swansea lecturers were given the 1994 Freedom of Information Award, presented by Michael Grade (then of Channel Four TV). Freedom to Care began helping conscientious employees from public sector organisations, especially nurses, doctors, social workers and other social care workers. Whistleblowers were coming from all sectors of working life, even police officers and air traffic controllers. A number of people began making their experience available to others and FtC's capacity to assist and clarify its ideas grew proportionately. It also led campaigns, most importantly on the malpractice of insurance company Colonial Mutual and on air pollution by National Power. FtC members have had their stories in the national and local press and a number have appeared on television and on radio. Geoff emphasised that altruism is the foundation of FtC: no one is paid, it does not charge for its guidance, and it receives no government or private sector funding. It does not pretend to any expertise, but offers what is most important to individuals who have been isolated and discredited simply for speaking the truth: moral support, comradeship and the advice of lived experience. He thanked a number of members for their continuing efforts, their integrity and magnanimity, and their generous donations.

Launch of Charter

Freedom to Care's new 'Charter for an Accountable Society' was also launched at the anniversary meeting. Copies of the Charter were distributed, and it is in member consultation until the 1st December 2001. The revolutionary Charter, which is also available on the website at <http://www.freedomtocare.org/charter.htm>, sets out eighteen principles in three groups:

TRANSPARENCY:
Openness, Engagement, Personal Responsibility, Independence, Non-Discrimination, and Reconciliation.

DUTY TO JUSTIFY:
Right to know, Duty to inform, Adequate information, Accessible information, Information of value, Application of information.

FREEDOM OF CONSCIENCE:
Consent, Facilitation, Comprehension, Pluralism, Participation, Raising Concerns.

The 8th Annual General Meeting

Reports were given on FtC's activities over the last year. For example, assistance had been given to a doctor who whistleblew on poor performance of colleagues screening for cancer – he has now got a new job in another region. A nurse in a private home who was demoted after raising concerns about poor standards was also supported, and has joined up. In Flintshire, despite 5 years of efforts by members & others, the feeling is that the local authority is protected at the highest level and further energy on this will be wasted - all information has now been passed on to Children's Commissioner to deal with. Pat, a whistleblower in childcare has now had disciplinary charges against her dropped and staff hostile to her are off sick or have moved - Pat is also now a member and offers support to others. Bunny Pinnington [*see this issue*], a nurse who lost her job for refusing to take instruction from a teacher not to resuscitate a disabled child has gone up to policy debate – the Welsh Assembly is holding a review of practice across Wales following her and FtC's persistence. Following AGM reports from the Treasurer and Company Secretary there was a well-informed discussion among members. One member warned about going to the press, because it can sometimes backfire if precautions are not taken. The feeling was that there has of late been a change for the better in work environments, with blame cultures being examined, but there was still a long way to go. One member suggested that FtC should contribute to the new National Curriculum on citizenship.

The meeting passed a resolution condemning Government plans to charge people for applying to tribunals for action against their employers.

RUSSIA PUTS WHISTLEBLOWER JOURNALIST Grigory Pasko ON TRIAL

In Russia 39 year old investigative journalist Grigory Pasko has been arrested the second time accused of espionage and treason. His trial in Vladivostok began on 11th July 2001 and will continue most of the year. He was first arrested four years ago by the security forces FSB. He spent nearly two years in prison, several months of this period in solitary confinement. His offence - telling the truth about the corrupt activities of high-ranking naval officials, and illegal sales of military equipment. His articles appeared between 1993 and 1996. More recently he blew the whistle, with the help of the media in Japan, on another subject: the pouring of nuclear waste into the Sea of Japan by the Russian navy. On 20th July 1999 Pasko was given a three-year sentence,

but was then released under an amnesty. There was an appeal by the prosecutor, and that's why there is now a second trial. Curiously the FSB has never made public any evidence against Pasko. There are twenty volumes of this evidence and, apparently, sixty six witnesses to be called. The writer Alexander Tkachenko has gone to Vladivostok to give Pasko his support.

Suspensions at Coventry hospitals

Sheila Porter-Williams

The University Hospitals Coventry and Warwickshire NHS Trust has two consultant surgeons who have been suspended for over a year for inadequate reasons, to the loss of the local community.

Alban Barros D'Sa queried the number of a colleague's patients who had died after colorectal surgery. He, as the person raising concerns and trying to ensure accountability for clinical incompetence, was suspended in September 1999. Subsequent enquiries confirmed his concerns. Mr Barros D'Sa sought the help of his Member of Parliament to lift his suspension. The NHS Trust justified the continuation of his suspension by claiming that speaking to his Member of Parliament was misconduct. On 27 March 2001 this case and consultants' general lack of confidence in the Trust were debated in Parliament. In that debate Minister announced that the Trust had accepted a recommendation to appoint a qualified colorectal surgeon. That surgeon has since started work, but the surgeon whose performance prompted Mr Barros D'Sa and others to raise their concerns is still performing colorectal surgery. Two other staff of the Trust who shared Mr Barros D'Sa's concerns have not been suspended but have been harassed in other ways.

Briony Ackroyd was suspended in February 2000 after performing an unsuccessful breast operation that led to a compensation payment by the Trust. It is estimated that her disciplinary hearing will not be held until nearly two years after the incident to which it relates. Meanwhile the cost of the suspension is likely to be of a similar order of magnitude to the cost of the compensation, and if she is reinstated she will not have been practising her skills for all that time. Both surgeons have substantial support from former patients and from colleagues.

This NHS Trust (and its predecessor – Walsgrave Hospitals Trust) has for many years had a "no whistleblowing" policy and treated any contact by its staff with the media as misconduct. This continues, even though Ministers claim to have banned gagging clauses in NHS contracts. Relations with the Press have been broken off. The Trust pursues policies, like marginalising the local hospital in Rugby and pursuing a grandiose private finance partnership at Walsgrave Hospital, to which there is substantial local hostility. For further information on the Trust see the Rugby Advertiser on http://www.rugbyonline.com/ and search with the keyword "Walsgrave".

These suspensions pose several issues of concern. *Freedom to Care* is aware that the NHS often misuses long suspensions, often of highly skilled and competent staff who ask awkward questions and identify abuses that could leave the NHS with compensation bills, as a way of gagging their staff and covering up abuses. If there is a valid disciplinary case against an employee who is suspended, there is no excuse for failure to bring the case to a conclusion (reinstatement or dismissal) within three months. When suspensions are lengthy, any disciplinary case is likely to be so weak that the suspension itself is unjustified and a waste of money and medical/surgical skill.

It is surprising that this NHS Trust used contact with a Member of Parliament as justification for continuing Mr Barros D'Sa's suspension. The Speaker ruled that the Trust was not in breach of Parliamentary Privilege. But the Public Interest Disclosure Act 1998 was intended to protect employees who disclose matters of public concern. Four judges in two courts have ruled that the Trust is wrong to treat correspondence with a Member of Parliament as a disciplinary issue. If there is any doubt that the Act protects from dismissal disclosures to Members of Parliament, or if suspensions are being wilfully used in circumstances where dismissal would be illegal under the Act, the Act needs to be strengthened, and harassment (such as by unjustified suspension) of employees who rely on the Act needs to be made a criminal offence.

There are also signs of factionalism among consultants. One of Miss Ackroyd's vociferous opponents is a surgeon who sent me away after a test that has since been discredited as unreliable three years before I was found to have breast cancer that kept me off work for almost a year. This same surgeon, when suspended from one of the hospitals where he worked for twice neglecting to attend when called by a junior colleague shortly before patients died, avoided disciplinary action by resigning that post, while continuing to work elsewhere as an NHS consultant.

Suspension is most serious for doctors and surgeons who commit themselves full time to the NHS. Those with multiple employments or private patients, who show less commitment to

the NHS, are also less affected by being suspended. Therefore the NHS management style that misuses suspensions also undermines the commitment to the NHS of experienced medical and surgical staff, and thereby undermines the NHS itself.

What should be done?

- The Public Interest Disclosure Act must be strengthened to impose criminal penalties on managers who harass (e.g. by suspension) employees who rely on the Act for protection.
- Rules for NHS suspensions must be changed, to prevent suspended employees being stopped from speaking to the media, and to limit suspensions to a maximum of three months.
- And NHS Trusts must be made democratically accountable to their local communities.

FtC's Response to All Wales Resuscitation Care Study (July 2001)

In The Whistle No 17 (Feb. 2001) we reported on the case of Bunny Pinnington, a nurse at a Swansea Special School, who refused to carry out a do-not-resuscitate order from her Head Teacher, an order she says was done against the opinion of the child's consultant and without any consultation with the carers. **Chris Clode** *of FtC has been assisting Bunny and pressing the policy dimension of the case with the Welsh Assembly, which has resulted in the Assembly's agreement to carry out a review of DNR policies. Here Chris Clode spells out FtC's views on the terms of the review.*

1. Terms of Reference of Study.

While we recognise that the Study is not an alternative stage to re-run employment matters specific to Mrs. Bunny Pinnington, we have considerable concern at the narrow remit of the Study and its Terms of Reference. We have argued that issues at the centre of the Pinnington Case were parallel to those at the core of the Waterhouse Inquiry, namely:

a) the flouting by senior managers of agreed procedures put in place to protect vulnerable children;

b) the harassment and denial of due process to those seeking to raise concerns on behalf of those children.

Although the child concerned was not accommodated or looked after by the Local Authority (as with the Waterhouse cases), the central issue in this matter was the denial of life to a child; even most of the Waterhouse victims were not threatened to the extent of the child in this case, yet the qualified professional challenging the instruction not to resuscitate from an unqualified person, was marginalised and finally disposed of in a way similar to Alison Taylor and other Waterhouse witnesses in North Wales. Like the Waterhouse evidence, the Pinnington Case demonstrates another case in Wales of the mutual protection of well-networked senior staff at the cost of another failure to protect a child. The Assembly are well aware, also, that the Pinnington Case is not simply historical and could be repeated today, because Freedom to Care and CloverCare consultancies have provided the Assembly with large quantities of evidence on similar matters that are recent or current within Welsh Local Authorities.

We would hope that the Study would address some of these wider issues of how safe care can be insured within a wider corporate environment where the protection of children (and other vulnerable people dependent on Council services) is not seen as a priority and indeed appears to be poorly understood, at best.

2. DNR Policy.

Firstly, having seen the extensive documentation on the Pinnington Case, including correspondence within Education and correspondence to and from Mrs. Pinnington, the Davieses (the child's carers), the Assembly and the RCN, Freedom to Care believes that there is clear evidence that a DNR instruction was in place in relation to the child, A; that its source was the Head Teacher, who altered A's Care Plan; that this was done without the consent of the medical consultant or GP and without consultation with the grandparents, the carers. She gave instructions to not resuscitate two children making her position clear in her letter dated 14th. May 1997. To further compound the issue the Head Teacher along with a senior member of the Authority sought a DNR order for child A without parental knowledge or consent. The Authority undertook a wholly inadequate investigation without element of independence and effectively took no action regarding this matter. Some months later the Head Teacher again took the initiative to get involved in medical matters by changing a child's care plan without parental or medical knowledge, that change to the care plan would have proved fatal if followed. Again the Authority investigated itself, did not connect the two issues and did nothing.

DNR orders clearly have no place in this school or any other school. If a child is well enough to be sent to school in the morning then it is reasonable to expect that the child will be sent home after school. Also it is reasonable to expect that if anything happens to that child while in school then all efforts will be made to ensure his/her health and safety. All medical decisions

must be made by medically qualified staff. Emergency situations in school must receive an instant response; followed by immediate transfer to hospital where senior medical staff will become responsible for the child and with the parents will make the necessary decisions.

The Policy we assume that events in Ysgol Grug and elsewhere in Wales will be measured by is "Decisions Relating to Cardiopulmonary Resuscitation", the Joint Statement issued by the BMA, the RCN and the Resuscitation Council (UK) (1999). Let us be quite clear that DNR orders are totally unacceptable in a school setting. However the Head Teacher at Ysgol Crug Glas supported by senior Officers of the LEA were actively seeking such orders in the Pinnington case.

A letter from the BMA to the Davies' says, "It was not the BMA's intention that its DNR policy note should be applied outside the in-patient hospital setting". In the case of a child we would consider it obligatory that parents/carers of children have their consent sort prior to any change in any care plan. Such consultation is in line with the partnership principle in the Children Act 1989, and failure to adhere to such consultation and seeking consent could expose the care agency to subsequent action by carers on behalf of their child. It is vital the above intention from the BMA is adhered to throughout Wales and again we stress that in relation to medical issues in particular, for all children consultation with the parents/carers must be obligatory.

The Kennedy Report into **Bristol Royal Infirmary** has been particularly critical of poor communication between parents and staff, contributing to the deaths of babies, "The sense is gained that informing parents and gaining their consent to treatment was regarded as something of a chore." In the Pinnington Case, there was no consultation and the initiator of the DNR was not qualified either!

3. Clinical and Line Management Supervision.

Where medical staff work in non-medical settings and may be supervised by Managers who are not medically qualified, arrangements should be in place that the medical staff receive professional and clinical supervision from a senior medically qualified person who may work elsewhere; for instance, in Bunny Pinnington's case she should have had regular clinical supervision perhaps from a Senior Community Nurse experienced in learning and other disabilities.

However, there was some evidence in the Pinnington Case of subsequent collusion between medical and education senior staff endeavouring to suppress her and the embarrassment she was causing various members of the "great and the good" in Swansea and the Assembly, perhaps a reflection of a wider "club culture" in Wales, resonant of the one Professor Kennedy describes in Bristol. Only major cultural changes at the most senior level could address this and Freedom to Care has little evidence that the Assembly, whose responsibility it would be to lead such change, has the will to address these issues on behalf of vulnerable children.

4.Public Interest Disclosure

Whistleblowing procedures must be in place in all settings and be available to staff and not subject to senior management decisions to pre-empt access to the Procedure by raising other matters. The availability of a Whistleblowing Procedure in each setting should be one of the measures included in the National Standards for Children's Health Services due to be published by the new National Director of Children's Health Services, Prof. Aynsley-Green. Also, the recommendations of the Study need to be considered for inclusion in the Special Educational Needs Draft Code of Practice, currently before Parliament.

Whistleblowers must have immunity from disciplinary action to silence them raising their concerns and discourage others coming forward to disclose harm and malpractice to children.

In addition, to enhance a growth away from the "blame culture", where staff commit acts of negligence through error (rather than through provable deliberate malpractice), they should have immunity from discipline and instead the matters dealt with via performance review; this will encourage discussion and debate about failures of practice and may correct the defensive cultures that seek to identify individuals to blame and encourage mutually litigious postures. This may enhance understanding errors through peer debate to improve future outcomes for patients/clients/students.

Parents, staff and others advocating on behalf of vulnerable children should be made aware of how to access the powers of Peter Clarke, the Commissioner for Children, Wales, if required. The Assembly may also have to review the powers of Mr. Clarke in the light of discussions in England on a Commissioner there with wider powers.

5. Summary.

As we outlined above, the outcomes of this Study cannot be simply procedural; the ongoing failures to adequately protect children in some settings in Wales and the persistent harassment of those raising just concerns and advocating on behalf of those children, show clearly that the solution lies in changing organisational cultures and the leadership of those who set those cultures. At the summit of this process must be the

Assembly Members and their Officers themselves. It is a challenge for them and frequently they will have to put the interests of vulnerable children before the interests of party loyalty. If they cannot do that at the National level in Wales, what hope have they of setting an example to local Councillors and Officers in the way that they deal with the embarrassments of incidents of institutional harm to children?

6. Recommendations.

6.1. DNR orders are not acceptable for a school.

6.2. Should a child collapse in school, emergency resuscitation procedures should be carried out immediately and the child transferred to hospital where senior medial staff assume responsibility for the child.

6.3. Care plans must address all areas of care for the individual and where medical issues are addressed it must be drawn up, monitored and updated by medical personnel only, in consultation with parents.

6.4. Where medical staff work in non-medical settings and may be supervised by Managers who are not medically qualified, arrangements should be in place that the medical staff receive professional and clinical supervision from a senior medically qualified person.

6.5. The availability of a Whistleblowing Procedure in each setting should be one of the measures included in the National Standards for Children's Health Services

6.6. Whistleblowers must have immunity from disciplinary action to silence them raising their concerns.

6.7. Where staff commit acts of negligence through error (rather than through provable deliberate malpractice), they should have immunity from discipline and instead have the matters dealt with via performance review.

6.8. Parents, staff and others advocating on behalf of vulnerable children should be made aware of how to access the powers of the Commissioner for Children, Wales.

6.9. The Assembly may also have to review the powers of the Commissioner for Children, Wales in the light of discussions in England on a Commissioner there with wider powers.

LEEDS UNIVERSITY - AGAIN!

Dr. H. Rachael Hill

After the Chris Chapman scandal, the University of Leeds adopted a new Code of Practice designed to deal with any allegations that scientific research was not up to the highest standards.

I was a professional scientist (1st class degree and PhD) working at Leeds (6 contracts in 4 years). In 1998 I reported concerns about poor quality science and that my boss, a professor, had made it clear that my repeated criticism of the science was very unwelcome. He countered by saying the science had been tested in response to my criticisms, shown to be "absolutely unambiguously" OK, and that my allegation was an attempt by me to pursue a "personal matter" against a former colleague.

An internal inquiry into scientific misconduct ***upheld*** my concerns about the soundness of the science, and agreed that these concerns were serious enough to require experiments to establish the validity of the work. About £400,000 of public money had been spent over the years producing results that were now going to have to be checked to see if they were valid, but the inquiry decided no one bad done anything wrong.

The results of the research were being used by the professor to attract millions of pounds of venture capital funding, to set up a private company on University premises. The University of Leeds is a major shareholder in the professor's company. The Pro-Vice Chancellor for Research, in charge of any disciplinary matters resulting from the inquiry, was the University's representative on the Board of the company.

I lost my job and was told to 'retrain" almost immediately after raising my concerns, whilst everyone else involved simply got on with doing more research. It took a full 14 months, and the intervention of my MP, before the University confirmed that the professor would give me a reference - a delay which effectively destroyed my career.

The University dismissed my allegation of suppression of scientific criticism (valid criticism that threatened the vested interests of the person who decided whether my employment would be continued) as just a managerial" matter, and irrelevant to investigations about scientific probity. The University also dismissed the professor's comments about my nursing a "personal matter" as "irrelevant" to their inquires, thus denying me the chance to respond to an allegation of professional misconduct.

The guideline time for the inquiry was four weeks. I was not told the outcome until ***eight months*** later; until after the University had tried to get me to sign a legally binding gagging clause about the science in exchange for a five figure sum to settle my legal action at an Employment Tribunal for unfair dismissal. (I refused).

I was promised the report of the inquiry "in any event", but I was denied both the report and

detailed discussion of the contents. I later learnt that the professor made a statement about the science that I believe to be knowingly false - something that fits even the University's definition of ***misconduct.*** But the University just don't want to know; they don't want to see my evidence, and they won't respond to my requests for the lab records, in the professor's hands, that contain the proof,

More than 18 months since I was told the outcome of the inquiry, the University still refuse to comment on the results of the validation experiments - a situation they can continue indefinitely. Contrary to guidelines, the University also kept the Funding Body completely in the dark, and continue to do so despite repeated requests from the Funding Body after I wrote to them 6 months ago.

In the last 2 years I've been through five internal inquires, all conducted by the same bunch of people who made the original decisions. For all these actions, Leeds University Administration are accountable to no one but themselves.

DOCTOR SPEAKS OUT ON ELDERLY

Junior doctor, Rita Pal, has presented a dossier to the General Medical Council of the cases of what she considers to be maltreatment of the eldely in care, cases she herself had witnessed while working in 12 hospitals. So indignant is she that she has left the medical profession.

She says, "In every hospital I have worked there is an attitude that if people are over 65 it is often not worth bothering to treat them ... Doctors are unilaterally taking the decision to put 'do not resuscitate' or 'nil by mouth' orders on patients' medical notes purely based on the age of the patient. Nurses are being bullied into doing things simply because doctors want a bed freed for another patient."

Dr Pal, from Sutton Coldfield, West Midlands, said on one occasion a doctor told her to withdraw all medication from a stroke victim who was conscious and could hear what was being said. Dr Pal decided to carry on the man's medication and held his hand, telling him: "You'll be all right." He was transferred to another unit where he died.

"I was sickened by the whole episode," she said.

On another occasion she was told to put a pneumonia patient on diamorphine. She injected the drug into the patient's mattress and the next day a senior doctor commented: "She is still alive. Didn't you start her on the diamorphine?" The patient recovered and went home.

Meat Inspector Victimised

FtC is assisting a meat inspector employed by the Meat Hygiene Service, who claims to have been bullied at abattoirs because he takes his public safety job seriously.

Nurse Demoted for Caring

A nurse has joined FtC with her story of work in a voluntary sector supported residential nursing home. Despite an excellent work record she was demoted following her raising of concerns about low standards of care for the elderly patients. On one occasion she expressed alarm that kitchen gloves were being used around patients instead of the proper surgical-type gloves. She says that her employer had won a contract by putting in a tender so low that they could not afford to maintain decent standards. As a regulated professional she is required to meet those standards. She is still in dispute with her employer.

Another experienced nurse in the south of England told FtC how she had been treated with suspicion after she had persisted with her report that an autoclave for sterilising equipment was not working properly. The machine was eventually repaired but she did not feel she could continue to work there. There has recently been an official report that about 5,000 [five thousand] patients a year die from hospital-contracted infections. (This is nearly two thousand more than die of road accidents each year.)

BRISTOL WHISTLEBLOWER VINDICATED

Anaesthetist **Dr Stephen Bolsin**, who blew the whistle on unacceptably high infant mortality rates following cardiac surgery at the Bristol Royal Infirmary (UK), has been completely vindicated by the Inquiry Report that appeared in July 2001. He accuses the UK medical establishment of making it impossible for him to work in the UK, so that he had to move to Australia. He is now Head of Anaesthesia at Geelong Hospital.

The Kennedy Report, commissioned by the UK Government, says that:

* "Too much power was in too few hands" and there was a "club culture", referring to the medical establishment at the Hospital.
* The young conscientious doctor Dr Bolsin was shut out by the arrogance and secrecy of this culture.
* Up to 35 babies died unnecessarily in just one year in the early 1990s.

One third of all the heart problem babies referred between 1984 and 1995 received less than adequate care. About 160 of them probably suffered long-term in some way as a result.

The Inquiry chairman, Ian Kennedy QC, emphasised that the real problem was the lack of adequate accountability in the entire NHS. The Government immediately accepted some of the Report's recommendations.

The Kennedy report identifies:

- lack of patient information and involvement
- conflicting standards set for doctors by different institutions
- the lack of monitoring of what hospitals achieve
- low priority given to children

Dr Stephen Bolsin has said of his experience: "No medical or non-medical professional in the NHS should have to endure the threats and discrimination that I was subjected to."

Speaking up from a Children's Home

Freedom to Care has recently (2001) been assisting a children's home worker who raised concerns. This is her story:

"Employed by my local authority for over 20 years, I was asked to go and help set up and work in a new children's home, along with two other female colleagues. The unit was unique to my authority and housed 3 female teenage women. The husband of one of my colleagues took an interest in the unit and spent most of his time there painting, decorating etc. It soon became apparent to me that he was getting too involved and too close with one of the girls. I reported incidents to management - and they responded by making him an approved "volunteer"! He started driving her around, picking her up late at night from friends, pubs etc.

Things became very difficult for me and for one of my colleagues, as management were unwilling to take our concerns seriously. I decided to speak to the man myself, but two days later I was asked to move out of the unit back to my old post as there had been a complaint made against me. It later emerged that the fabricated complaint was made by the young woman and the male volunteer.

Two weeks later one of the other young women made a false complaint that I had physically assaulted her. I was suspended and am still under suspension 24 weeks later. While I have had tremendous support from my colleagues, I have been isolated from them and management were unwilling to listen to any of the numerous concerns raised.

I contacted *Freedom to Care*. They were sufficiently convinced that my story showed evidence that the "volunteer" may have been "grooming" one or two of the girls, so FtC took the unusual step of contacting our Child Protection Unit. A full investigation is apparently underway, but I have had to appoint a solicitor to act to protect me, as the concerns I have raised have implied criticisms of some of my managers. Have they been listening, have they been acting in the children's best interests and protection? The outcome of their inquiries will show."

FREEDOM TO CARE

.. is an independent, non-profit & entirely voluntary organisation. We are not lawyers. We are the UK's first whistleblower organisation, founded in 1991. We are a company limited by guarantee (**Reg. 2973440**).
PATRONS are John Hendy QC, Allan Levy QC and Austin Mitchell MP.
FOUNDER is Prof. Geoffrey Hunt.
WHAT WE DO We lobby and campaign for greater public accountability of large organisations and support conscientious employees who speak up.
STRUCTURE *Board of Directors*: Harold Hillman, Geoff Hunt, Tim Field, Lawrence Smyth; *Company Secretary*: Rob McGregor; *Network Coordinator*: Chris Clode; *Treasurer*: Chris Thomas; *Membership Secretary*: Anne Burge.
WEB SITE: http://www.freedomtocare.org
MEMBERSHIP: £21 p.a. (£10 for those on low income); £35 group affiliation.
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MAPMAKER SACKED: English-born American **Ian Thomas** is a cartographer - he makes maps using his computer and satellite images. He was sacked by the United States Geological Survey for being too good at his job. In March 2001 he enhanced an image of Alaska, USA. He was at that time interested in following the habits of the herds of Caribou, a kind of deer. What he didn't realise was that his map was so accurate it showed everyone what President Bush's environmental policy was in Alaska, particularly the Arctic National Wildlife Refuge. In the Refuge is a strip of land that Bush and his corporate backers in the oil industry are planning to destroy with oil exploration. They were not too pleased when Ian Thomas put this map on the Internet, because it showed the world that the exploration plans would be very harmful. Thomas was sacked on the spot.

Within days Thomas received thousands of email messages of support from people concerned about the environment. Pressure groups took up his case. He is now making maps for the World Wildlife Fund, where he is appreciated.