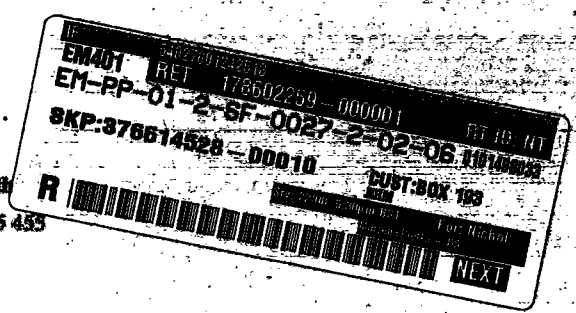
The Report of the Inquiry into Quality and Practice Within the National Health Service Arising from the Actions of Rodney Ledward

June 2000



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To: The Secretary of State for Health

On 17th March 1999 your predecessor asked us to inquire into quality and practice within the National Health Service arising from the actions of Rodney Ledward.

We have carried out our investigations and now submit our Report and recommendations.

Jean Ritchie Q.C.
Chairman

Heather Mellows F.R.C.O.G.

Jan Chalmers R.G.N.

John Bash O.B.E., J.P.

1st June 2000

AN INQUIRY INTO QUALITY & PRACTICE

WITHIN THE NATIONAL HEALTH SERVICE ARISING FROM THE

ACTIONS OF RODNEY LEDWARD

THE REPORT

1st June 2000

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PART I - INTRODUCTION

1. TERMS OF THE INQUIRY

1.1. On 17th March 1999 the Secretary of State for Health set up an Inquiry into quality and practice within the National Health Service arising from the actions of Rodney Ledward, who was struck off the Medical Register by the General Medical Council on 30th September 1998. We were asked to carry out the Inquiry and our terms of reference were:

> **1. To consider why the serious failures in the NHS clinical practice of Mr Rodney Ledward at South Kent Hospitals NHS Trust were not identified and acted upon earlier and to consider the action taken when those failures came to light. In doing so, to review the role of the management and staff of the Trust (and its predecessor body) and other external bodies concerned with the quality of patient care and to consider the adequacy of systems, including clinical audit, to ensure quality.**
>
> **2. In so far as it is relevant to the inquiry into 1 above, to inquire into the care of the NHS patients treated by Mr Rodney Ledward at South Kent Hospitals NHS Trust between 1990 and 1996, but including earlier events where appropriate.**
>
> **3. To make recommendations for the NHS arising from the case,**

particularly in respect of the development of clinical governance within the NHS locally and nationally.

4. To report to the Secretary of State as soon as possible from the commencement of the inquiry.

The Inquiry will be conducted in private and the Inquiry Panel's Report to the Secretary of State will be published.

1.2. Initially we considered that the investigation should be directed to Rodney Ledward's NHS practice. However it soon became clear as a result of representations made to us by former patients, that many of the concerns relating to Rodney Ledward's work occurred within the private sector. We came to the view that the role of private hospitals, being "external bodies concerned with the quality of patient care" was a matter that we ought to consider within the context of our Inquiry. We wrote to the Secretary of State on 8th June 1999 and informed him that we intended to consider whether there were any shortcomings in Rodney Ledward's practice in relation to his private patients, and would make such recommendations in our Report as we felt necessary. We have therefore investigated Rodney Ledward's work both at the NHS hospitals - the William Harvey Hospital in Ashford, the Buckland Hospital in Dover, the Victoria Hospital in Deal and the Royal Victoria Hospital in Folkestone, and also at private hospitals - the St Saviour's BUPA hospital in Hythe and the BMI Chaucer Hospital in Canterbury. We have also considered his practice at other private hospitals in London, for example the Portland and Cromwell Hospitals.

1.3. Secondly, although we were directed primarily by the terms of reference to events post 1990, it became clear soon after we had commenced our investigations, from what we were told by former patients, by hospital doctors who worked alongside Rodney Ledward and by General Practitioners who referred patients to Rodney Ledward, that [illegible] concerns went back to the early years after his appointment. In those [illegible] we have considered events before 1990.

2. PROCEDURE

2.1. The Panel met together for the first time on 22nd March 1999. We were anxious to publicise our Inquiry and its terms, so that we might contact interested parties as soon as possible. Although time was short as the Easter holiday was close upon us, we held a public meeting at The River Room, Stour Centre, Tannery Lane, Ashford, Kent on 31st March 1999. We also advertised in the local Kent press, in the national press and in medical journals to ensure that people, who might have useful contributions to make to the Inquiry, were aware of its existence.

2.2. We drew up a procedure to be followed by the Panel in carrying out the Inquiry and the full text of that procedure is produced at **Appendix 1.**

2.3. As regards former patients of Rodney Ledward we asked all who contacted us to give their consent to their medical records being disclosed to and for the purposes of the Inquiry, and also asked them to set out in writing anything they wished to tell us about the treatment they had received under Rodney Ledward. Many did so. We were also put in contact with the Support Group for Former Patients of Rodney Ledward set up after he was struck off the Medical Register. We wrote to local General Practitioners; to medical, nursing and administrative staff at the William Harvey Hospital in Ashford; to solicitors who had been retained by a number of former patients; and to those who were identified by the South Kent Hospitals NHS Trust in its report to the NHS Executive, dated November 1998, as having been involved in their inquiries.

2.4. We fixed dates for hearing oral evidence in Kent and in London to try to suit the convenience of witnesses.

3. DOCUMENTS

3.1. As important factual background we saw and read:

1. the Confidential Report of the Inquiry held into the Professional Competence and Conduct of Mr Rodney Ledward for South Kent

Hospitals NHS Trust chaired by Roger Henderson QC. This was the Disciplinary Inquiry which reported to the Trust in December 1996 and upon which the Trust relied in dismissing Rodney Ledward from his Consultant post in December 1996;

2. the full transcript of the disciplinary hearing concerning Rodney Ledward before the General Medical Council (GMC), which took place between 14th September 1998 and 30th September 1998, and as a result of which he was struck off the Medical Register.

3.2. The Trust Disciplinary Inquiry adopted the highest civil standard of proof (a strong balance of probabilities) and the GMC hearing adopted the criminal burden of proof (beyond reasonable doubt). We accepted their findings in their entirety although, as we will refer to within, allegations in respect of one patient were found proved by the Disciplinary Inquiry on the civil standard, but not by the Professional Conduct Committee of the GMC on the criminal standard.

3.3. We also had available to us the full medical records of each patient who gave their consent to our seeing their records. We therefore obtained every NHS file of such patients and every private hospital file of such patients save where (in the case of private hospital notes made more than 7 years previously) they had already been destroyed. Every set of notes (some of which extended to 2 or more lever arch files) has been read and fully considered.

3.4. We have read every contemporary document with which the Trust was able to provide us which related to Rodney Ledward, including copies of all written complaints made after 1990. We were told that any complaints regarding Rodney Ledward before that date could no longer be traced. We point out that although we saw copies of letters of complaint and replies thereto, the identities of the various complainants was not disclosed to us.

3.5. Finally we have read many Department of Health Circulars which were published during the 16 years when Rodney Ledward was a Consultant and also considered the other documents listed in the bibliography in **Appendix 2.**

4. HEARINGS

4.1. We heard oral evidence from a number of former patients but by no means all. Over 160 former patient consented to our seeing their medical records and many of those provided written statements as well. We did not feel that we could see all of those patients. Some did not wish to give oral evidence and we felt that some would be unlikely to add significantly to what they had written to us, as supplemented by their medical records. We saw the majority of patients who expressed a strong wish to give oral evidence to us. We hope that we have obtained a full picture of the complaints and concerns of Rodney Ledward's former patients. Overall we considered that we had to balance the need to speak to every patient who contacted us, with the need to carry out our Inquiry with reasonable expedition. We have tried to get the balance right; we sincerely hope that we have not offended any patient.

4.2. Since our Inquiry sat in private, and since we were not exercising judgment on Rodney Ledwards' practice, we adopted an informal approach to witnesses of fact. It was clear that many of Rodney Ledward's former patients who contacted us had been through a traumatic experience and we did not want our hearings to add to their trauma. We recognised that our Inquiry had re-awoken feelings which many patients had wished to bury. We explained to patients that we could not do our job unless we heard from them. They responded positively and we felt that it was important that they were made welcome and they found a friendly and listening ear when they came to talk to us.

4.3. Similarly we felt that an informal approach was most likely to allow staff at hospitals where he worked to unburden themselves of what had been going on.

5. OUR FINDINGS AND CONCLUSIONS

5.1. We were not set up as a Court of Law and, given our terms of reference, we did not consider that it was part of our task to make findings as to whether Rodney Ledward had acted negligently in his treatment of any of the patients about whom we heard. We have accepted the findings made by the Trust's Disciplinary Inquiry and by

the GMC and all that we have seen and heard in respect of those cases supports their conclusions. However we have not been able to ask Rodney Ledward about the other cases which we have considered. As we have said, findings have already been made against him by the General Medical Council in the cases for which his registration as a doctor has been removed. That does not mean that he was guilty of professional incompetence in respect of every patient he treated. What we were looking for was evidence of concerns or problems, indicative of failures in his practice, that were or should have been picked up by others.

5.2. Based on the evidence we have heard and read, and where it has been relevant to do so, we have drawn conclusions which we shall set out in our Report. We considered that our task was to identify the concerns which patients, colleagues, nursing staff, administrative staff, General Practitioners or anyone else may have had about Rodney Ledward over the 16 years he was in practice as a Consultant. We needed to inquire into how they responded to such concerns and to identify as far as possible why Rodney Ledward had been permitted to continue to practice if there were real concerns about him or his work. In short, if there were concerns about him, why were such concerns not dealt with more quickly so as to prevent his patients from being harmed and his career being destroyed? We have also asked ourselves whether Rodney Ledward himself considered that there might be a problem with his practice.

6. RODNEY LEDWARD

6.1. Rodney Ledward was appointed by the South Thames Regional Health Authority as a Consultant Gynaecologist and Obstetrician on 1st January 1980. He was then aged 41. He was a Member of the Royal College of Obstetricians and Gynaecologists (1971) and a Fellow of the Royal College of Surgeons (1976). Immediately prior to his appointment he had been Senior Registrar and Clinical Tutor to the Department of Obstetrics and Gynaecology at the University of Nottingham and had been seconded to the Riyadh Military Hospital in Saudi Arabia in 1979. We have not seen the confidential references which accompanied his application for the post of Consultant; they have been misplaced over the years. However we have been told that he was seen as "a breath of fresh air" in the Department of Obstetrics and Gynaecology, and that he

came with excellent recommendations and a high professional standing. He was acknowledged to have a good academic reputation and he was very enthusiastic. His curriculum vitae was impressive. It seemed that he had the potential to raise the academic profile of the Obstetric and Gynaecology division of the South Kent District Health Authority. One of his former patients described him as "very dashing, quite the Womens' Weekly hero". He was flamboyant, a colourful character with bow tie, black jacket and pinstripe trousers, and a liking of fast cars. He obtained admitting rights to a number of private hospitals and practised private work alongside his NHS commitments.

6.2. At the beginning of February 1996 Rodney Ledward was suspended by the Trust and at the end of 1996, after disciplinary proceedings, he was summarily dismissed by the Trust from his Consultant post. On 30th September 1998 he was struck off the Medical Register, the Professional Conduct Committee of the General Medical Council expressing itself in these terms:

> "During the course of this inquiry the Committee has heard evidence of your lack of care and judgment pre-operatively, failings in your surgical skills, inappropriate delegation and your poor post operative care and judgment. The standard of care which you provided fell lamentably below that which the public requires and which the medical profession expects of its members."

6.3. What had gone wrong? Why did someone who appeared in 1980 to have a glittering career before him, act in such a way? Why was he not prevented from harming patients, the hospitals and staff where he worked, and ruining his career? These were the sort of questions we posed at the start of our investigations.

6.4. Soon after the Inquiry was set up, Rodney Ledward wrote to us stating that he was willing to attend our oral hearings to give full details of the events leading to his dismissal, and we arranged an appointment for him to attend. He then sent us a short written summary of the evidence he wished to put before us. On the morning he was due to appear, he sent us a confidential letter from his specialist, which stated that he

had just been diagnosed as having a serious medical condition. In those circumstances we did not press him to attend. We only mention his health now because it has since become public knowledge. As we have already stated, we have accepted the findings of the Trust Disciplinary Inquiry and the Professional Conduct Committee of the GMC, and we did not consider it necessary to decide whether he had acted negligently in relation to any of the other patients about whom we heard evidence. In those circumstances we did not feel that his inability to give oral evidence caused us serious problems, although obviously and for the sake of completeness, it would have been preferable to hear what he had to say. We have not had that opportunity; but we do not feel that the lack of oral evidence from Rodney Ledward has prejudiced us in coming to the conclusions and recommendations which follow. Perhaps it gave us less insight into the man himself; we do not consider that it has undermined our Inquiry. Of course, we have had the advantage of reading his oral evidence to the GMC, of seeing the medical records he made while he was a Consultant, of reading a number of his letters as well as a statement and other material which he sent to us or which was sent on his behalf.

6.5. Rodney Ledward's NHS and private secretaries gave oral evidence to us. They could not have been more supportive of him; they were both intensely loyal to him and both felt that he had been the victim of a vendetta. We have also seen a number of letters written by fellow Consultant Gynaecologists and other doctors from this country and abroad, and from patients and friends in support of Rodney Ledward. Many felt he had been made a scapegoat and had not been treated fairly. We have borne constantly in mind that we have not had the advantage of hearing from Rodney Ledward in person. We have endeavoured throughout to keep a fair and open mind.

7. FORMER PATIENTS

7.1. Over 500 former patients of Rodney Ledward have so far contacted the NHS helpline set up at the William Harvey Hospital after he was struck off. Some were not treated by him at all, some have had their concerns resolved satisfactorily, some have outstanding claims. We were told that many of these former patients have not come forward to our Inquiry because they were unwilling to relive their experiences again. It was a chapter in their lives which they had put behind them. We respect their wishes

and views. We have found that there are some patients, of those we have considered, who were treated appropriately by Rodney Ledward but unfortunately their problems have persisted. We acknowledge that medicine is not an exact science and that sometimes, and even in the most careful of hands, patients' conditions are not cured. We have found that for some patients he provided exemplary care. We also acknowledge that there are many of Rodney Ledward's former patients who have not contacted our Inquiry at all.

7.2. We would not have been able to carry out our task if some of Rodney Ledward's patients had not contacted our Inquiry. We have heard from over 160 of his former patients in response to our Inquiry and we are most grateful to them all. It is only those patient's cases which we have looked at in detail because in only those cases did we have consent to view their medical records. The vast majority of those who contacted our Inquiry, but not all, made complaints about him. A few were very supportive of him. They told us that, as far as they were concerned, he had been an excellent and caring doctor. Copies of letters from other patients were also sent to us by his NHS and private secretaries, and these were also supportive.

7.3. However it is clear to us that there were many of Rodney Ledwards' former patients who were unhappy with his care and treatment. Without making further findings of negligence we express within the body of our report the areas of Rodney Ledward's practice that have caused us concern and which should, in our view, have caused concern to those who were working with him at the time.

7.4. We have been made aware that many patients were caused upset, worry, and anxiety by Rodney Ledward and many were also caused physical injury. Many have been scarred physically and emotionally. Some had a physical problem which ought to have been readily capable of correction under Rodney Ledward's care, but they were caused injury or further problems. Some appear to have been subjected to repeated and unnecessary surgical procedures. Some already had both physical and emotional problems when they were referred to Rodney Ledward; it seems that his treatment exacerbated their condition. We also became aware during the course of our Inquiry that some patients only began to have doubts about Rodney Ledward's treatment of

them after the publicity consequent on his being struck off the Medical Register. In respect of some of those patients it may be that his treatment was entirely proper, but they have been caused doubt, distress and anxiety and to that extent were also victims.

7.5. Only a handful of patients complained about their treatment at the time; a few brought civil proceedings against him. Most thought that they had just been unlucky. Many did not know how to complain or to whom to complain, many were too embarrassed to do so; for example, problems of incontinence are not the easiest of subjects to raise, and many were stoical and felt that they simply had to get on with their lives. Many placed complete trust in Rodney Ledward - he was their Consultant to whom they had been referred for specialist care by their General Practitioner. They did not feel that they had the knowledge to question his expertise; they accepted his advice and treatment without demur.

7.6. We asked each patient who gave consent to their records being disclosed to state whether they were content for their identity to be disclosed within our Report. A large majority did not, for very understandable reasons, want their identities published. A few patients were willing for us to disclose their identities, for the very laudable reason that they did not wish it to be said that they were only prepared to make allegations anonymously. We admire their courage. It is not easy to allow publicity of very personal and private problems. However overall we did not consider that we needed to identify any of Rodney Ledward's former patients. We do not consider that lack of identification of patients should detract at all from our conclusions and recommendations. We have seen some of the patients who contacted us, we have read the written evidence of those who sent statements to us, and we have read all the available medical records of patients who gave consent to our seeing their records. We have been able to build up a clear picture of their treatment under Rodney Ledward. Disclosing their names adds nothing to our views or our Report.

7.7. We mention that we have heard evidence from the Chairperson of the Patient Support Group. She has taken on, with the help of many others, the role of supporting many women who were treated by Rodney Ledward and felt that they had cause for complaint. Many women have found the Group supportive. Others did not wish to join

the Group, or remain within the Group, - we can well understand that some would wish to keep away from publicity. The very existence of the Group is however of note. It shows the depths of anger, confusion and hurt that many of Rodney Ledward's former patients feel. We have tried throughout our Inquiry to bear that constantly in mind.

7.8. We repeat, in order to avoid any doubt, that we did not consider that we had to make findings of fact in respect of each patient about whom we heard. If our role had been to decide whether Rodney Ledward had been negligent or otherwise in respect of each patient, we would have allowed cross examination of all such patients and other witnesses, and would have had to hear from expert witnesses on each case, just as in a Court of law. We were not set up on that basis and we did not consider that in order to carry out the terms of our Inquiry we needed to hold a judicial hearing. We did not set out to re-determine what had already been decided by the Trust's Disciplinary Inquiry or the GMC.

7.9. Finally we should point out that when a witness, who was not the patient herself, told us about one of Rodney Ledward's former patients, the identity of such a patient was not disclosed to us.

8. MEDICAL STAFF

8.1. We heard evidence from many of the medical staff at the William Harvey Hospital. Some were fellow Consultants in Obstetrics and Gynaecology, some were colleagues from other specialities. Some told us that they were aware of problems with Rodney Ledward's practice going back to the early years after his appointment. Some told us they were unaware of any concerns about him or his practice until the day he was suspended. In the closed and closet atmosphere within a hospital we found it incredible that some doctors had no idea that there was a problem until February 1996.

8.2. We found it difficult to talk to junior doctors who had worked with Rodney Ledward over the years. However some contacted us and told us what a good teacher he was and how supportive he had been of them. Some we wrote to, but they failed to reply to our letters. It became clear very early in our investigations that there was, and probably still is, a culture of junior doctors being reluctant to criticise their seniors

because it might jeopardise their careers, as they are so dependent on their senior colleagues for references. We also recognise that junior doctors from overseas who came to work with Rodney Ledward may have been placed in even greater difficulty, as a result of cultural differences and the fear of discrimination.

8.3. We have mentioned the names of Rodney Ledward's medical colleagues to whose evidence we refer, in our Report. This is because in our view if they had concerns about him or his practice they were able to report such concerns to senior management. They also had the duty to report him to their professional body, the General Medical Council, if it was felt he had been in breach of a doctors' professional code of practice.

9. NURSING STAFF

9.1. Amongst the nursing staff, we again found some considerable reluctance to give oral evidence or to make contact with the Inquiry. Initially there were some who refused to attend at all and one Staff Nurse was told by another nurse on the morning when the former was due to attend our oral hearings, "more fool you". We deplore that attitude. There was no doubt that many nurses felt that their views were insignificant, and that it was not for them to criticise a consultant. Many felt frightened about coming to give evidence to our Inquiry because they were worried that they might be criticised for not having spoken out about Rodney Ledward earlier. They were anxious that if they did give oral evidence they might, as a result of what they said, be reported to their governing body, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), and their registration as nurses and their livelihoods might be placed in jeopardy. We have been assured by the UKCC that there is no question of disciplinary action being brought against any nurse by virtue of the fact that she has given evidence to us.

9.2. We were therefore delighted that a number of nurses volunteered to come to give evidence to us. They spoke clearly and eloquently about what they had seen and heard. Indeed we found that those members of the nursing staff who did respond positively to our request to give oral evidence acted according to the best professional standards.

9.3. We have decided, after considerable thought, not to identify by name the nurses who gave evidence to our Inquiry, although we have referred to their positions within the various hospitals in which they worked. This is because, although they were in a position to report any concerns about Rodney Ledward to a more senior nurse, it did not lay in their hands to do anything more.

10. ADMINISTRATIVE AND MANAGERIAL STAFF

10.1. Amongst the administrative and managerial staff from whom we heard evidence, we found the same mix of those who said they knew nothing or very little about any problems with Rodney Ledward's practice, and those who said they were well aware of the ongoing concerns about his practice but felt constrained, for a variety of reasons, from dealing with the problem. Some told us that they had tried to tackle the problems about Rodney Ledward's practice with which they were faced.

10.2. We have named members of the administrative and management staff in our Report from whom we heard evidence because collectively they shared managerial responsibility for ensuring that the care provided by Rodney Ledward to his patients was proper and of the standard to be expected within the National Health Service. They also had joint responsibility for ensuring that he worked properly with his professional colleagues. The degree of responsibility, of course, varied according to the individual's position.

11. GENERAL PRACTITIONERS

11.1. We heard from a number of General Practitioners in the Kent area, but by no means all. Some GPs told us that they were completely happy with the care their patients received from Rodney Ledward and that they were unaware of any concerns about him over the 16 years he was a Consultant in the locality, but we also heard from many who began to have worries about his practice and manner within the first few years of his appointment. While it is more understandable that doctors outside the hospital setting may not have picked up anything untoward about a local Consultant, and some may genuinely never have encountered any problems with their patients,

generally we found that those who professed to be unaware of problems were those who tended to bury their heads in the sand, who did not listen to patients' concerns or who felt that any Consultant must, almost by virtue of his appointment, be good at his job and beyond challenge.

11.2. We have decided, again after considerable thought, not to identify by name the GPs who gave evidence to our Inquiry. They were never part of the Health Authority or Trust management. Their duty to report Rodney Ledward to the General Medical Council only arose if they considered that he was in breach of a doctor's professional code of practice.

12. COMPLAINTS AND LEGAL CLAIMS

12.1. We have only been able to see documents relating to complaints made by patients about their care by and under Rodney Ledward after 1990, as any earlier documents are no longer available. In the light of out terms of reference, we have only considered those complaints which were raised by patients before February 1996 when Rodney Ledward was suspended. Similarly we have only considered legal claims brought in respect of his care when such claims were notified prior to February 1996. We wished to consider what concerns were known by the hospital and its staff before his employment was suspended.

13. ST SAVIOUR'S CHARITABLE TRUST

13.1. It became clear to us soon after we embarked on our inquiries that a number of Rodney Ledward's patients were treated at the private hospital, St Saviour's, and the cost had been borne by the St Saviour's Charitable Trust. We were told that this was a charity set up in January 1987 to make grants for the relief of sickness of persons in need who reside in Hythe and its neighbourhood. As part of its role, the charity provides financial assistance to persons who fall within this category, who are treated in a private hospital. The charity relies on the opinion of a patient's Consultant as to the need for such treatment. The charity also asks the patient's Consultant to give a view as to whether the patient will suffer from "exceptional hardship" while waiting for treatment under the NHS. St Saviour's Hospital was, we were told, originally a

religious foundation but it has been run as a private hospital for some years and has been managed and owned by the BUPA organisation since 1989.

14. EVIDENCE - GENERAL MATTERS

14.1. We heard oral evidence from a number of witnesses and many witnesses provided written evidence to us. Of those we asked to give evidence, only a handful did not respond positively to our invitation. As we had no power to enforce attendance at our hearings, we were very pleased that witnesses responded to our requests, even if after some initial misgivings. However few NHS employees volunteered to give evidence to us and at the outset of our Inquiry it was by no means easy to identify exactly which witnesses we should contact. Therefore even at this stage we cannot be sure that we have heard from everyone who might have had useful evidence to give us.

14.2. We have no hesitation in relying on what many witnesses told us in that they were clearly honest and doing their best to recall events accurately. However a few other witnesses were in our view either unable or unwilling to recall events with accuracy and we have therefore not relied on such evidence at all or have sought some further evidence to confirm what they told us. In some cases we have felt bound to comment adversely on witnesses. In such cases we have sent them a copy of the relevant parts of our draft report relating to them so that they might have an opportunity to comment and correct any matter of fact which they felt we had not properly understood.

14.3. We have already mentioned that many patients consented to our seeing their medical records and many set out their concerns in writing to us. We have gone through each and every one but we have not felt it necessary to refer to each patient within the body of our Report. This is not because such patients were any less important to our considerations, but to keep our report within manageable bounds. We should state at the outset that we disregarded anonymous evidence and all press reports.

14.4. In the narrative which follows our comments are highlighted in italics to separate our views from matters of fact. However we do not comment on every patient's care

that we refer to; it is our view that in many cases the facts speak for themselves.

15. MEDICAL TERMINOLOGY

Primary haemorrhage. We have used this expression when a patient suffered a bleed within 24 hours of surgery.

Secondary haemorrhage. We have used this expression when a patient suffered a bleed after surgery at any time after the initial 24 hour post operative period. This can be caused for example by infection or trauma.

Oophorectomy. Although gynaecologists use the term oophorectomy to describe **removal of an ovary**, we have preferred to use the latter expression in our Report.

Anterior repair. We have used this expression to describe the operation of repair of the anterior vaginal wall.

HRT. We have used this abbreviation throughout our report to refer to Hormone Replacement Therapy.

D&C. We have used this abbreviation throughout our report to refer to the operation of dilatation of the cervix and curettage of the uterine cavity.

EUA. We have used this abbreviation throughout our report to refer to an examination under anaesthetic.

16. SITE VISIT

16.1. During the course of our Inquiry we visited the William Harvey Hospital so that we could see for ourselves the environment in which Rodney Ledward and his colleagues worked.

17. THE FACTUAL REPORT

17.1. The factual part of our Report (Parts II -V) as to the events leading to Rodney Ledward's suspension by the Trust in February 1996, is set out in chronological order. We have also included in the narrative relevant parts of Department of Health Circulars and Guidelines which were published during the 16 years in question, the GMC pamphlets on professional practice, the UKCC Codes of Conduct, and other relevant documentation and events in order to place matters, so far as possible, in context. We have referred to the DoH Circulars in passing in the narrative and then have gone on to consider them in more detail towards the end of each section.

18. NON FACTUAL EXPERT WITNESSES AND OTHER INTERESTED PARTIES

18.1. After we had concluded hearing evidence about factual matters relating to Rodney Ledward's practice, we went on to hear evidence from a large number of non factual expert witnesses and other interested persons in relation to quality and practice in health care. We list the names of those who gave such evidence to us in **Appendix 3.** We also took into account evidence we heard from the South Kent Hospitals NHS Trust employees about changes that have been introduced to the Trust in the provision of health care, since February 1996. There have been a number of changes throughout the National Health Service over the last four years in relation to the quality of care, particularly as a result of the advent of Clinical Governance and of course, our terms of reference required us to consider the development of Clinical Governance within the NHS. We have also looked at other areas where, as a result of our inquiries, we consider that care could be improved for patients.

19. RECOMMENDATIONS

19.1. We have drawn on all the evidence we have heard, both factual and expert, in coming to our recommendations. We have tried to apply a common sense approach, building and improving on existing strengths in the NHS, rather than advocating change for change sake. Our recommendations are set out in Part VII of the Report and a short summary of our recommendations appears at **Appendix 4.**

20. OUR THANKS

20.1. We are most grateful to all those who gave evidence to us, whether oral or in writing. We could not have done our job without their assistance and many gave considerable time and thought to giving evidence to us. We thank them all.

20.2. We also wish to record our thanks to Ali Mohammed, formerly Deputy Human Resources Director at the South Kent Hospitals NHS Trust, who responded most helpfully to all our requests for documents and information.

20.3. We are also very grateful to our administrative staff: to Jan Dowlen our administrator, who smoothed our way; to Matthew Pitt, upon whom we called at short notice to help our Inquiry; and to Angie Way, who proved a most efficient secretary. We thank them for their help and cheerfulness throughout.

PART II - APPOINTMENT OF RODNEY LEDWARD AS CONSULTANT GYNAECOLOGIST AND OBSTETRICIAN - 1ST JANUARY 1980

PART II

APPOINTMENT OF RODNEY LEDWARD AS CONSULTANT GYNAECOLOGIST AND OBSTETRICIAN 1st JANUARY 1980

1. INTRODUCTION

1.1. Mr Rodney Ledward was offered the position of Consultant Gynaecologist and Obstetrician to the South East Kent District Health Authority on 31st May 1979. He took up his post on 1st January 1980. The new William Harvey Hospital had opened in Ashford the year before. The post was vacant because one of the three Consultant Gynaecologists at the William Harvey Hospital was retiring.

2. RODNEY LEDWARD'S APPLICATION FOR THE POST OF CONSULTANT

2.1. Rodney Ledward's curriculum vitae showed a range of academic and surgical skills. He had originally obtained a degree in Pharmacy in 1959 and then came to medicine as a mature student. He attended Liverpool Medical School where we were told he was well thought of by academics and students alike. He became President of the Medical Students' Society. He is remembered by Professor Symonds, who was then a Senior Registrar at the Maternity and Women's Hospital in Liverpool when Rodney Ledward was a student, as a good and dedicated student who worked his way through medical college by doing pharmaceutical locums. After a series of House Officer, Senior House Officer and Registrar jobs in a number of hospitals throughout the country, in 1975 Rodney Ledward was appointed Senior Registrar at the City and Women's Hospital in Nottingham and Clinical Teacher at the University of Nottingham. He had obtained his Membership of the Royal College of Obstetricians and Gynaecologists in 1971 and was to obtain Fellowship of the Royal College of Surgeons in 1976. Professor Symonds recalls that Rodney Ledward was the outstanding candidate for the post of Senior Registrar at Nottingham. Nothing adverse was heard about him by the interviewing panel.

3. SENIOR REGISTRAR IN NOTTINGHAM 1975 - 1979

3.1. He was appointed Senior Registrar in Nottingham to Mr Marcus Filshie, Consultant Gynaecologist and Obstetrician. Mr Filshie told us that he considered that Rodney Ledward was a very competent surgeon who had remained so throughout his 3 or more years at Nottingham. Mr Filshie had inherited a very busy practice with a long waiting list. He said that he had taught Rodney Ledward to operate quickly when possible but to go slowly and with all care at crucial times. He had always found that Rodney Ledward performed well and had no misgivings about his competence or skills as a gynaecologist. He was therefore very happy to provide a glowing reference for Rodney Ledward when he applied for the Consultant post. We have not seen the reference as none is now available. However we entirely accept that Mr Filshie would have provided a good reference and that other references were probably forthcoming in similarly approving terms, one of which may well have been provided by Professor Symonds.

3.2. Professor Symonds told us that while Rodney Ledward was Senior Registrar, one of the Consultants at Nottingham had voiced some misgivings about him on a personal basis and there was also some suggestion that he was not always available when he should have been. However he said that these were minor concerns which in no way altered the view that he was a good surgeon who merited a consultant post.

4. PUBLICATIONS

4.1. During his time as Senior Registrar in Nottingham, Rodney Ledward began his MD for which he wrote a thesis - Professor Symonds told us that initially it was not up to scratch and Rodney Ledward was told to re-write and re-edit it. Eventually in 1984 he obtained the degree of Doctor of Medicine. Professor Symonds also told us that Rodney Ledward had come up with a variety of schemes during his time at Nottingham, some of which Professor Symonds had told him were foolish and of which nothing more was heard. However some schemes, for example the writing of short texts on a variety of medical subjects were considered a good idea, and once he had been properly

guided and helped with them, the booklets were published.

4.2. Professor Denis Hawkins, Honorary Consultant in Obstetrics and Gynaecology at the Hammersmith Hospital and Emeritus Professor of Obstetric Therapeutics in the University of London, told us that Professor Symonds had introduced Rodney Ledward to him. Rodney Ledward had drafted a book on drugs in obstetrics and in Professor Hawkins' view it required a good deal more work. He said that Rodney Ledward worked at the Hammersmith Hospital for a few weeks as a research assistant primarily "to revise his book and bring it up to some sort of standard." Professor Hawkins told us that he was able to oversee and advise on the text and that in the end he "...wrote most of the obstetric part and changed a lot of the pharmacy." He was therefore made co-author and the book was entitled "Drug Treatment in Obstetrics". It was published by Chapman and Hall in 1983. Professor Hawkins told us that it was a very successful book and that he and Rodney Ledward collaborated on the second edition in 1990.

4.3. *The impression we have gained from Professor Symonds (and to a certain extent from Professor Hawkins) is that even in the days when Rodney Ledward was a Senior Registrar, there was something slapdash and unmethodical in his character; an element of seeing what he could get away with.*

4.4. Professor Symonds gave us a clear example of this: Rodney Ledward apparently collected together the undergraduate notes from the University of Nottingham Medical School and tried to publish them without any prior agreement with the lecturers and professors who had written the notes. Professor Symonds was upset and angry about this and made his views known. Rodney Ledward was very sorry and apologetic and the project was dropped. Professor Symonds felt that until it was pointed out Rodney Ledward had no appreciation that what he was doing was wrong.

5. RODNEY LEDWARD'S EARLIER CAREER AS A SENIOR HOUSE OFFICER

5.1. We have heard from 2 Consultant Gynaecologists who worked alongside Rodney Ledward in the early 1970s when he was a Senior House Officer and they were Senior Registrars. One told us that he seemed to be a man on the make whom it was difficult to trust. The other told us that in his view Rodney Ledward was intellectually and slyly clever. He explained that Rodney Ledward would try to skate across the surface of things, "the quickest and shortest way of getting things done seemed to be what he achieved. It did not matter about quality." He felt that Rodney Ledward was not committed to his work and told us that his ward rounds were perfunctory. This witness went on to say that Rodney Ledward cultivated a number of eminent surgeons whom he assisted with their private work. We comment that even in his training days Rodney Ledward could attract criticism but at the same time could attract high plaudits. It is an inconsistency we have been faced with on a number of occasions when considering his career.

6. TUTORIAL SYSTEMS INTERNATIONAL LIMITED

6.1. In 1978, while Rodney Ledward was at Nottingham, he and a colleague set up Tutorial Systems International Limited. In Rodney Ledward's words: "The Foundation was to encourage Continuing Medical Education at all levels of the profession. The sole aim was to bring, at low cost, international speakers to the UK. They would visit various centres throughout the country ie Hospitals, General Practitioner Centres et al during their multi-centre tour of the UK. It was both professional and social." A number of eminent Gynaecologists joined the Advisory Board but others, from whom we have heard, were not prepared to become involved in the organisation.

7. THE OFFER OF A CONSULTANT POST

7.1. In May 1979 Rodney Ledward was offered the post of Consultant Gynaecologist and Obstetrician by the South East Thames Regional Health Authority on the advice of the Advisory Appointments Committee. He had been seconded to Saudi Arabia as

Consultant in Obstetrics and Gynaecology in the last year of his Senior Registrarship at Nottingham and it appears that, despite the offer of the Consultant post at Ashford, he hoped to obtain the position of Professor of Obstetrics and Gynaecology at the King Faisal University, Dammam, Saudi Arabia. He asked for the offer of his Consultant post to be deferred for 2 years. The Regional Health Authority was not prepared to agree to such a deferment. In September 1979 Rodney Ledward applied for a Consultant post at St Thomas' Hospital in London but his application was not successful. He finally agreed to start at the William Harvey Hospital on 1st January 1980. There was no doubt that the delay in taking up his appointment caused some difficulty for the division of Obstetrics and Gynaecology because there were only 2 permanent Consultants left to run the department.

7.2. Rodney Ledward was appointed to a maximum part-time contract so that he was paid 10/11ths of the full time salary of a NHS Consultant and was allowed to undertake private work. We were told this was accepted practice. Although his contract was with the Regional Health Authority his work was to be carried out in hospitals run by the South East Kent District of the Kent Area Health Authority. The Region therefore would have little or no contact with Rodney Ledward's day to day practice. This was an anomaly which was followed throughout the NHS at the time; the body which employed a consultant was not the body directly responsible for the provision of health care at the hospitals where the consultant was required, under his contract, to work.

7.3. Although we have heard evidence that the Obstetric and Gynaecology division at the William Harvey Hospital in Ashford was not a happy unit when Rodney Ledward joined the Consultant team, he told us, in written evidence, that as far as he was concerned it was a happy team. He continued, "I felt I was joining a good District Hospital (named after one of the medical greats, William Harvey) and I would try to make my contribution to its success." His fellow gynaecologists at the time were Mr Kenneth Pool, who retired in 1987, and Mr William Ursell who retired in 1998. Thus Rodney Ledward became one of three Consultants and it is clear that he was seen as young blood with a strong academic and professional record. The speed of his surgery was acclaimed; he was considered to be a breath of fresh air. He was said to be charming to patients and staff. He was something of an eccentric, flamboyant character

who dressed smartly often with a buttonhole and drove fast, flashy cars. Some staff and patients liked his style, others did not.

7.4. Rodney Ledward's initial job plan was that he was free to pursue his private practice on Monday morning and Thursday afternoon. On Monday afternoon he was to be at the William Harvey Hospital (WHH) in Ashford between 1400 and 1730, on Tuesday at WHH from 0900 until 1730, on Wednesday at WHH from 0900 until 1830, on Thursday at the Buckland Hospital in Dover and the Victoria Hospital in Deal between 0900 and 1400, and on Friday at Dover and then at the Royal Victoria Hospital in Folkestone from 0830 to 1730. He was to work on call one in every 3 nights.

PART III - RODNEY LEDWARD'S PRACTICE 1980 - 1985

PART III

RODNEY LEDWARD'S PRACTICE 1980 - 1985

1. INTRODUCTION

1.1. We have tried to put the information we have obtained into chronological order so as better to understand how matters developed and what influences may have been at work. This has not been an easy task because we have been looking at a period of 16 years and memories for exact dates and times have obviously faded. We have used patients records and other documentation available to us as landmarks and have tried as best we can to put matters into context.

2. THE HEALTH AUTHORITY ORGANISATION

2.1. In 1980 the South East Kent District formed one of the 6 Districts for which the Kent Area Health Authority was the statutory body responsible for policy and strategy. The District was run on the basis of consensus management and the District Management Team was responsible for running the health service in the NHS hospitals where Rodney Ledward was a Consultant. These hospitals were principally the William Harvey Hospital in Ashford (to which we shall refer as the WHH), the Royal Victoria Hospital in Folkestone, and the Buckland Hospital in Dover. The District Management Team comprised an Administrator, a Nurse, a Treasurer, a Medical Officer, a Consultant representative and a GP representative. The South East Thames Regional Health Authority was responsible for resource allocation, the regional computer centre, major capital developments, implementation of government policy and employment of senior doctors. In effect the Regional Health Authority was the body which existed

between the Area Health Authority and the Department of Health.

2.2. In 1982 the NHS underwent a major reorganisation and the South East Kent Health Authority was created. The management of the new Health Authority was still carried out by the District Management Team on consensus management lines. The South East Thames Regional Health Authority remained in being and exercised broadly similar functions to those it had exercised previously.

2.3. In 1985 a further re-organisation took place. Mr Russell was appointed District General Manager to the South East Kent Health Authority and was given individual and overriding responsibility for managing the Authority. He appointed a Senior Management Team which comprised a team similar in personnel and experience to the previous District Management Team.

2.4

Reporting of Accidents in Hospital

We mention at this stage of our report a Department of Health Memorandum, entitled Reporting of Accidents in Hospital, which was published in 1955 and was still operational in the 1980s. The memorandum set out the procedure to be followed where an accident or untoward event occurred in a hospital. It advised that statements should be obtained from staff who were involved in the event so that any ensuing complaint or litigation could be dealt with by the Health Authority. Such statements were to be confidential so that they would not be disclosed to a complainant or litigant subsequently. *We consider that this Memorandum reflected the culture that existed in the 1980s. Openness with the patient was not encouraged.*

1980

3.1.1. In **July** 1980 Rodney Ledward performed a total abdominal hysterectomy on a NHS patient during which he tied both ureters. He subsequently appreciated that he had tied the ureters and attempted to repair them himself the following day but did not ask for assistance from a urological colleague. The patient went on to develop a vesico-vaginal fistula and was eventually referred to Mr Girling, Consultant General Surgeon with a particular interest in urology. The patient told us that Rodney Ledward had never explained anything about this surgical mishap and she had always thought hers was a one off case - that in effect she had been unlucky. She told us that the surgical error had a profound effect on her life and marriage.

3.1.2. Mr Girling told us that he could not recall this case but, from looking at the patient's records now, he accepted that he would have been aware that her ureters had been damaged when she was referred to him in about **August** 1980. He said that it was a rare occurrence for a gynaecologist to damage a ureter and during his career he had been asked to see 3 or 4 patients where the gynaecologists suspected ureteric damage. He said that he would have been concerned by this case.

3.1.3. *We have been told by a number of consultant gynaecologists that in their careers they might have damaged 1 or 2 ureters, but that such a surgical mishap causes the surgeon real concern especially if the damage occurred during an uncomplicated operation. We understand that there is no published literature on the number of ureters that a Gynaecologist can expect to damage during his or her career. It is however widely recognised by the profession that the cutting or tying off of a ureter is a rare and serious surgical mishap. To tie 2 ureters in the same patient and not to recognise this at the time, would have caused most gynaecologists distress and serious concern. We understand that the accepted response would normally be to ask a Consultant Urologist to repair the damage.*

3.2. In **October** 1980 Rodney Ledward performed a vaginal hysterectomy on a private patient; she developed a pelvic abscess subsequently and had to be readmitted in November and again in December 1980. *We accept that pelvic abscess is a recognised and serious complication of such surgery. We understand that it should be an uncommon event.*

3.3. One NHS patient told us that she was pregnant in **November** 1980 and suffered complications. Her baby had to be delivered prematurely by caesarean section but sadly died shortly after birth. She complained to us that Rodney Ledward had not shown any interest in her plight and she had found him arrogant in his manner.

3.4 In **1980** a NHS patient was advised by Rodney Ledward to undergo a D & C for which he said there was a long waiting list of about 2 years. The patient told him her husband's firm had just joined a private health scheme and she told us Rodney Ledward had said "Oh well, you might as well use the bloody thing then. I will see if I can get you into St Saviour's tomorrow." She was operated on 2 days later and subsequently Rodney Ledward advised the patient to have a hysterectomy for an enlarged uterus. This was carried out in 1981 after which she suffered a primary haemorrhage requiring re-operation. The wound then became infected. Within a few months of the hysterectomy we were told that the patient was advised by Rodney Ledward that she had developed an ovarian cyst and he carried out a further operation to remove the ovary. Thereafter intercourse was painful and she had incontinence problems. Rodney Ledward advised her that "this sometimes happens after a hysterectomy".

3.5 One former patient wrote to us to tell us that Rodney Ledward had performed a hysterectomy on her in **1980** and that it had been a complete success. She wanted to express her support for him and said that in her view there must be many more women like her.

1981

4.1. On the **1st January** 1981 Rodney Ledward was appointed the Chairman of the Obstetrics and Gynaecology Division for 2 years, that is until 31st December 1982.

4.2. In **January** 1981 one of Rodney Ledward's NHS patients suffered a post operative wound haematoma. This patient told us she had suffered a "dreadful time" in hospital but that Rodney Ledward had told her that the haematoma was "normal". She thereafter suffered continuing bladder problems. *We accept that haematoma is a recognised complication of such surgery. We understand that it should be an uncommon event.*

4.3. In **January** 1981 Rodney Ledward carried out a ventrosuspension on a private patient. Over the course of the next 2 years he carried out a further 5 surgical procedures on the same patient. *We express our concern as to whether all these procedures were medically necessary.*

4.4. We were told about a NHS patient who in **early 1981** felt pressurised by Rodney Ledward to have a Caesarean Section at 38 weeks of gestation because he was going away for 2 weeks and would not be able to attend her during that time. The patient resisted the pressure and was delivered of a healthy child 5 weeks later. She was concerned that had she succumbed to the pressure placed upon her, her child would have been born 5 weeks early. She and her husband felt that the pressure they had been put under was improper.

4.5. We were told by a GP about a NHS patient who was pregnant in **early 1981** and being cared for under Rodney Ledward. It became clear towards the end of her pregnancy that the fetus had severe developmental abnormalities incompatible with life. The mother then became his private patient as the terms of her private insurance covered complications of pregnancy. The baby was delivered and died. The mother was very distressed. Rodney Ledward sent her a bill for all her antenatal care

although most of it had been provided under the NHS. Her GP had been very concerned about this case.

4.6. We heard about a NHS patient who in **July** 1981 was pregnant and under the care of Rodney Ledward. She was admitted to hospital where it was found that the baby had died in utero. It was 3 days before the mother was delivered of her stillborn baby during which time she remained on an antenatal ward and she was very distressed. We were told that when she was seen at her post-natal examination by Rodney Ledward, he asked her how her baby was.

4.7. A NHS patient told us that Rodney Ledward had carried out a laparotomy on her in **1981**. She said that after the operation she developed a large swelling around her incision, but Rodney Ledward told her it was part of the process of healing. She was discharged from hospital and later on that day when she was in the bath, the swelling burst. She called her GP out to see her and he explained that it was a haematoma. The patient told us that Rodney Ledward had attended the hospital on one occasion in his riding clothes. She became Rodney Ledward's private patient in 1982 and he carried out 4 further surgical procedures between November 1982 and May 1984. *We express our concern as to whether all these procedures were medically necessary.*

4.8. We were also told about a private patient who in **1981 or 1982** had an advanced gynaecological cancer. During the course of an operation upon the patient Rodney Ledward tore both her ureters and then attempted to re-implant them without the assistance of a urologist.

4.9. Another private patient told us that Rodney Ledward had carried out an abdominal hysterectomy at St Saviour's Hospital in about **1981**, followed by a laparoscopy in February 1982, and then removal of her left ovary in July 1982. He then carried out appendicectomy in 1983. *We express our concern as to whether all these separate procedures were medically necessary.*

4.10.
Health Service Complaints Procedure
In April 1981 the Department of Health published its Health Service Complaints Procedure. It set out the procedures to be followed when a patient made a complaint and reminded doctors and nursing staff that a prompt and sympathetic response to complaints would frequently solve patient's concerns.

1982

5.1. In **March** 1982 Rodney Ledward carried out an anterior repair on a private patient. The patient has been incontinent ever since. For many years she told no one because it was a subject she found difficult to broach with family, friends or her doctor. She told us that her incontinence had seriously affected her life and marriage. *We have been impressed by the number of women, of whom this patient is but one example, who did not feel able to speak about their problems of incontinence to their GPs, friends or even to their husbands and partners. We recognise that there is a culture amongst women that women's problems just have to be borne and not discussed. It seems to us to be a subject which is one of the last "taboo" areas.*

5.2. In **July** 1982 a NHS patient was admitted for sterilisation under Rodney Ledward's team. She was X rayed post operatively but not told why. It was only several days later that she was told that a piece of bakelite from the equipment had been left in her abdomen.

5.3.

The Three Wise Men procedure

In July 1982 the Department of Health issued another circular. It advised that each District Health Authority should set up a panel (known as the "three wise men") to investigate any concern about the risk of harm to patients as a result of physical or mental disability of a doctor.

5.4. We were told that in **1982** Rodney Ledward advised a NHS patient to undergo a hysterectomy. He said that there was a 2 year waiting list and that she might have an underlying malignancy. *From all we have seen and heard about this patient we can find no evidence whatever for this assertion, beyond the risk in the normal population.* Rodney Ledward offered to carry out the surgery privately and the patient agreed. It was carried out at St Saviour's and the patient suffered a primary haemorrhage so that she had to be readmitted to theatre for surgery and required a blood transfusion. Rodney Ledward's discharge letter to the GP made no mention of this complication and he only referred to it subsequently. *We accept that post operative haemorrhage is a known complication of such surgery but understand that it should be an uncommon event.*

5.5. We were also told about a patient upon whom Rodney Ledward carried out an amniocentesis in **1982 or 1983**. Despite warning signs of miscarriage that were then present, Rodney Ledward nevertheless continued with the procedure. However the patient went on to miscarry.

5.6. In about **1982** Rodney Ledward was the Consultant in Obstetrics and Gynaecology who compiled with 2 of his junior staff, a Clinical Report of the Division which covered the period from 1st January 1980 to 31st December 1981. The Report set out in detail the work of the division, its strengths and its weaknesses. *In our view it was an early attempt at audit which was advanced for its time.*

1983

6.1. In **May** 1983 Rodney Ledward gave advice to a patient about the well-being of her fetus, based on the results of a blood test. She alleged that his advice had been negligent and a claim was notified by the patient to the Health Authority in November 1983. Her claim was finally settled in February 1995.

6.2. In **July** 1983 Rodney Ledward carried out a total abdominal hysterectomy on a private patient and he then performed 2 further surgical procedures on her during the course of the next 10 months. *We express our concern as to whether these 2 further procedures were medically necessary.*

6.3. In **July** 1983 Rodney Ledward made a hole in a NHS patient's bladder during an anterior repair, which he recognised at the time and repaired. The patient however has remained incontinent ever since. She told us that Rodney Ledward had not informed her that her bladder had been damaged and there was no mention of this surgical mishap in his discharge letter to her GP.

6.4.
UKCC Nursing Code July 1983
The first Code of conduct for the nursing profession was published in July 1983. It provided that "The registered nurse...shall at all times, act in such manner as to justify public trust and confidence, to uphold and enhance the good standing and reputation of the profession, to serve the public interest and the interests of patients...".

6.5. We heard evidence about a private patient who was referred to Rodney Ledward in **1983** for a termination of pregnancy. He said that he would only carry out a termination if she was also sterilised at the same time. She agreed and she was admitted to the William Harvey Hospital for both procedures.

6.6. One patient told us that she had undergone total abdominal hysterectomy for fibroids under Rodney Ledward as a private patient in **1983** and that thereafter she attended follow up appointments with him for many years. *We express our concern that there may not have been any clinical reason for such follow up.*

6.7.

NHS MANAGEMENT INQUIRY - the Griffiths Report

In October 1983 Mr Roy Griffiths chaired an Inquiry into the Management of the NHS and made a number of recommendations to the Secretary of State. The recommendations included the proposal that a Health Services Supervisory Board should be established to determine policies with the Secretary of State, with a full time Management Board to implement such policies and control performance. Accountability was to be extended from Unit Managers through to Regional Health Authorities and a General Manager was to be appointed with overall responsibility for management. Decisions were to be made at local level. The Report stated: "It cannot be said too often that the National Health Service is about delivering services to people." *We understand that a number of Consultants saw these proposed changes as a threat to their autonomy.*

6.8. We learned of a private patient (to whom we have already referred above) upon whom Rodney Ledward carried out surgery in **November** 1983 to remove a lump on her chest wall. She was left with an unsightly scar. Rodney Ledward saw this patient privately for a number of follow up appointments over the next 10 years.

6.9. In **1983** Rodney Ledward advised a private patient soon after she had given birth that she needed a hysterectomy urgently. He advised the operation although the patient was only 26 years old. *We understand that it would be unusual clinical practice to advise hysterectomy for such a young patient, in the absence of malignancy.*

6.10. The Community Health Council told us about a NHS patient who was referred to Rodney Ledward in **1983** when he advised her that she required an operation. He told her that there was a waiting list of at least 2 years on the NHS and that it would be in her best interests to have the operation done privately at St Saviour's Hospital. She agreed and she then had surgery carried out at St Saviour's by Rodney Ledward in 1984, 1986 and 1988.

1984

7.1. In **March** 1984 a patient was referred privately to Rodney Ledward. He failed to obtain consent from his patient before carrying out a deforming surgical procedure. While the patient was in hospital he told her that she did not have cancer, a diagnosis that had never been raised prior to the operation. The patient told us that he had come to see her at St Saviour's in "a dusty sweater and jodhpurs" which she had felt was inappropriate. She was also critical of his manner when later, at an outpatient appointment, she complained of pain on intercourse and he told her "to work at it". She told us that she did not go to see him again.

7.2. In **April** 1984 during a vaginal hysterectomy operation Rodney Ledward caused a hole in a NHS patient's bladder, which he attempted to repair at the time and inserted a catheter. In the recovery room the patient was found to be draining urine from her vagina and the catheter appeared to be blocked. She was taken back to theatre where Rodney Ledward was unable to identify the urethra. He asked Mr Girling, Consultant General Surgeon to assist. Mr Girling carried out a laparotomy at which he found holes in the patient's bladder and urethra which he attempted to repair. However the patient continued to suffer from incontinence and suffered from vesico and urethro vaginal fistulae. Rodney Ledward made 2 further unsuccessful attempts to repair the patient's injuries before referring her to a Consultant Urologist at a London hospital. We were told that the patient was very unhappy with the care

she received and that she had spoken to the nursing staff who knew that "something was wrong" with Rodney Ledward's practice. He did not give any explanation to the patient about her problems.

7.3. We were told that in **April** 1984 Rodney Ledward and his senior House Officer put improper pressure on one of his NHS patients, who was then aged 25 years, to undergo sterilisation at the same time as D&C. *We express our concern as to whether the patient ever gave proper consent and also as to whether it was appropriate for her to be sterilised at the age of 25.* The patient told us that she had found Rodney Ledward arrogant and patronising.

7.4. In **May** 1984 Rodney Ledward carried out a laparotomy and anterior repair on a private patient without obtaining consent to the anterior repair. The patient was very unhappy with the care she had received and felt that he had abused her trust.

7.5. In **June** 1984 Rodney Ledward carried out a laparoscopy on one of his private patients following a termination and sterilisation. Over the following 18 months he carried out a further 5 surgical procedures including a hysterectomy. *We express our concern as to whether all these further procedures were medically necessary.* After the hysterectomy the patient suffered a secondary haemorrhage and she was given a blood transfusion. Rodney Ledward could not be contacted and another doctor had to be called in as an emergency. The patient told us that Rodney Ledward had subsequently attended her and said to her, "you have just had a terrible run of bad luck." She also said that he appeared in his riding clothes which she felt was not right. His only explanation for her problems was that she had suffered a slight infection and a little bleed. She continued to suffer problems and needed further surgery but could no longer afford private care. She told us that Rodney Ledward's attitude changed completely when she became a NHS patient - she said he was then abrupt and offensive.

7.6. In **July** 1984 Rodney Ledward carried out a laparoscopy and in August 1984 a laparotomy on one of his private patients at the Portland Hospital in London. He appears to have returned to Kent after each procedure leaving the care of the patient

in the hands of the Resident Medical Officer at the hospital. *We express our concern at this practice. It seems to us to be inappropriate for a surgeon to travel home many miles from the hospital where he has just carried out surgery, and to leave a patient without the benefit of his own or any other Consultant's readily available cover. We comment that it also seems inappropriate in such circumstances to leave post operative care to the Resident Medical Officer who has responsibility for emergency care for the whole hospital. However we understand that Rodney Ledward may not have been the only gynaecologist to have followed such a practice at that time.*

7.7. In **September** 1984 a private patient told us that Rodney Ledward had advised a hysterectomy for fibroids but in fact no fibroids were shown on histology. The patient suffered a primary haemorrhage post operatively and had to be returned to theatre. The patient told us that she had not liked Rodney Ledward's attitude at all when he saw her the next day. He said words to the effect of "Who's a naughty girl then?" which she found offensive as indicating that her post operative complications were her own fault. She was also unhappy about his attending her in riding clothes, tapping his boots with his riding crop. Rodney Ledward wrote to her GP without making any reference to the post operative complication.

7.8. In **September** 1984 one of Rodney Ledward's private patients suffered a primary haemorrhage after hysterectomy carried out by him. During the night following the operation he was contacted by the Consultant Anaesthetist about the patient's blood pressure and pulse rate but Rodney Ledward did not attend. On the following day he went to see his patient and took her back to the operating theatre. Rodney Ledward wrote to her GP but made no mention of her post operative complications. She told us that he had subjected her to a "brutal internal examination" when she attended some 6 weeks later for a follow up appointment. The patient complained to the private hospital who simply passed her complaints to Rodney Ledward. The patient asked her GP to refer her to another Gynaecologist but he was unwilling to do so saying it was unethical to change specialists. Finally she consulted solicitors and brought proceedings against Rodney Ledward. In due course her claim came to trial but failed in respect of the allegation that Rodney Ledward had said to her, before he operated on her, that he would definitely cure her

incontinence. The Judge accepted Rodney Ledward's version of events that he had made no such promise. It was conceded by the patient's counsel during the course of the trial that there was no evidence to support her claim that the hysterectomy had been carried out negligently.

7.9. In **November** 1984 a NHS patient told us that Rodney Ledward had examined her vaginally and caused her considerable hurt. When she complained he told her to "stop being so stupid". She had found his attitude lacking in compassion and unpleasant. On one occasion he had passed a comment about the size of her stomach saying that she should do them both a favour and lose some of the fat.

7.10. In **November** of the same year Rodney Ledward carried out a total abdominal hysterectomy on a NHS patient. Post-operatively the patient suffered a primary haemorrhage and she was returned to theatre for internal resuturing. The following day she suffered a further secondary haemorrhage and underwent laparotomy. She then suffered 2 further secondary haemorrhages during the course of the following month and had to undergo 3 further surgical procedures.

7.11. We were told about a private patient upon whom Rodney Ledward carried out a vaginal hysterectomy and repair in **November** 1984 during the course of which the patient's bladder was damaged. She told us how concerned she had been that she would remain incontinent forever and said that Rodney Ledward was very blase and told her not to worry. Her problems continued and Rodney Ledward then advised a rectocele repair which he carried out in 1985. She told us that he had examined her internally soon after the surgery, without any warning, and she had been caused great pain. It seems, from the records we have seen, that Rodney Ledward failed to countersign the consent form in respect of each of these operations.

7.12. A former patient wrote to us to tell us that in **November** 1984 Rodney Ledward had operated on her for ovarian cancer. She wrote: "I cannot speak too highly of Mr Ledward's treatment and care afterwards and his polite and caring manner towards me afterwards." She said that he had visited her in his riding clothes on one occasion and she had felt "very much cheered up to see that and his smiling face."

7.13. We were told about a private patient upon whom Rodney Ledward carried out a repair operation in **1984** after which she suffered haemorrhage and needed blood transfusions. Rodney Ledward thereafter wrote to her GP and made no mention of her postoperative complications.

7.14. The Community Health Council told us about a NHS patient who was referred to Rodney Ledward in **1984**. He suggested he treat her as a private patient as she had private health insurance. He advised removal of an ovary which was carried out in 1984 and then in 1985 he removed her other ovary and started HRT implant therapy. We were told that she had further surgery in 1986, 1987, 1988, 1989 and 1990 all of which were carried out privately. *We express our concern as to whether all these further procedures were medically necessary.*

7.15. In about **1984** Rodney Ledward presided over and was Consultant Editor to the 2nd Biennial Report of the Division which covered the period from 1st January 1982 to 31st December 1983. The Report once again set out in detail the work of the division and its strengths and weaknesses. The foreword was written by Mr Pool, Mr Ursell and Mr Ledward in which they stated that the Report was an internal audit which it was intended to carry out every 2 years. *We comment that this report, like its predecessor published in 1982, was advanced for its time. It showed the importance and benefits of audit at a time when audit was in its infancy.*

7.16. One of Rodney Ledward's former patients wrote to us to say that in about **1984** Rodney Ledward had operated on her and she was completely satisfied with his performance and care.

1985

8.1. In **January** 1985 Rodney Ledward carried out a vaginal hysterectomy on a NHS

patient during the course of which he made a hole in her bladder which he recognised and repaired. The patient was unable to pass urine post operatively for 12 hours and he instructed his Senior House Officer to take the patient back to theatre for catheterisation which was only achieved with difficulty. A vesico vaginal fistula developed which Rodney Ledward attempted to repair himself on 2 occasions before asking for the assistance of a urological colleague, Professor Blandy at the London Hospital. Investigation revealed that the patient had 2 urethro vaginal fistulae as well as a vesico vaginal fistula. Her problems continued. *We understand that it is accepted practice for a vesico vaginal fistula to require specialist surgery.*

8.2. We were told that in **January** 1985 Rodney Ledward had carried out a laparoscopy and sterilisation on a private patient and then advised her to undergo hysterectomy for fibroids. She was then 38 years old. He carried out a vaginal hysterectomy in March 1985 but she suffered secondary haemorrhage for which she was given blood transfusions and then further surgery. After her discharge from St Saviour's Hospital she suffered another haemorrhage and she was admitted to the Chaucer Hospital for further repair surgery by Rodney Ledward. She was then discharged from hospital but suffered a third haemorrhage at home, was readmitted to the Chaucer Hospital where Rodney Ledward carried out another operation. This patient continued to see him for follow up appointments every 6 months until he was suspended in February 1996. We should point out that not all of this patient's notes have been available to us.

8.3. In **September** 1985 Rodney Ledward wrote to Professor Blandy, Professor of Urology at the London Hospital referring a patient to him who was suffering from a vesico vaginal fistula. He stated that this was the third of his patients he had referred to Professor Blandy with a vesico vaginal fistula. Rodney Ledward wrote that the patient "had kept her fistula silent for several months" and that he had attempted a repair which had been unsuccessful. He was asking Professor Blandy to help. *We emphasise that this patient is <u>not</u> one of the patients to whom we have already referred above.*

8.4. Later that year, in **November**, Rodney Ledward delegated surgery for urinary

incontinence on a NHS patient to his registrar. After the procedure the patient suffered more serious incontinence and she was eventually referred to another hospital where a vesico vaginal fistula was diagnosed and repaired. The patient described to us how Rodney Ledward came to see her post operatively. She said: "He sort of breezed on by ... that was his way." She had found his flamboyant dress and carnation buttonhole rather odd. The patient was very critical of the fact that she had never been given any explanation by Rodney Ledward of her problem and told us that she has remained incontinent ever since.

8.5. We were also told about a patient who went to see Rodney Ledward for problems of incontinence in the early 1980s as a NHS patient but whom, as we were told, he persuaded to become a private patient because she was anxious and he told her there was a long waiting list. The patient's records were not available to us. Post operatively the patient told us that she continued to have incontinence and also felt that the entrance to her vagina had been altered at surgery which made sexual intercourse difficult. She did not tell anyone about her problem, for as she said, "I belong to the generation that believe that doctors could do no wrong.".

9. *Our Concerns about the Care of those Patients to whom we have referred above.*

9.1. *From a consideration of those patients who received care under Rodney Ledward during 1980 to 1985 and whom we have considered above, we express the following concerns:*

* *a number of patients suffered ureteric or urinary tract damage. We have already commented that damage to ureters is an infrequent and worrying complication of general gynaecology. Gynaecologists are also concerned when one of their patients develops a fistula.*

* *a number of patients suffered from haemorrhage, haematoma,*

infection or pelvic abscess. These are recognised complications of gynaecology but we are concerned at the number about which we have heard during this 6 year period.

* *a number of patients seem to have been pressurised by Rodney Ledward to become private patients.*

* *a number of private patients seem to have been subjected to repeated and unnecessary surgical procedures.*

* *a number of patients seem to have been given unconventional medical treatment or did not consent to all the surgery carried out.*

* *a number of patients told us that he was unkind and uncaring and that he did not provide full explanations of their treatment or subsequent complications.*

* *in a number of cases we have been concerned that he failed to give full information to patients' GPs.*

* *In a few cases when patients suffered complications it seems that Rodney Ledward did not attend them or could not be contacted.*

* *in a few cases Rodney Ledward seems to have delegated surgery inappropriately to junior doctors*

10. EVIDENCE OF CONSULTANT COLLEAGUES - GYNAECOLOGISTS

10.1. Rodney Ledward's senior Gynaecology Consultant colleague during this period was Mr Kenneth Pool who retired in 1987. We have not heard evidence from him. However we have heard evidence from Rodney Ledward's other Consultant Gynaecology colleague, Mr Ursell who retired from his NHS practice in 1998.

Mr Ursell

10.2. Mr Ursell told us that he was not aware of any concerns about Rodney Ledward or his practice at any time before 1995. He had never noticed that there was anything unusual about Rodney Ledward's complication rate when he (Mr Ursell) had been on call. He said that Rodney Ledward was flamboyant and told us, "I know that in his consulting rooms he was an extremely caring consultant and well liked by many of his patients." He said that Rodney Ledward had published many articles and books, most of which were extremely good.

11. EVIDENCE OF CONSULTANT COLLEAGUES - OTHERS

Mr Girling

11.1. Mr Girling, who had been a Consultant General Surgeon at the William Harvey Hospital since 1966, told us that the general view when Rodney Ledward was appointed was that he was an extrovert, larger than life character who involved himself very much in teaching, research and lectures. He said he "was an admirable character in many ways, ... but uncomfortable to live with." He said that during the 1980s there was a growing sense of unease about Rodney Ledward and his practice.

Mr Griffiths

11.2. We were told by another Consultant General Surgeon, Mr Griffiths, that there had been concerns about Rodney Ledward's technique almost from the beginning. He said that Rodney Ledward was known to be quick and rough and was a difficult colleague to talk to. He said that he thought that there was a private practice ethos within the department.

Mr McPartlin

11.3. Another Consultant Surgeon, Mr McPartlin, told us that soon after Rodney Ledward's appointment he had been invited to go and watch him operate. His reputation was of being quick and good. The general surgeon was not impressed; he felt Rodney Ledward was rough. This surgeon told us that he recalled an occasion in about 1985 when he had been called in to assist at an operation when Rodney Ledward had damaged the patient's small bowel. He was aware, as he said were his colleagues, that Rodney Ledward pressured patients to go privately. He was concerned about that and Rodney Ledward's complication rate. He did not speak to anyone about his concerns save to his surgical colleagues but he stopped referring his patients to Rodney Ledward in the mid 1980s.

Mr Derry

11.4. A further consultant surgical colleague who had a special interest in urology, Mr Derry, told us that he felt that Rodney Ledward's complication rate was lower in the early years, but that the number of complications increased as the years went by.

Mr Bates

11.5. One consultant general surgeon, Mr Bates, told us that he noticed a slow drip feed of concerns about Rodney Ledward from the time he was appointed. Much was gossip from a variety of quarters: from general gossip, to corridor chat, to patients who had complications.

Dr Bradfield

11.6. A Consultant Anaesthetist, Dr Bradfield, told us that Rodney Ledward was a quick but accurate surgeon at the beginning. Over a period of years surgical mishaps began to emerge, his concentration level deteriorated and he began to attend the operating theatre late leaving junior staff to start the operating list. He told us that from about 1983/1984 staff in the hospital had begun to realise that Rodney Ledward's practice was not as good as it should have been.

Dr Padley

11.7. A Consultant Pathologist, Dr Padley, said that when Rodney Ledward came to Kent he was known to have an international standing. He established a large private practice in London, working at prestigious hospitals there, and he was well thought of as a teacher by his students. He was flamboyant and generally charming. Dr Padley said that there was some adverse feeling amongst Rodney Ledward's colleagues that he was leaving some of his NHS work to others, while he concentrated on his private practice. However he said that there were those who did not hold Rodney Ledward in high esteem. He said "there was almost a split reputation". Dr Padley told us that he himself had found Rodney Ledward difficult because he was very reluctant to give full clinical information on the pathology request forms, despite being asked repeatedly to do so. Sometimes Dr Padley would telephone Rodney Ledward to ask for the information and in the early 1980s Rodney Ledward would be at the hospital and would give the information orally. However we were told that he never changed his ways and it became more difficult to contact him as the years went by.

Dr Bhatia

11.8. One Consultant in Geriatric care, Dr Bhatia, who was also one of the hospital "three wise men", told us that he had never been asked to deal with any concern about Rodney Ledward and he had been unaware of any problem until Rodney Ledward was suspended in 1996.

Dr Kenwright

11.9. A Consultant Physician, Dr Kenwright, told us that Rodney Ledward had been considered a breath of fresh air in terms of what he did for education after he was appointed in 1980. He held educational meetings, he wrote booklets, he introduced TSI to the William Harvey Hospital and did a great deal for the postgraduate centre. He commented that Rodney Ledward was a flamboyant character with a flower in his buttonhole. He was unaware of any problems or concerns about Rodney Ledward in the early 1980s.

12. EVIDENCE OF JUNIOR DOCTORS

Dr Ogunsanya

12.1. Dr Ogunsanya wrote to us to tell us that Rodney Ledward had been his Consultant when he was a Junior Doctor at the WHH between 1985 and 1986. He told us that Rodney Ledward "is the most human Consultant I had worked with. His commitment to the teaching of Juniors and their welfare is exemplary. He definitely cared for his patients, and my observations were that he was liked by patients and staff."

Dr Agbaje

12.2. We also received written evidence from Dr Agbaje who said he had been Senior House Officer and locum Registrar under Rodney Ledward between 1985 and 1987. He wrote: "While I worked at the WHH I can honestly say that the largest contribution I had to my career development has been through Mr Ledward. He is the single greatest contributor to my success in becoming a Member of The Royal College of Obstetricians and Gynaecologists. Today, several of us, my colleagues and myself inclusive, all trained by Mr Ledward, have been successful in achieving our career goals." He continued: "He was the most human of all the Consultants I worked with at the WHH. Not surprising he was also the most loved both by patients and staff."

13. EVIDENCE OF NURSING STAFF

13.1 An out-patient Sister told us that in the early years Rodney Ledward was superb with his patients.

13.2. We heard evidence from a former student nurse who had worked with Rodney Ledward for a number of weeks in 1981 and 1982. She told us that, as far as she could judge, he was a good surgeon and was very pleasant with his patients.

13.3. A Health Visitor told us that in the early 1980s Rodney Ledward enjoyed a

very good reputation and that a lot of people thought the world of him.

13.4. We also heard from another out-patient Sister that in about 1984/5 she considered that Rodney Ledward was a good gynaecologist but she went on to say that his bedside manner with patients "left quite a lot to be desired."

13.5. We also heard from another former student nurse that in the 1980s Rodney Ledward's Secretary had asked her to collect cash from a private patient and then give it to the secretary. She had considered that was improper.

13.6. A midwife who worked in the Obstetric department from 1979 told us that when Rodney Ledward had first come to the area he was seen as a dynamic and up and coming Consultant. She had no problems with him at that time and she said that he was good with patients in the early years. She was appointed midwifery manager and she told us that problems began to emerge from about 1984. She said it was a gradual process.

14. EVIDENCE OF GENERAL PRACTITIONERS

14.1. A local General Practitioner gave evidence to us that Rodney Ledward had come to the Health Authority with a high reputation so that he was happy to refer patients to him. However after 2-3 years the GP became concerned about the number of complications suffered by the patients he referred to Rodney Ledward, and he was also concerned that improper pressure was put on his patients to go privately. The GP discussed the matter with his senior partner, and they even discussed reporting the complaint of steering to private practice, to the General Medical Council. However they felt that the GMC would probably do nothing and so no referral was made. From about 1983 the GP stopped referring his patients to Rodney Ledward. He fully accepted that Rodney Ledward was not bad all the time.

14.2. We heard from another GP that when Rodney Ledward had first come to Kent he was considered to be a "bright spark" who was full of good ideas and seemed to be the Consultant of the future. However this GP had stopped referring patients to Rodney Ledward after the first 2-3 years because he was concerned about his care of patients. He became aware of an adverse feeling about Rodney Ledward in the Kent area. He had also been told by his patients that Rodney Ledward had tried to persuade them to become private patients.

14.3. Another GP told us that in the early years after Rodney Ledward had become a Consultant "he presented a charming and helpful addition to the gynaecological team."

14.4. Another GP told us that he was unaware of any problems with Rodney Ledward. He did not think any of his partners had any concerns either.

15. EVIDENCE OF NHS MANAGEMENT AND ADMINISTRATIVE STAFF

Miss Watkins

15.1. Miss Watkins, Nursing Officer for Gynaecology, told us that she had been nursing officer for midwifery from 1984 and that Rodney Ledward was responsive to suggested changes, and that where innovative patterns of care were being considered "you would ask Mr Ledward because he would say yes." She also commented that his ward rounds and antenatal clinics were carried out quickly.

Mrs Darling

15.2. Mrs Darling told us that she was assistant director of nursing for midwifery from 1984 at the Channel Ports Unit which comprised the Dover, Deal and Folkestone Hospitals. She told us that when she came to Kent in 1984, Rodney Ledward had a very good reputation and he was popular with staff and patients. She said that he had worked well with the midwives and she had found him extremely helpful when she had been setting up a pilot study for team midwifery in about 1985. She said he was the only consultant who would entertain the idea when it had first been broached.

Mr O'Neill

15.3. Mr O'Neill was Assistant General Manager at the Buckland Hospital from 1977 to 1986. He told us that he was unaware of any problems with Rodney Ledward's practice during those years.

Mr Girling

15.4. Mr Girling, Consultant General Surgeon, was appointed to the Management Team in about 1976. He remained a member of the team when the South East Kent District Health Authority was created in 1982. We have already mentioned above that it was his impression that there was a growing sense of unease about Rodney Ledward and his practice during the 1980s, which he told us was known by the Management Team.

Miss Kennett

15.5. We heard from Miss Kennett who was Chief Nursing Officer from 1982 to May 1994 and who was also a member of the District Management Team. She said that she first went to the South East Kent Health Authority when it was created in 1982. She told us that Rodney Ledward was relatively new and was well thought of. She said that a number of members of staff were happy to be treated by him and she felt that was a good indication of his standing at the time. During the 1980s she had become generally aware of concerns about him. However she did not believe that anything had been raised formally about Rodney Ledward at District Management meetings during the period 1980 to 1985.

Mr Cain

15.6. In 1974 Mr Cain was made responsible for the finances of the hospitals in the area. He too was a member of the District Management Team. He told us that Consultant contracts were at that time held by the Regional Health Authority and that any complaints about a Consultant's clinical performance would be referred by the Medical Advisory Committee (a committee of Consultants) to the Regional Medical Officer. He said that he would not have been involved if that occurred and our impression from him was that the Management Team would not have been involved either. He also told us that the Regional Finance Department was responsible for

16. EVIDENCE OF THE REGIONAL HEALTH AUTHORITY

Dr Forsythe

16.1. We heard evidence from Dr Forsythe who was Director of Public Health at the South East Thames Regional Health Authority between 1978 and 1992. He verified that all Consultants, Senior and Junior registrars and doctors of other training grades, were employed by the Regional Health Authority, and that he had been the accountable officer for hiring and firing them. All other staff were employed at District Health Authority level. He told us that he was involved with the deployment of manpower across the Region. He said that he had quite frequent contact with Mr Russell. Dr Forsythe said that legal claims brought against consultants were his responsibility and he told us that had there been multiple legal claims against Rodney Ledward, he would have picked this up and gone to see him for an explanation. In fact it appears that no claims involving Rodney Ledward's NHS patients had been settled by the Health Authority before the end of 1990 or indeed before Professor Forsythe left the Region. He told us that he was having to try to recall matters from memory because the Regional Health Authority has destroyed all files, including Dr Forsythe's confidential files, during one of the Health Service re-organisations. However to the best of his recollection he did not think that he had created a file on or been concerned about Rodney Ledward. *It is our impression that no concerns about Rodney Ledward reached the Regional Health Authority between 1980 and 1985.*

17. EVIDENCE BY AND ON BEHALF OF RODNEY LEDWARD

Rodney Ledward

17.1. In his written evidence to us, Rodney Ledward said that no criticism or concern had ever been mentioned to him during all the time he had been a Consultant. He told us that in the early years there were 2 occasions when Management had spoken to him about minor non-surgical problems both of which had been resolved after discussion. He said he had worked hard as a Consultant and that after his arrival in post he had set up a weekly teaching programme for junior staff. We are happy to accept that throughout this period Rodney Ledward was well thought of by his junior

staff who considered that he was an able and willing teacher. We have been told that Rodney Ledward set up a link with Ross University in the West Indies whereby junior doctors came to Kent for training. We were told that this provided additional revenue for the hospitals although we have not been able to verify that. We also accept that Rodney Ledward was furthering the academic profile of both himself and the William Harvey Hospital. Through TSI he organised a number of international speakers, who were recognised as leaders in their field, to talk to staff on various topics of gynaecology and obstetrics. In addition Rodney Ledward was invited to speak at various international conferences, for example he delivered a lecture at the University Department of Obstetrics and Gynaecology at Dallas in February 1982, and presented a paper at the 10th world Congress in Obstetrics and Gynaecology in San Francisco in October 1982. He also told us that he had shown a keen interest in audit and he made available to us 2 Biennial Reports of the Obstetric and Gynaecology division, which we have already referred to above. We repeat that they were models for their time.

Miss Harris

17.2.1. Miss Harris became Rodney Ledward's private secretary in 1984 looking after his private practice. She had taken early retirement from her administrative post at Kent University. She gave evidence to us. She made appointments for his private patients, sent out bills and recorded fees received. She told us that she also arranged appointments for him to conduct mock examinations at Queen Charlotte's Hospital in Hammersmith and other London Hospitals. She told us that he had a private practice at a number of London hospitals for example the Portland Hospital, the Cromwell Hospital and the London Medical Centre.

17.2.2. Miss Harris told us that Rodney Ledward had between 1200 and 1300 private patients. She ran his business accounts, and she also carried out secretarial work for him. She told us that on one occasion he gave her cash received from a patient rather than a cheque. She told us that she had told him that this was not a good idea and that it had never happened again. She said Rodney Ledward was always full of fun and was a proud man. She had liked working for him and they were a good team.

17.2.3. She told us that after Rodney Ledward was dismissed by the Trust a patient wished to help him at the GMC hearing. Miss Harris wrote a letter for the patient in which she asked other patients to write in his support; the patient then amended and signed the draft letter. Miss Harris sent it to 240 of Rodney Ledward's former patients. She received 54 replies which she sent on to Rodney Ledward's solicitors before the GMC hearing. We have seen copies of some of these letters. Miss Harris told us that she felt that the Trust and staff at the Trust had pursued a vendetta or witch hunt against Rodney Ledward and she thought that this may have been prompted by jealousy.

18. DEPARTMENT OF HEALTH CIRCULARS 1979 - 1985

Patients First

18.1. In December 1979 a consultative paper was issued by the Department of Health on the structure and management of the service. It was stated in the Foreword, "our approach stems from a profound belief that the needs of patients must be paramount." It continued: "it is doctors,.. nurses and their colleagues in the other health professions who provide the care and cure of patients....It is the purpose of management to support them in giving that service." It was suggested that management needed simplifying and improving with delegation to hospital level. It was envisaged that a review of the structure in a particular region should be carried out by the Regional Health Authority. It also proposed that consultant contracts should be devolved to District Health Authorities from Region. The whole aim of the discussion paper was to make management more responsive to the needs of patients and those who cared for them.

Health Service Complaints Procedure - HC(81)5

18.2.1. In April 1981 the Department of Health published its Health Complaints Procedure for hospitals in a memorandum annexed to Circular HC(81)5. Hospitals were advised to produce booklets containing information for patients, and to set up systems for monitoring complaints.

18.2.2. Part I of the memorandum, for all staff who might be in regular contact with patients, stressed that good communication was vital. It reminded them that an immediate sympathetic response would frequently resolve patients' concerns, and stressed the importance of giving explanations and the opportunity to discuss matters with the Consultant.

18.2.3. Part II set out the procedure for investigating complaints not involving clinical judgment.

18.2.4. Part III set out the procedure for investigating complaints about clinical judgment, which was divided into three stages. The **first stage** was preferably to involve the Consultant meeting the patient after any necessary discussion with other doctors and the patient's GP. The district administrator would send a written reply, after discussion with the consultant. If the patient was not happy with the reply he or she could renew the complaint and the **second stage** would begin. This was to involve the Regional Medical Officer (RMO) who would discuss the complaint with the consultant, who could ask to discuss the issues with professional colleagues, and then perhaps meet the complainant again to resolve the complaint. If the complaint still remained unresolved, the RMO would consider using the **third stage** - an independent review by two consultants who would read the medical records, and meet the complainant and the consultant. The district administrator would tell the complainant the result of the review. However this procedure was not to be used if the complainant was likely to bring legal proceedings. The procedure was additional to an earlier procedure set up in 1966 in respect of complaints. We point out that it was not until 1996 that complaints about clinical judgment came within the remit of the Health Service Ombudsman.

18.2.5. *In our view the complaints procedures were complicated and unwieldy. The plethora of procedures would have been difficult for patients and staff to follow. What was needed was far greater emphasis on the need for sympathetic explanation, with one simple and speedy procedure for formal complaints. In our view the Memorandum needed to emphasise the importance of giving a prompt explanation to a patient, but this message seems to have been buried within the procedural steps we have described.*

As we said at the outset of our Report, we have not seen any documents relating to any complaints about Rodney Ledward made to the Health Authorities before 1990, as records of such complaints are no longer available.

The Three Wise Men Procedure - HC(82)13

18.3.1. In July 1982 the Department of Health issued a circular HC(82)13 which provided for what is commonly known as the "three wise men" procedure. In essence

it advised that each Health Authority should set up a panel (the three wise men) to investigate any concern about the risk of harm to patients as a result of physical or mental disability, including addiction, of a doctor. The circular stated at paragraph 2:

> **"The medical and dental professions fully agree that a collective responsibility for the safety of patients rests upon the professional staff as a whole..."**

18.3.2. The Circular also stated at Paragraph 16:

> "Regional Health Authorities, District Health Authorities ...are asked to remind the relevant professional committees annually of the need to elect the panel, and to ensure that all staff liable to be concerned know of the machinery and that all medical....staff know of the identity of panel members."

18.3.3.
We were told that a committee of three wise men was set up at the William Harvey Hospital but few from whom we have heard, knew the identities of the three wise men, and we were told that it met only very rarely. Rodney Ledward was never discussed by the committee.

NHS Management Inquiry - the Griffiths Report

18.4.1. In October 1983 Mr Roy Griffiths chaired an Inquiry into the Management of the NHS and made a number of recommendations to the Secretary of State. The recommendations included the proposal that a Health Services Supervisory Board should be established to determine policies with a full time Management Board to implement such policies and control performance. Accountability was to be extended from Unit Managers through to Regional Health Authorities and a General Manager was to be appointed with overall responsibility for management. Decisions were to be made at local level. The Report stated: "It cannot be said too often that the National Health Service is about delivering services to people."

18.4.2. The Report continued:

> **"One of our most immediate observations from a business background is the lack of a clearly-defined general management function throughout the NHS. By general management we mean the responsibility drawn together in one person, at different levels of organisation, for planning, implementation and control of performance. The NHS is one of the largest undertakings in Western Europe. It requires enormous resources; its role is very politically sensitive; it demands top class management."**
>
> **"If Florence Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge."**

18.4.3. It set out a number of recommendations to improve management within the existing structure of the NHS. The Secretary of State adopted the recommendations and envisaged that changes in management functions would begin to be implemented in April 1984.

19. Professional Conduct and Discipline Pamphlets published by the General Medical Council (GMC) known as "The Blue Books"

We mention only those parts of the GMC Books which we consider are relevant to our Inquiry.

Pamphlet published in May 1977

19.1.1. In May 1977 the GMC published a new Blue Book which was operational when Rodney Ledward became a Consultant. The GMC was empowered by the Medical Act 1858 - 1969 as amended, to admonish a doctor, to place him on probation, to suspend him for a period not exceeding 12 months or to erase his name from the Medical Register if the doctor had been convicted of a criminal offence or had been found guilty of **serious professional misconduct.** This was interpreted to mean "serious misconduct judged according to the rules .... governing the profession." (Scrutton L.J.)

19.1.2. The Pamphlet stated that every complaint about a doctor received meticulous scrutiny and that a decision was made by the President, or another member of the Council, as to whether the matter should be referred to the Disciplinary Committee of the GMC. Where a matter was referred to the committee the charge had to be strictly proved by evidence. It stressed that "the primary duty of the Disciplinary Committee is to protect the public." A doctor whose name was erased from the Register was entitled by statute to apply for his name to be restored after 10 months from the date of the erasure.

19.1.3. Under the heading **Failure to treat or visit patients** the Book then stated:

> "The Council in pursuance of its primary duty to protect the public institutes disciplinary proceedings when a doctor appears seriously to

have disregarded or neglected his professional duties to his patients, for example by failing to visit or to provide or arrange treatment for a patient when necessary." It continued, " The Council is not concerned with errors in diagnosis or treatment."

19.1.4. Under the subheading **delegation of medical duties** it was stated:

> "...a doctor who delegates treatment or other procedures must be satisfied that the person to whom they are delegated is competent to carry them out. It is also important that the doctor should retain ultimate responsibility for the management of his patients because only the doctor has received the necessary training to undertake this responsibility."

19.1.5. It was also said in this edition of the Blue Book that deprecation by a doctor of another doctor's professional skill, knowledge, qualifications or services was capable of amounting to serious professional misconduct.

Pamphlet published in August 1980

19.2. The Medical Act 1978 had been passed since the earlier Blue Book to which we have just referred. Under this Act the GMC was given additional powers, namely (i) to impose a maximum of 2 months interim suspension during the time when the doctor's cases was being transferred to the Professional Conduct Committee, and (ii) to make a doctor's registration conditional on his compliance, for not exceeding 3 years, with such requirements as the Disciplinary Committee thought fit to impose for the protection of the public. Otherwise the relevant parts of the Pamphlet were in very similar terms to that published in 1997 to which we have referred in some detail above.

Pamphlet published in September 1981

19.3.1. New headings: **neglect or disregard of personal responsibilities to patients for their care and treatment** and **responsibility for standards of medical care** were set out in this revised Blue Book. It was also stated:

> "In considering complaints... about the conduct of a doctor, the Council is not ordinarily concerned with errors in diagnosis or treatment. But in pursuance of its primary duty to protect the public the Council may institute disciplinary proceedings when a doctor appears to have disregarded or neglected his professional duties to his patients, for example by failing to visit or to provide or arrange treatment for a patient when necessary."

19.3.2. There was also a new section containing advice on standards of professional conduct and on medical ethics. Otherwise the pamphlet seems to have been in similar terms to those referred to above.

19.3.3.	**Medical Act 1993**
A new Medical Act was published in 1983 which permitted the Preliminary Proceedings Committee of the GMC to order a doctor's interim suspension or interim condtional registration, while concerns regarding the doctor were being referred to the Professional Conduct Committee of the GMC.	

Pamphlet published in August 1983

19.4.1. This Blue Book under the subheading: **responsibility for standards of medical care**, stated:

> "The Council is not ordinarily concerned with errors in diagnosis or treatment, or with the kind of matters which give rise to action in the civil courts for negligence, unless the doctor's conduct in the case has involved such a disregard of his professional responsibility to his

patients or such a neglect of his professional duties as to raise a question of serious professional misconduct."

19.4.2. Under the heading **Personal behaviour: Conduct derogatory to the reputation of the profession it was** stated:

> "A doctor who treats patients or performs other professional duties while he is under the influence of drink ..... is liable to disciplinary proceedings."

19.4.3. We do not consider it necessary to mention any other changes in this pamphlet.

Pamphlet published in April 1985

19.5.1. Under the subheading: **responsibility for standards of medical care** it was now stated:

> "The public are entitled to expect that a registered medical practitioner will afford and maintain a good standard of medical care. This includes:
>
> (a) conscientious assessment of the history, symptoms and signs of a patient's condition;
>
> (b) sufficiently thorough professional attention, examination and, where necessary, diagnostic investigation;
>
> (c) competent and considerate professional management;
>
> (d) appropriate and prompt action upon evidence suggesting the existence of a condition requiring urgent medical intervention; and
>
> (e) readiness, where the circumstances so warrant, to consult appropriate professional colleagues....
>
> The Council is concerned with errors in diagnosis or treatment, and with the kind of matters which give rise to action in the civil courts for negligence, only when the doctor's conduct in the case has involved

such a disregard of his professional responsibility to patients or such a neglect of his professional duties as to raise a question of serious professional misconduct....."

19.5.2. Other changes to the Blue Book do not appear to us to be relevant for the purposes of our Inquiry.

19.6. *Our Commentary on the GMC Blue Books*

It seems to us that there was a change of emphasis during the years we are considering in the GMC's pamphlets on Fitness to Practise. However the changes were not highlighted in the different editions. Therefore unless a doctor read each pamphlet diligently and then sat down and compared one to another, these changes would most probably have been missed. We have not been reassured that doctors read each and every Blue Book as and when it was published. We also consider that it is relevant to point out that negligence of a doctor in the care and treatment of a patient did not, on its own, merit disciplinary action. The GMC required misconduct which demonstrated a serious dereliction of a doctor's duties to his patients. As we understand it, only if there were a number cases where a doctor had been negligent and/or where the degree of negligence was very serious, would such actions fall within the GMC's remit of serious professional misconduct.

20. Code of Professional Conduct for Nurses, Midwives and Health Visitors published by the United Kingdom Central Council for Nursing (UKCC)

We mention only those parts of the Codes which we consider are relevant for the purposes of our Inquiry.

Code July 1983

20.1.1. The first Code was published in July 1983. It provided that:

> "The registered nurse...shall at all times, act in such manner as to justify public trust and confidence, to uphold and enhance the good standing and reputation of the profession, to serve the public interest and the interests of patients...".

20.1.2. A nurse was also required to:

> "...act in such a way as to promote and safeguard the well being and interests of patients...for whose care she is professionally accountable and ensure, that by no action or omission on her part, their condition or safety is placed at risk."

Code November 1984

20.2. The duty to safeguard the interests of individual patients was to be overriding. It was stated:

> "Each registered nurse...shall...act always in such a way as to promote and safeguard the well being and interests of patients...; ensure that no action or omission on his/her part or within his/her sphere of influence is detrimental to the condition or safety of patients...; make known to appropriate persons...any circumstances which could place patients... in jeopardy or which militate against safe standards of practice."

21. *Our Commentary on Rodney Ledward's practice during the period 1st January 1980 and 31st December 1985*

21.1. *We remind ourselves at the outset that we are looking at events which occurred between 14 and 20 years ago. Recollections have become hazy. Some witnesses have chosen not to give evidence to our Inquiry, and some we have not been able to contact. Some did not reply to our letters. We acknowledge that we have not been able to gain a complete picture of Rodney Ledward's work but we feel that our enquiries have allowed us to draw some conclusions.*

21.2 *Secondly it has been made abundantly clear to us as we have looked through patients' notes, that Rodney Ledward was a poor note keeper. His notes are sparse. This has not made our task easier, nor indeed would it have made the task of any doctor who subsequently came to treat patients, any easier. The lack of notes may have meant that we have not always obtained the fullest picture, but we have endeavoured to piece together events on the information we have had before us. Overall we have not felt hampered in coming to our conclusions because of the brevity of some of the medical records.*

21.3. *Thirdly we should comment that during the years 1980 to 1985 the cases we have considered have included an almost equal division of NHS and private patients. Nursing and theatre staff at the William Harvey Hospital would not have been aware of problems occurring with Rodney Ledward's private patients, and nursing staff at St Saviour's and the Chaucer Hospitals would not have been aware of any problems with his NHS patients. Some of his consultant surgical colleagues would have known about his private patient cases that were referred on to them, and one or other or both of his Consultant Gynaecology colleagues would have been aware of his private patients who had complications, if they were called in when he was not available. However we fully accept that they are unlikely to have known about all the cases to which we have referred above.*

21.4. *It must also be recalled that we have only seen those cases which have been brought to our attention. There may be many patients who were entirely happy with*

his care who have not contacted us. There may be others who felt his care left much to be desired but who also have not contacted us. However in our view Rodney Ledward's Consultant colleagues, who were working in the South East Kent Health Authority alongside him during this period of 6 years, would have been likely to learn about his practice and any problems arising from his practice, particularly within the sheltered hospital environment.

21.5. *We also consider it necessary to state, as we have mentioned previously, that his employers, who were then the Regional Health Authority, had little or no contact with his practice in the hospitals managed by the South East Kent Health Authority. A number of witnesses voiced their concerns about this anomaly and suggested that it meant that any problems were not picked up by his actual employers, unless they were specifically brought to their attention by those who worked in hospitals with Rodney Ledward.*

21.6. *We have also already mentioned that Rodney Ledward was a good teacher, who at the same time was furthering the academic profile of himself and the hospital through, for example, TSI. During the course of the period we have been looking at, he had been invited to speak at international conferences. We also comment that he seems to have taken a leading role in an early form of audit of the division.*

21.7. *There is no doubt that we have heard mixed messages from patients, staff and others about Rodney Ledward during the years 1980 to 1985. We consider that the same mixed messages were probably being voiced within the hospital during those years.*

22. *Rodney Ledward's Competence*

22.1. *From our consideration of the cases that have been brought to our attention we have no doubt that, in the first few years after his appointment, Rodney Ledward was thought to be a good Consultant who treated patients well. However we have been made aware of a number of cases, which started to occur within 6 months of his*

appointment, where we are concerned as to whether Rodney Ledward treated some patients appropriately or competently. Serious surgical mishaps, such as ureteric damage and creation of fistulas, should all be matters which would normally cause serious concern to a surgeon. In addition there were a number of cases where the patient suffered complications, where he failed to attend, and where we are concerned that he may have carried out unnecessary procedures. The primary responsibility must be Rodney Ledward's for he, and only he, knew exactly what was going on. He was certainly aware by 1985 that 3 of his patients had developed fistulas after his surgery as is clear from the letter dated 11th September 1985 which he wrote to Professor Blandy asking for help. Given all we have been told we would have expected any competent Consultant Gynaecologist, (particularly one who professed an interest in medical audit) to have looked objectively at his work, and to have realised that his surgery was causing problems, some of them serious, to a number of his patients.

22.2. *Of course every surgeon has mishaps, but it is the character and number of the complications caused to Rodney Ledward's patients that have impressed us during the period from 1980 to the end of 1985. We find it difficult to believe that he would not have noticed. The lack of explanation to patients and the inaccuracy of letters to their GPs suggests to us that he either ignored the problems with his surgery, or attempted to cover up his failings. We are aware that in the early 1980s there was not a culture of openness or self criticism in the NHS, still less in private practice.*

22.3. *We have also noted that a number of Rodney Ledward's patients, who had already suffered complications or had concerns about his practice, were nevertheless referred back to him in subsequent years. Sometimes a patient asked her GP to refer her elsewhere but the GP was unwilling to do so. Other patients were content to be referred back to him by their GPs for surgery and advice, because they placed the utmost faith in him as a Consultant. Many women indicated to us that they had assumed he was the expert and were happy to place themselves in his hands trusting that he was a good and competent surgeon. Their trust was not shaken by complications or adverse outcomes arising from his surgery.*

23. *Rodney Ledward's Conduct*

23.1. *We have heard strong evidence that Rodney Ledward put improper pressure on some NHS patients to persuade them to become private patients during this time. The evidence has been confirmed by a number of different witnesses. The background to this misconduct was his part time contract of employment with the Regional Health Authority which meant that was able to do private work. Secondly private work clearly appealed to him. Thirdly his fellow Gynaecologists were also keen on private work; thus he joined a team where private work was the norm.*

23.2. *We are concerned that Rodney Ledward may have stepped beyond the limits of acceptable practice in persuading and pressurising patients to go privately. We have heard evidence directly from patients, but we have also heard evidence from a number of GPs whose patients complained to them. Informing a patient that she had a risk of cancer (for which there appears to be no evidence at all, save for the risk which applies to the normal population), is a mattes of serious concern. We have been given the clear impression that Rodney Ledward advised and carried out unnecessary surgery on a number of his private patients.*

24. *Rodney Ledward's Attitude and Manner*

24.1. *We have heard from a number of different witnesses about Rodney Ledward's arrogance, his lack of compassion, his wearing of inappropriate clothing when he attended patients, and his wish to attribute problems to the patients rather than his care. We also have the impression that a number of his former patients felt belittled by his manner. There is strong evidence from all that we have seen and heard that between 1980 and 1985 Rodney Ledward exhibited all these characteristics. He seems to have been unaware of the hurt and upset he caused.*

25. *Should Rodney Ledward's failings have been noted and acted upon by the South East Kent Health Authority or the South East Thames Regional Health Authority?*

25.1. *We accept that Rodney Ledward came to the area with excellent references and that at the beginning of his employment all seemed well. Many witnesses told us that he was good in the first few years. However we are particularly troubled by the patient whose ureters were both tied by Rodney Ledward in July 1980 and who was referred to Mr Girling who told us he would have been concerned about this patient. He also said that his surgical colleagues and the District Management Team had become increasingly uneasy about Rodney Ledward and his practice over the 1980s.*

25.2. *We also accept that Rodney Ledward would have enjoyed a honeymoon period at the William Harvey Hospital having arrived with such glowing testimonials. Our overall impression is that consultant colleagues, nursing and managerial staff and GPs all felt that Rodney Ledward was a breath of fresh air when he arrived and for a period of time thereafter. It would no doubt have taken time and a number of mishaps to alter that view. However from the evidence we have heard, some of his surgical colleagues had misgivings about his competence quite early on and that is echoed by a number of GPs to whom we have spoken. The honeymoon period seems to have ended after 2-3 years. Although some witnesses told us they had heard nothing adverse about Rodney Ledward, we are driven to the conclusion that those who had awareness and insight knew that all was not well. Some GPs took matters into their own hands and referred their patients elsewhere.*

25.3. *We have heard from a few of the junior doctors and nursing staff who worked with Rodney Ledward before 1985. Those from whom we have heard were generally complimentary about him and his practice. Even if a junior doctor or nurse had been aware of shortcomings in his work, we understand that the culture that existed in the early 1980s was that neither would challenge, let alone criticise or report on a Consultant.*

25.4. *We have not seen any documents relating to any formal complaints about Rodney Ledward during this 6 years period, nor indeed have we been shown any information booklets designed by the South East Kent Health Authority to be given to patients to tell them how to complain. As we have already commented, the Department of Health Complaints Procedure was so complicated that it would have probably acted as a deterrent to both staff and patients who might have been minded to complain. We also remind ourselves that in the early 1980s patients did not complain about their doctors, women tended not to mention their gynaecological problems, and most of them placed complete faith in their Consultants.*

25.5 *We accept that one or two members of the Management Team had picked up concerns about Rodney Ledward's practice by the end of 1985. At this distance in time we cannot be sure that they discussed their concerns with the rest of the Management Team. It seems odd to us that no such concerns were raised but we have heard evidence from at least 2 of the Management Team that concerns were not brought to their attention. This was a time of consensus management where the members of the Management Team shared responsibility for any failures in management. We accept that it was their collective view that any concerns about a Consultant's practice had to be dealt with by the Regional Health Authority, because contracts of employment were held by the Region. The difficulty is that since the Region operated at a considerable remove from the Consultants, they had to rely on complaints and concerns being raised with them by the Management Team. We are not satisfied that any concerns about Rodney Ledward's practice were mentioned to anyone at the Regional Health Authority by the end of 1985. We consider that they should have been, and that it was the Management Team's collective responsibility to be aware of any problems with a Consultant working in the Hospitals they were managing.*

25.6. *On the other hand we are aware that other doctors who were practising within the NHS at this time, and about whom there have subsequently been serious concerns, were also able to carry on their practices without let or hindrance. In the early 1980s we consider that the prevailing culture was that a consultant could not be questioned or criticised.*

25.7. *As regards Rodney Ledward's consultant colleagues who had concerns about his practice before the end of 1985, we accept that in the culture that existed, they would not have been expected to report him to management. In any event, as they well knew, one of their number, who shared their concerns, was himself a member of the Management Team. We can also see that they would have been dissuaded from reporting any concerns to the GMC in the light of the professional guidance contained in the "Blue Books" that, in effect, negligence of a doctor on its own did not justify consideration by the GMC.*

25.8. *We may charitably understand why the Management Team of the South East Kent Health Authority did not act on the concerns that at least some of them had about Rodney Ledward's practice before the end of 1985, and we accept that the Regional Health Authority were probably unaware of any problems with his practice. We are satisfied that the primary responsibility for any failings in his practice, about which we have heard during this 6 year time period, must fall on Rodney Ledward himself.*

26. *Should Rodney Ledward's failings have been noted and acted upon by the private hospitals where he habitually worked?*

26.1. *We have not been able to hear evidence from any employee who worked in the early 1980s at the 2 main private hospitals where Rodney Ledward had admitting rights, St Saviour's and the Chaucer. However we accept that they were even less likely than the Health Authorities to pick up any problems before the end of 1985. In those days private hospitals did not concern themselves with the quality of the care and treatment provided by the Consultant, for that was a matter entirely between the patient and the Consultant themselves. Furthermore we understand at that time there*

was no resident doctor employed at the hospitals and the Consultant was wholly responsible for his or her own patients. Nursing staff might have appreciated that patients were suffering from more complications after Rodney Ledward's surgery, but they would have been unlikely to mention their concerns to the Matron in the light of the culture that existed at the time that a consultant could do no wrong.

PART IV - RODNEY LEDWARD'S PRACTICE 1986 - 1990

PART IV

RODNEY LEDWARD'S PRACTICE 1986 - 1990

1. INTRODUCTION

1.1. We now turn to consider Rodney Ledward's practice between 1st January 1986 and 31st December 1990. Once again we have done our best to put matters into chronological order. In our view it is important to consider this period of his practice during this time against the background that there were already, by the end of 1985 (as we have referred to above), some concerns about his practice. The Consultant General Surgeons at WHH clearly were aware of problems with his surgery and a number of local General Practitioners had stopped referring their patients to him because of concerns about his skills and his conduct. In addition there was some corridor gossip about him. It appears that some members of the Management Team were also aware of at least some of the concerns.

2. THE HEALTH AUTHORITY ORGANISATION

2.1. During the period from 1985 to 1990 South East Kent Health Authority was the body which ran the NHS hospitals where Rodney Ledward worked. Mr Russell was appointed the District General Manager from 1985 and retained that post until 1994 when he retired. It was in 1985, for the first time, that an individual held responsibility for the Authority. After the 1985 re-organisation the various parts of the Health Authority were divided into Units: the William Harvey Unit, the Channel Ports Unit, and a Unit in respect of community services. The South East Thames Regional Health Authority remained in being throughout this five year period.

1986

3.1. We were told about one of Rodney Ledward's private patients who in **January** 1986 underwent total abdominal hysterectomy at St Saviour's. He told her she would have a low incision. After the operation an abscess developed in the wound and she was left with a large overlap of skin and an unsightly scar. She told us that Rodney Ledward had come to see her at least twice in his riding clothes, wearing a buttonhole and carrying a whip, which she had felt was not appropriate for a doctor coming to see his patient. She remained an inpatient for 15 days although she had originally been told that she would only need to be in hospital for 6 days. She told us that he had said that she was "unlucky". The patient was very upset with what she felt was his lack of care and at the time considered bringing legal proceedings. She decided however against that step as she felt it was more important to "get on" with her life.

3.2. In **February** 1986 Rodney Ledward carried out a total abdominal hysterectomy on a private patient when she had only requested sterilisation. He carried out the operation in less than 15 minutes. 5 days later her left ureter was found to be obstructed. Mr Derry, Consultant General Surgeon was asked to see her and he repaired the ureter. Ever since the hysterectomy she has suffered incontinence. She said that Rodney Ledward told her that her incontinence was normal. In his letter to the patient's GP he did not mention that the ureter was obstructed nor did he mention her incontinence. She told us that at a number of outpatient appointments he repeatedly said that it would settle down in time. Eventually he referred her to a Consultant Urological Surgeon who referred her to Guy's Hospital for further treatment.

3.3.1. We heard from a private patient of Rodney Ledward who in **May** 1986 underwent a total abdominal hysterectomy for fibroids and endometriosis at St Saviour's Hospital. The surgery was carried out in less than 30 minutes. Her recovery was delayed by wound infection and she was discharged after 10 days. 4 days later the patient was readmitted and a urinary fistula was diagnosed. Rodney

Ledward reoperated but her problems continued. She told us that he came to see her after her operation wearing his riding clothes and smelling of alcohol. He did not explain what was the matter with her and she said he was arrogant and unsympathetic; he said he was going on holiday. The patient decided she did not wish to be cared for by Rodney Ledward any further and a Consultant General Surgeon, Mr Derry, was asked to see her. He re-operated and found that one of her ureters had been damaged, which he repaired. The patient told us that she decided to bring legal proceedings against Rodney Ledward but, for financial and other reasons, she did not pursue the case.

3.3.2. We were told by Mr Derry that he had mentioned the above patient to Mr Girling, Consultant General Surgeon and Unit General Manager of the WHH, and a member of the District Management Team. During the conversation Mr Girling told Mr Derry that a patient of Rodney Ledward's had been referred to him with a similar problem of a cut ureter. Mr Derry said that they had a long discussion about a number of Rodney Ledward's cases but Mr Girling apparently told him that there was little he could do about their concerns regarding Rodney Ledward's surgical abilities. Mr Derry told us that as far as he was aware Mr Girling did not take the matter further. Mr Girling told us that he could not recall any conversation with Mr Derry but he agreed that as the years went he was aware of increasing anxiety about Rodney Ledward and his practice.

3.4. In **October** 1986 an NHS patient, who was under the care of Rodney Ledward, underwent a total abdominal hysterectomy which he delegated to a Senior House Officer. One of her ureters was caught by a suture and she developed a uretero vaginal fistula. She said that Rodney Ledward came to see her after the operation and told her that mistakes do sometimes happen. She underwent a further operation when 2 sutures were removed. Her problems continued and she was seen by Mr Derry, Consultant Surgeon. He reoperated. The Senior House Officer spoke to the patient and said that he had made a mistake in doing a horizontal incision during the hysterectomy and he apologised. Eventually the fistula resolved without the need for further surgery. The patient expressed concern to us that her operation had been delegated to an inexperienced house officer. The patient made a formal complaint

and the matter was referred to the Regional Director of Public Health, Dr Forsythe, and the Postgraduate Dean, Dr King. We understand that the patient was seen by Rodney Ledward and that she did not thereafter pursue the complaints procedure.

3.5. We were told about the tragic death of one of Rodney Ledward's NHS patients in **November** 1986. The patient was expecting a baby and was found to be suffering from high blood pressure. She was admitted to the William Harvey Hospital under Rodney Ledward's care. After 3 weeks her condition deteriorated. Rodney Ledward saw her and decided that she should be delivered the following week. There was further deterioration later that day and a junior doctor decided that she needed to be delivered immediately by caesarean section. After delivery her blood pressure dropped dramatically and she suffered a cardiac arrest from which she did not recover. Her post operative management was also left to junior doctors. Her husband asked to see Rodney Ledward for an explanation. He was told that "these things do happen".

3.6. In **December** 1986 Rodney Ledward delegated to his registrar a repeat operation on an NHS patient for incontinence. *As a general principle we understand that it is not appropriate to delegate a repeat operation for stress incontinence to a registrar.*

3.7. In about 1986 the third biennial Clinical Report of the Obstetric and Gynaecology division was published. Rodney Ledward was the Consultant editor. It covered the period between 1st January 1984 to 31st December 1985. In effect it was a clinical audit of the division. *We comment that this third audit was again in the vanguard of clinical audit within the NHS. It seems that Rodney Ledward was the only Consultant in the Division to contribute to the Report and he took on an overseeing role.* We have not been able to discover whether any further similar audit reports were ever published by the division but, from what we have heard, it seems unlikely.

1987

4.1. On **1st February** 1987 Mr Malcolm Stewart was appointed Consultant Gynaecologist and Obstetrician by the South Thames Regional Health Authority to the South East Kent Health Authority, when Mr Pool retired. Mr Stewart had previously been lecturer and Senior Registrar at St George's Hospital and this was his first Consultant appointment. He was told that the existing Consultants in the Obstetric and Gynaecology Department could be difficult. Thereafter there were 3 Consultants in the Obstetric and Gynaecology division, namely Mr Ursell, Rodney Ledward and Mr Stewart.

4.2. In **March** 1987 Rodney Ledward carried out a hysterectomy on a private patient with conservation of her ovaries which he said were healthy. The patient suffered a wound infection post operatively. She then complained of continuing pain and it was thought she had a cyst on an ovary. Rodney Ledward advised laparoscopy which he carried out in August 1987 when he said he was unable to disperse the cyst because it was too large. He advised laparotomy to remove the ovary which the patient underwent in September. The patient suffered wound infection after the laparotomy. She told us that she had asked Rodney Ledward why he had not removed the cystic ovary at hysterectomy and he replied, "these things happen". At a follow up appointment Rodney Ledward said the patient needed hormone replacement therapy which he informed her incorrectly was only available to private patients. In June 1988 she was referred back to Rodney Ledward as a NHS patient with an incisional hernia which was unsuccessfully repaired by his Locum Consultant. The patient was then referred to a Consultant General Surgeon who operated successfully. The patient told us that she had trusted Rodney Ledward implicitly.

4.3. A NHS patient told us that she had seen Rodney Ledward in **October** 1987 to discuss the possibility of her having a normal vaginal delivery for the birth of her second child, although she had undergone caesarean section for her first child. The patient told us that she was outraged by his arrogant attitude and described how he

had spoken at her. She complained to the South East Kent Health Authority about his behaviour. She was not satisfied with the Health Authority's response nor was she satisfied with the care given to her after her second child was delivered. She told us that she did not take the matter further because she was not eligible for legal aid and could not afford to fund any possible litigation.

4.4 A GP told us about one of his patients who had both ovaries removed by Rodney Ledward privately in **November** 1987, after undergoing a series of operations in the early 1980s. During the course of the operation Rodney Ledward caused damage to the patient's bowel which he attempted to repair. The patient developed a colo-vaginal fistula and she was referred to Mr McPartlin, Consultant General Surgeon. We were told that the patient was very upset at Rodney Ledward's manner, and by the fact that (a) he had injured her during the course of his treatment, (b) he had made a great deal of money out of treating her privately, (c) he had never explained what had happened and (d) he tried to conceal that there was any problem.

4.5. We were told by a patient that in **December** 1987 Rodney Ledward pressurised her to become a private patient in order to have a laparoscopy for adhesions, because he said there was a long NHS waiting list but that he could do the procedure promptly if she went privately. He then advised sessions of ultrasound and diathermy and HRT implants which were all done privately.

4.6. We have seen some documentation dated **November** 1987 which suggests that Rodney Ledward was making claims for travel expenses describing his journeys as "emergencies". The South East Kent Health Authority took the view that they were in fact ordinary "home to base travel" to which he was entitled because he had to attend 3 hospitals at different sites. He was paid the expenses on that basis. A comment was made on the travel claim to the effect that if Rodney Ledward queried the payment then the Health Authority would make further inquiries. It appears, although we have not been able to confirm this, that Rodney Ledward accepted what he was paid and did not raise the matter further.

1988

5.1. In **January** 1988 a NHS patient was advised by Rodney Ledward to undergo hysterectomy. She had previously had colposcopy which had been very painful and she was advised by a locum Consultant that a cone biopsy was the appropriate treatment. She told us that she was seen later by Rodney Ledward who simply looked at her notes and said "Oh, hysterectomy, 2 weeks". The patient asked why and he said "You have 6 months, you have cancer" which came as a great shock to her. Because of her family history she had found this horrendous news which was made worse by the fact that, as she told us, Rodney Ledward stood up throughout the consultation, did not talk to her or examine her and simply waved her away after he had told her she needed a hysterectomy. The patient was then aged 22 years. She said that he treated her like "a silly little girl". Cancer had not been mentioned to her before the consultation. She underwent hysterectomy in February 1988. *From the medical records we have seen, we have found no evidence that the patient did have cancer and we therefore express our concern that such a drastic measure should have been undertaken on such a young patient.*

5.2. On **22nd February** 1988 Mr Russell, District Administrator wrote to Rodney Ledward, after he had failed to reach him by telephone, about his increasing anxiety at Rodney Ledward's "non-attendance or very limited attendance" at his Tuesday morning clinic in Folkestone. In addition Mr Russell stated that Rodney Ledward had not been available to cover for Mr Stewart on 19th February although he had previously agreed to do so. Mr Russell emphasised the difficulty in which this placed other staff and asked to meet to discuss the problem. When we asked Mr Russell about this matter he was not able to recall the discussion at all. However he told us that Rodney Ledward's poor timekeeping did surface from time to time. He said that he tackled him about the matter and spoke to Dr Rideout, Assistant to the Regional Medical Officer, Dr Forsythe. He said that there were no sanctions that could be applied.

5.3. We were told by a NHS patient that in **March** 1988 Rodney Ledward advised her to undergo immediate hysterectomy for an enlarged womb with numerous growths. He said there was a 15 month waiting list on the NHS and so she decided to go privately. She had previously undergone a D&C as a NHS patient in July 1987 when the findings were normal. He carried out the hysterectomy and she suffered a wound haematoma and infection post operatively. Her length of stay in St Saviour's Hospital was in the event considerably longer than she had originally been told. In September the same year Rodney Ledward removed both her ovaries and the following April he carried out a laparotomy on her. She remained a private patient throughout. *We express our concern about this patient. She is an example of a private patient upon whom Rodney Ledward carried out a number of surgical procedures within a short space of time, and we have doubts as to whether all the procedures were necessary.*

5.4. A private patient told us that Rodney Ledward carried out a hysterectomy on her in **March** 1988. Post operatively she suffered serious pain and discomfort but Rodney Ledward simply told her it would soon go away. In fact the patient had extensive bruising which he only discovered when she was taken to theatre some days later for an HRT implant. She told us that he had not previously examined her despite her complaints of pain post operatively. He said he could not carry out the implant in the light of the bruising and told her that she must bruise easily. She told us that she had therefore had to remain longer in hospital at considerable extra expense to herself.

5.5. We were told by another patient that she was pregnant in **early 1988** and had arranged to be a private patient of Rodney Ledward as she had a history of infertility and had suffered a previous miscarriage. She said that he seemed very confident and she had absolute confidence in him, but she did feel that he was rather flippant or casual in his attitude. She asked for an amniocentesis test because of her concerns and Rodney Ledward carried out this procedure. She told us that he did not advise her about any risks associated with amniocentesis. She said that the first attempt was unsuccessful, after which he allowed her to go to the lavatory after the failed attempt and, without rescanning her, carried out another amniocentesis. Rodney Ledward shortly afterwards went away on holiday and made no arrangements for the result of

the test to be given to the patient in his absence. In addition during the course of her pregnancy the patient had a scan at 16 weeks which showed normal fetal growth but it was not plotted on the fetal growth chart. When the next scan was carried out at 22 weeks Rodney Ledward apparently failed to notice that fetal growth had reduced. The patient's GP and midwife were concerned about the lack of growth, so the patient and her GP brought their concerns to Rodney Ledward's attention. He reassured the patient that everything was normal. She said it was very difficult to question Rodney Ledward about the contradictory advice she was receiving because she understood he was one of the top consultants in the area. Her child was born with a severe congenital abnormality.

5.6. A patient told us that Rodney Ledward had carried out a laparoscopy on her as a private patient in 1987. She described him as all smiles and the perfect gentleman. Subsequently when she was a NHS patient in **May** 1988 Rodney Ledward had advised her to have a hysterectomy. She said he was completely different on that occasion: he was rough, pompous, abrupt and had no time for her.

5.7. A GP told us about his patient who was treated privately by Rodney Ledward in **June** 1988. He had carried out a laparoscopy in March 1988, vaginal hysterectomy in June, a laparoscopy in November, a further laparoscopy in October 1989 and removal of her ovaries also in October 1989. Her GP questioned whether her hysterectomy had ever been necessary. *She is another example of a private patient upon whom Rodney Ledward carried out a number of surgical procedures within a short period and we express our concern as to whether all these procedures were medically necessary.*

5.8. In **June** 1988 a NHS patient told us that she underwent hysterectomy on the advice of Rodney Ledward although she was only 25 years old. She said that she had seen him before the surgery when he had said that he wished to examine her internally. She asked whether this was necessary as she was menstruating at the time but he said it was. She told us that she was given no blanket to cover herself and she said that during the examination 2 other men, whom she assumed were students, entered the room. She said that she had been very distressed and on her insistence

the 2 men left the room. She told us that Rodney Ledward completed the examination although no nurse was present. She told us that she had found his manner very offhand.

5.9.	**Hospital Complaints Procedure Act 1985**
In **June** 1988 the Department of Health published a circular regarding complaints made pursuant to the Hospital Complaints Procedure Act 1985. It was stated in this circular: **"It is important that no one (staff or patient) should be inhibited from making valid complaints and that there is full confidence that these will be given full, proper and speedy consideration."**	

5.10. In **August** 1988 Rodney Ledward carried out a laparoscopy on a private patient. He then performed a hysterectomy and then another laparoscopy privately on the same patient during the next 7 months. *This patient is another example of a private patient upon whom Rodney Ledward performed a number of surgical procedures within a short space of time and we express our concern as to whether all these procedures were medically necessary.*

5.11. In **September** 1988 a private patient was advised by Rodney Ledward to undergo hysterectomy. The patient told him that her husband had just been made redundant so that she would not be covered by his former employer's insurance. Rodney Ledward said "It is not your lucky day - your husband loses his job and you are about to lose your womb". The patient said that she was very upset by what he had said and burst into tears in the corridor when she had left his consulting room. She asked for a second opinion and was advised that only a D & C was necessary. Her second Consultant told her that different gynaecologists may have different opinions as to treatment.

5.12. In **October** 1988 a fourth Consultant in Obstetrics and Gynaecology was

appointed by the South East Thames Regional Health Authority to work in hospitals managed by the South East Kent Health Authority. The Consultant appointed was Mr Joe Davies and it was his first Consultant post.

5.13. In **December** 1988 Rodney Ledward carried out a laparoscopy on a private patient. He then advised and carried out a total abdominal hysterectomy, another laparoscopy and then removal of her right ovary over the next 8 months. All these operations were carried out privately. *This patient appears to be yet another example of a private patient undergoing multiple operations within a short timespan, which may not have been medically necessary.*

1989

6.1.	**Working for Patients**
In January 1989 the Department of Health published a White Paper entitled **Working for Patients**. This reflected the Government's new policies that some hospitals should have self governing status within the NHS and that quality of service within the NHS should be audited.	

6.2. In **January** 1989 a private patient underwent surgery under Rodney Ledward and subsequently suffered a haemorrhage. She was returned to theatre to be resutured by him although she had by then stopped bleeding. *We have already referred to this patient during the course of our narrative as Rodney Ledward had previously carried out 3 surgical procedures on this patient within a 10 month period in 1983. We point out that in spite of this repeated surgery and the complication the patient suffered in 1989 she wrote in 1997 to the hospital, after Rodney Ledward was summarily dismissed, to say that she "always had and will continue to have the utmost faith in his professional abilities. He has always treated me with great care and kindness." We comment that she is but one example of a patient who continued to place complete*

trust in her Consultant.

6.3. We were told about another private patient who said she did not like Rodney Ledward's manner and told us that he was rough when examining her internally. She described to us her concerns that "he abused his position to demean and control his patients." This patient suffered wound infection and a pelvic abscess after he carried out an operation on her in **February** 1989.

6.4.

Medical Audit

In early 1989 the Department of Health published a circular on Medical Audit. It followed the White Paper, Working for Patients, referred to above and was intended as a discussion document. Medical audit was defined as "the systematic, critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources, and the resulting outcome and quality of life for the patient." It was said that effective medical audit was central to the provision of good quality care.

6.5. We understand that in **1989** Rodney Ledward was appointed the Director of Medical Audit in the Obstetric and Gynaecology division.

6.6. In **March** 1989 Rodney Ledward performed cystoscopy and posterior repair on a private patient after which she suffered from severe incontinence. In November 1990 he carried out a repeat repair operation on her which did not resolve her problem. She was then seen by a Consultant Urologist who was only able to provide her with temporary respite. Her incontinence continued and we were told that this caused the patient "great loss of dignity and upset".

6.7. A private patient told us that in **March** 1989 Rodney Ledward had carried out a laparotomy and ventrosuspension. She said that he had not specifically discussed with her the possibility of proceeding to ventrosuspension and she had not consented to

that procedure although we must point out that Rodney Ledward had stated in a letter to her GP dated 14th March 1989, before the surgery was carried out, that the patient had "given us permission to proceed if necessary". *We express our concern from what we have been told about this patient and from her medical records, that the procedure may not have been necessary.* The patient also said that when she had asked for her husband to accompany her in the consultation before the surgery was carried out, Rodney Ledward had said, "Don't be stupid, he can wait outside." She said the consultation lasted less than 3 minutes, that he suggested she was being selfish in not having children and that during the course of the consultation in response to a question she asked about the proposed surgery he had replied, "Don't be silly". She said that he did not bother to say goodbye to her, and that he did not carry out a vaginal examination before advising her to undergo surgery. She said that she had found the consultation very upsetting and complained about Rodney Ledward to her GP.

6.8. In **April** 1989 Rodney Ledward wrote a letter about a patient of his to her GP. It was clear from the terms of the letter, in which he discussed whether the patient might want another child, that he had not read her notes, which indicated that he had previously sterilised her.

6.9. In **April** 1989 Rodney Ledward carried out an anterior repair on a private patient who was suffering from incontinence. However the patient told us that she continued to suffer from incontinence which then became worse. She was seen regularly by Rodney Ledward for follow up treatment but it was not until May 1994 that he mentioned her continuing urinary incontinence in a letter to her GP. He then referred her for urodynamic tests and transferred her care to Mr Deane, Consultant Urologist. Despite further surgery and further referral her incontinence has continued.

6.10. In **May** 1989 Rodney Ledward advised a NHS patient that she required delivery of her baby by caesarean section. She asked to be sterilised at the same time but he said this was not possible and that she would have to be sterilised as a private patient 6 weeks after the delivery. The Trust's Disciplinary Inquiry into Rodney

Ledward's practice in 1996 held that on the balance of probabilities he had been guilty of serious professional incompetence and misconduct in respect of this patient. However we point out that the Professional Conduct Committee of the GMC, when it considered these facts at Rodney Ledward's disciplinary hearing, held that the charge of serious professional misconduct was not proved beyond reasonable doubt in respect of this case.

6.11. In **June** 1989 Rodney Ledward carried out a sling operation on a NHS patient. The patient subsequently suffered from incontinence and she was referred to a Consultant urologist. In fact Rodney Ledward had perforated the patient's bladder at operation, had repaired it during the course of the operation and then proceeded to insert the sling at the same site. The sling eroded the patient's urethra. This case was considered by the GMC at their disciplinary hearing in respect of Rodney Ledward and the allegation of serious professional misconduct against him was found proved.

6.12. We were told that in **July** 1989 Rodney Ledward advised a private patient to undergo an anterior repair and buttress to the bladder neck without previously carrying out a vaginal examination. She told us that Rodney Ledward said he would do a bladder repair and if he found that things were unhealthy he would do a hysterectomy. She had not felt happy with his advice and so had gone back to see her GP who had told her that Rodney Ledward knew what he was doing. She said that after the operation she could not pass urine and that Rodney Ledward told her that he needed to re-operate. She told us that he had said it was her fault because she had given birth previously to a large baby and that her muscles had given up. She told us that he said to her after the operation, " I have done such a good job on you, your husband will think he is taking a 16 year old home". She said that after she was discharged from hospital she found she could not control her bladder. She said she lived with the problem and told no one as she felt it was all her fault. She said she had not been able to play sport again. Later in 1995 she had wanted to be sterilised and her GP suggested she go to see Rodney Ledward. She had asked to be referred to someone else but he asked her why. She felt that she could not criticise Rodney Ledward. She went to see Rodney Ledward who said he would carry out laparoscopy

LAPA and sterilisation at the same time. He had asked her about her bladder and simply told him it was fine. She told us that he had then said to her, "Yes I did a brilliant job didn't I?".

6.13. We were told about a NHS patient who was advised by Rodney Ledward in November 1989 to undergo abdominal hysterectomy and removal of her ovaries. The patient told us that she did not like Rodney Ledward's attitude and felt that he should have discussed the available options with her. She told us he was dismissive of her concerns. She decided to seek a second opinion and was seen by Mr Stewart. He advised a cone biopsy which he then carried out. The patient also told us that when Rodney Ledward learned that she had been referred to Mr Stewart, he wrote to her GP in strong terms complaining that this should not have been done without his knowledge.

6.14
The Bevan Report
In December 1989 the Bevan report into the Management and Utilisation of Operating Departments was published. One of its recommendations was that every operating theatre should maintain a full record of every operative procedure undertaken.

6.15. We were told about a private patient upon whom Rodney Ledward carried out a number of laparoscopies between **1989 and 1995**. *We express our concern as to whether all these procedures were medically necessary.*

6.16. Mr Davies, Consultant Gynaecologist, told us that he recalled a case in about 1989 where he was asked to see one of Rodney Ledward's private patients who had developed an abscess post operatively. Rodney Ledward could not be contacted as he was in London and he had not arranged cover.

6.17. We were also told by a Consultant Gynaecologist from outside the Kent area

that some years ago he had been asked to advise about a patient in respect of her proposed litigation concerning Rodney Ledward. He saw the patient and her records. He told us that in **1989** she had undergone emergency laparotomy by Rodney Ledward's registrar and that during the course of the operation the registrar had found himself in difficulty, and had telephoned Rodney Ledward for advice and assistance. Rodney Ledward had not attended and simply advised the registrar to close the patient's abdomen. The Consultant told us that he did not approve of Rodney Ledward's failure to attend when his registrar had asked for help. *We understand that in this situation it would be proper practice for a consultant to attend.*

6.18. We were also told by the same Consultant Gynaecologist that a patient had been referred to him who had previously been treated as a private patient by Rodney Ledward. He said that Rodney Ledward had carried out a laparoscopy on the patient in **1988** when she was 14 years old, cauterisation under anaesthesia D&C in **1989** when she was 15 years old, and a further laparoscopy in **1991**. Rodney Ledward had then written: "if her problems continue....she could be a candidate for vaginal hysterectomy in due course." The patient was then aged 17 years. *We understand the Consultant's concern about this case. It appears that this patient was subjected to a number of surgical procedures at a very young age and that the suggestion of hysterectomy may not have been appropriate in the absence of serious pathology.*

1990

7.1. We heard evidence about a NHS patient upon whom Rodney Ledward advised hysterectomy in **January** 1990 when she was only 23 years old. *Although the patient consented to the operation, there is no evidence we can find that Rodney Ledward advised or tried conservative treatment before resorting to such a drastic measure in this young patient.*

7.2 A private patient told us that Rodney Ledward had carried out a laparoscopy and D&C in **January 1990**, a ventrosuspension in March 1990, another laparoscopy, D&C and sterilisation in October 1990, a vaginal hysterectomy in January 1991 and division of adhesions in July 1991. The procedures had all been carried out at St Saviour's Hospital. The patient told us that she was concerned that all these procedures might not have been necessary. *We share her concerns.* It also seems that Rodney Ledward failed to countersign the consent forms in respect of each operation.

7.3. A NHS patient (who was a nurse) told us that in **March 1990**, when she was 33 years old, she attended Rodney Ledward in his clinic. He advised her to have hysterectomy saying, "Oh my dear you need a vaginal hysterectomy - it's on its way out anyway down there." The patient underwent the proposed surgery in December 1990 and after her discharge home she suffered a secondary haemorrhage and an infection for which she had to be re-admitted to hospital. The patient told us that she went to see Rodney Ledward for a post operative check and that she asked him about HRT. She said that he had laughed at her question and made her feel silly by saying that of course she did not need HRT because her ovaries had not been removed.

7.4.
Disciplinary Procedures for Doctors
In March 1990 the Department of Health published a circular entitled: DISCIPLINARY PROCEDURES FOR HOSPITAL...STAFF. This document divided concerns about a doctor's practice into 3 areas: personal conduct, professional conduct and professional competence. The circular set out a number of different procedures to be followed where disciplinary action was contemplated against a hospital doctor.

7.5.1. On **28th March** 1990 the husband of a NHS patient complained about Rodney Ledward's treatment. He had carried out vaginal hysterectomy in 1983 and the

patient had suffered serious medical problems over the following year. In 1989 she was advised by Rodney Ledward to have a repair operation and she was admitted on 17 March 1990. A doctor came to speak to her after she was admitted, and told her that she might have a hysterectomy. This caused her grave distress as she had already undergone hysterectomy, as was clear from the notes. The junior doctor discussed the matter with Rodney Ledward who, without attending the patient, then advised that no operation at all was necessary. Rodney Ledward did not explain the matter to the patient and was unavailable when her husband wished to speak to him.

7.5.2. When asked by the Unit General Manager for the Channel Ports, Mrs Richards, about this complaint, Rodney Ledward's written response was to state that the patient "was reassessed on admission and we have decided to try medical treatment before further surgery." The Hospital sent a letter of apology to the patient and Mrs Darling, Director of Nursing Services, visited her. *We comment that the response from Rodney Ledward appears to be inaccurate; the patient had not been reassessed on admission. The change in her treatment seems to have been prompted by the patient telling a junior doctor that she had already undergone a hysterectomy 7 years previously, and we understand was made without being seen by Rodney Ledward.*

7.6. On **26th April** 1990 a private patient was sent an invoice by the Health Authority for inpatient day care at the WHH. She made an oral complaint to the Chief Nursing Officer, Miss Kennett in May 1990. The patient said that she had been referred to Rodney Ledward as a NHS patient for termination of pregnancy and that he had told her that he was not willing to carry out the procedure on the NHS but he was prepared to do so on a private basis for £600 cash. He said that as she was nearly 12 weeks pregnant no one else would carry out the procedure for her. She was admitted to the WHH and Rodney Ledward's secretary came to see her on the ward and asked for payment. The patient was given a receipt for the cash she handed over. She then received the invoice from the WHH, to which we have referred above, which she refused to pay. Subsequently she had made inquiries of private clinics in London and learned that termination before the 12th week cost £170 and termination between the 12th and 18th week cost £250. The patient felt she had been morally

blackmailed by Rodney Ledward and wanted an assurance that this conduct would not be repeated in the future.

7.7. On **11th May** 1990 another patient made a formal complaint about Rodney Ledward's lack of sympathy and tact when she had been referred as a NHS patient for termination of pregnancy. The patient considered that he had asked her inappropriate questions about her place of origin, her age and place of work. She had been referred at 8 weeks but was not seen until she was over 11 weeks. Rodney Ledward told her it was then too late for termination on the NHS and the only option was for a termination to be carried out privately. He told her he could "squeeze her in" to a clinic and told her to bring £600 in cash with her to the hospital. The patient made enquiries of other private clinics and said that none charged a fee "even remotely close to £600". Mrs Richards, Unit General Manager for the Channel Ports, went to see this patient to discuss her complaint.

7.8.1. On **24th May** 1990 Mr Russell wrote to Rodney Ledward about the above 2 matters. He also raised a further concern about his non attendance at certain sessions. This matter had been highlighted by the proposal from Rodney Ledward that he should become a Senior Teaching Fellow (Honorary) at the Academic Unit of the London Hospital, working there on Monday afternoons. By a letter also dated 24th May 1990, Professor Grudzinskas of the London Hospital Medical College offered Rodney Ledward the post of Senior Teaching Fellow.

7.8.2. Mr Russell spoke to Rodney Ledward about the 2 complaints regarding termination of pregnancy and followed the meeting by a letter in which he set out what had been agreed between them. It was agreed that a policy for terminations should be put forward by the Obstetric and Gynaecology division, agreed with the Authority and sent to GPs. *We have not been able to discover whether a policy on termination of pregnancy was ever agreed or sent to GPs.* It had also been agreed at the meeting that in future, if termination could not be carried out on the NHS, this would be notified to the patient's GP for the GP and the patient to decide between them whether to refer for private care and, if so, to whom. It was also agreed that collection of fees for private procedures performed in a NHS hospital should be

undertaken by the hospital. The Authority agreed that he could take up the appointment on Monday afternoons at the London Hospital and cancelled his operating list at the Buckland Hospital, which he was due to carry out under the terms of his contract.

7.9. We heard evidence from Professor Grudzinskas, of the Royal London Hospital, who told us that after Rodney Ledward's appointment as a Teaching fellow he attended the Royal London Hospital to lecture students on a Monday afternoon one week in every 8 of the students' training cycle. It was his impression that students liked his teaching sessions and that they were always well attended. He said that Rodney Ledward also attended some of the operating lists carried out by Professor Grudsinskas on a Monday afternoon. He said that Rodney Ledward attended the Royal London Hospital on most Monday afternoons.

7.10. In May 1990 a NHS patient was admitted for EUA and D & C. She complained that after her admission one of Rodney Ledward's junior doctors had informed her that she was to have a hysterectomy which she vehemently denied. The doctor then looked at the notes and apologised. While in the operating theatre the anaesthetist then said to the patient that she was to have a hysterectomy. Again she denied this and another doctor confirmed that she was to have only EUA and D & C. She had found the whole process most upsetting particularly as she had to wait all day for a bed to be available. Rodney Ledward when asked about the matter wrote: "I cannot see any firm criticism can be attached to Dr ... since he is in the training grade and was doing his best."

7.11. In May 1990 Rodney Ledward carried out a hysterectomy on a NHS patient who was only 22 years old. *From the evidence we have seen about this patient, there was no significant pathology to justify hysterectomy and, in the absence of such pathology, we express our concern as to whether it was appropriate to take such drastic action in such a young patient.*

7.12. We were told about a NHS patient who underwent a non urgent total abdominal hysterectomy under Rodney Ledward's care in June 1990 in spite of

having a low haemoglobin count. The Registrar appears to have made the decision to proceed with the operation without any discussion with Rodney Ledward. The patient told us that the Registrar seemed to her to be more concerned about not upsetting the operating list than whether she was fit for surgery. She only saw Rodney Ledward once during her 9 day inpatient stay and she had been upset by the way her case had been managed and the attitude of the junior doctors.

7.13.1. On **28th September** 1990 Mr Russell received a formal letter of complaint from a NHS patient who had been advised by Rodney Ledward to undergo hysterectomy. She complained that he had told her that there was about a year's waiting list but that if she went privately she could have the operation within 3 weeks. He had quoted her a figure of £2,500 - £3,000 for the operation. The patient complained that in her view "Mr Ledward was canvassing for private business and I have to seriously question if this is appropriate in the case of a patient referred through the NHS." Rodney Ledward was asked about the matter and in a letter dated 12th October 1990 said that it was reasonable to advise patients of alternatives available when there was a long waiting list. He was affronted by the suggestion that he had been canvassing for private business when "one is providing the patient with the best care within the facilities available and informing them of the alternatives..."

7.13.2. Mr Russell apparently spoke to Rodney Ledward about this complaint and it was agreed that in future he would advise patients of the waiting list and leave it to the patient and her GP to decide whether to take alternative steps. *We consider that Rodney Ledward's response was disingenuous. He did not deny the patient's assertion as to what he had said. We also consider that the management response was inappropriate, particularly in the light of the complaints made in April/May 1990 to which we have referred above.*

7.13.3. During the course of our Inquiry we showed Mr Russell the correspondence in relation to the May and September complaints about Rodney Ledward in which it was suggested that he had pressurised patients into having treatment privately. Mr Russell told us that he could not recall the incidents at all. He did however have a general recollection that Rodney Ledward was suspected of steering patients towards

private practice. He could also recall that he had spoken to Rodney Ledward about patients bringing cash into hospital when they were to undergo a termination of pregnancy. Mr Russell said he had objected to that practice which he described as unpleasant and distasteful. He told us that Rodney Ledward had said it was a difficult area because of a patient's emotional response to termination of pregnancy, and that he asked patients to bring in cash, as previously he had not been paid for procedures he had carried out privately.

7.14. We learned that in **September** 1990 one of Rodney Ledward's private patients underwent a laparotomy, drainage of a cyst and division of adhesions at St Saviour's Hospital. She had become Rodney Ledward's private patient at his suggestion in 1984. Thereafter she underwent 7 further surgical procedures before September 1990, at least one of which was carried out at a private hospital in London. After the operation carried out in September 1990 she began to leak faecal fluid from her abdominal wound. Rodney Ledward re-operated and afterwards told her he had damaged her bowel. She was then referred to Mr McPartlin, Consultant General Surgeon, who carried out a further operation when he removed part of her bowel. We heard evidence that this patient still suffers from pain but has been told that it is caused by adhesions as a result of the amount of abdominal surgery she has undergone. The patient told us that on one occasion Rodney Ledward came to see her dressed in riding clothes. *We express our concern as to whether all the surgical procedures carried out on this patient were medically necessary.*

7.15. On **2nd October** 1990 the Community Health Council wrote a letter of complaint to the Unit General Manager on behalf of a NHS patient who had undergone amniocentesis carried out, we understand, by Rodney Ledward. She attended the antenatal clinic 5 weeks later for the result, waited for some considerable time and was told that Rodney Ledward had gone home.

7.16. On **26th November** 1990 a NHS patient wrote to complain in graphic terms about Rodney Ledward's manner when he examined her internally. She had found his examination rough and was upset by the fact that it had taken place in front of 4 students who also examined her when her consent had not been sought. Rodney

Ledward was asked about the matter and he replied " Patients are advised that there is a presence of students ....I am sorry that on this occasion she felt her modesty was violated...". The outpatient manager advised the nursing staff to tell patients that they did not need to be examined in the presence of or by students. The nurses responded by saying that this was usually a matter for the doctor concerned who should ask the patient as she enters the room whether she objects to the students being present. Nursing staff were therefore asked to give such information to the patient if the doctor did not in fact do so. *We are unimpressed by Rodney Ledward's response to this complaint. We are also unimpressed by the management response to this serious complaint. In our view it was not for the nurses to ensure that consent was obtained. We consider that it is a doctor's responsibility to obtain his patient's consent to the presence of and examination by medical students.*

7.17. We also heard about a patient who told us that in about **1990** she had been referred to Rodney Ledward for a termination of pregnancy and, as she was anxious to have the procedure carried out as soon as possible, she asked him what it would cost as a private patient. She was admitted to the WHH where the procedure was carried out. She was then telephoned and asked to go to see Rodney Ledward at St Saviour's Hospital and to take the money in cash. She handed over the money and then Rodney Ledward told her that she would need another operation as not all the fetus had been removed. She was admitted to the Buckland Hospital for the further surgery. She has subsequently been informed that her uterus was perforated at the original surgery although, as she told us, Rodney Ledward never informed her about this at the time. She believes that her failure to conceive since that time was caused by the perforation of her uterus.

7.18. A patient wrote to us to say that Rodney Ledward had carried out a hysterectomy on her "many years ago". She said that "his treatment was of great benefit to me and his manner was never less than professional and courteous." She said that she had been shocked by the allegations that have been made against him by some of his patients about which she has learned. We also received another letter from a former patient of Rodney Ledward in which she said that he had always treated her with kindness, courtesy and expertise. Another patient wrote to tell us that

Rodney Ledward had carried out a hysterectomy on her as a private patient in about 1987 and that he had always dealt with her in a straightforward and professional manner. Yet another patient wrote to say that Rodney Ledward had carried out a hysterectomy on her and that "his care and attention saw us through a traumatic time". She said that she owed her life to his skill and expertise. Another patient told us that she had been Rodney Ledward's patient from the 1980s and she had always found him charming and friendly. She said that he had helped her through a difficult pregnancy and expressed her gratitude for all he had done for her and her child.

8. ***Our Concerns about the Care of those Patients to whom we have referred above.***

8.1. *From a consideration of those patients who received care under Rodney Ledward between the beginning of 1986 and the end of 1990 and whom we have considered above, we express the following concerns:*

* *a number suffered ureteric, urinary tract or bowel damage.*

* *a number suffered from haemorrhage, haematoma, infection or pelvic abscess.*

* *a number seem to have been pressurised by Rodney Ledward to become private patients and/or were asked to make payment in cash.*

* *a number of private patients seem to have been subjected to repeated and unnecessary surgical procedures.*

* *a number seem to have been given unconventional medical treatment or did not consent to all the surgery carried out.*

* *a number told us that he was unkind and uncaring and that he did not provide full explanations of their treatment or subsequent complications.*

* *in a few cases we have been concerned that he failed to give full information to patients' GPs.*

* *in a few cases it seems that Rodney Ledward could not be contacted when on call or when emergencies arose, and failed to attend the patient.*

We comment that these concerns are very similar to our concerns about Rodney Ledwards' practice between 1980 and 1985.

9. EVIDENCE OF CONSULTANT COLLEAGUES - GYNAECOLOGISTS

Mr Stewart

9.1. Mr Stewart, Consultant Gynaecologist, told us that he was concerned about Rodney Ledwards' commercial approach towards his patients in that he pressurised patients to become his private patients. He told us that very soon after he had been appointed a Consultant in 1987, he had developed the heaviest workload in the Unit and that when Mr Davies arrived in 1988 he too soon had a heavy workload, although there were now 4 Consultants in the division. They raised the matter with Mr Ursell, who was then Chairman of the division, who replied that they must get on with it, they were the junior consultants and the practice had always been for the junior consultants to take on the heavy part of the workload. When we asked Mr Ursell about this inequality of workload he told us that he considered that he undertook a heavy workload and that a large proportion of his cases were major surgical procedures.

Mr Davies

9.2.1. Mr Davies, Consultant Gynaecologist, said in evidence to us that after he was appointed in October 1988 he had been taken out to dinner by Rodney Ledward and Mr Ursell. They both made it clear that they did not like Mr Stewart, or the way he worked, and during the course of the dinner made a number of derogatory remarks about him. We should point out that Mr Ursell told us that he did not recall any detail about the dinner with Mr Davies. Mr Davies had also seen Mr Stewart to discuss matters and he had been struck by the fact that Mr Stewart did not voice any criticism of either Rodney Ledward or Mr Ursell. In addition soon after his appointment Mr Davies was told by the Regional Medical Officer, Dr Forsythe, that there was a problem with the Division and that the Consultants were keen to foster their private practices. Mr Davies told us that he had soon realised the department was divided.

9.2.2. He told us that in about 1989 or 1990 he was asked to attend one of Rodney Ledward's private patients who had developed a pelvic abscess. Rodney Ledward was not available because he was in London. Mr Davies expressed his concern to us

that Rodney Ledward had left his patient with no proper cover while he had gone to London.

9.2.3. He told us about a particular problem in the division which occurred in 1989/1990 on Monday afternoons when the senior SHO was required to be in 2 places at once. Rodney Ledward was due to have an operating list on Monday afternoons at the WHH under the terms of his contract, but he was often in London and did not attend. His senior SHO therefore carried out the operating list for him in his absence, although the SHO was supposed to be assisting Mr Davies in an antenatal clinic and covering the labour ward. The problem was compounded because the Registrar to the Gynaecology and Obstetric division, who was on duty, was required to be with Mr Ursell in Folkestone, carrying out a gynaecology clinic on Monday afternoons.

9.2.4. Mr Davies mentioned the matter to Rodney Ledward who said he would shorten the SHO's operating list so that the SHO could help with the antenatal clinic once he had finished operating. Mr Davies disapproved of that suggestion and made his views known. Rodney Ledward then directed his SHO not to leave the operating theatre until he had finished the list. We were told that Rodney Ledward had argued about the matter vehemently and that he had been very aggressive. Mr Davies said that he had been able to withstand this aggression but he doubted that a junior doctor would have been able to do so. Mr Davies went to see Miss Kennett, Chief Nursing Officer about the matter. This was one of the issues raised by Mr Russell in his letter to Rodney Ledward dated 24th May 1990 (see above) which was resolved by Rodney Ledward being offered an honorary post at the London Hospital on Monday afternoons so that his operating list at the at the WHH on a Monday afternoon was then cancelled.

Mr Ursell

9.3. Mr Ursell, Senior Consultant Gynaecologist, said that he was unaware of any problems about Rodney Ledward's practice save for one occasion in the late 1980s. A concern had arisen about Rodney Ledward carrying out a termination of pregnancy privately on a patient who had been referred to him as a NHS patient. He said he had

spoken to Rodney Ledward about the matter and told him that it was extremely foolish, and that it would be better in the future to refer such a patient to another Consultant. Mr Ursell did not pursue the matter further.

Locum Consultant

9.4. We heard evidence from a locum consultant in the division that Rodney Ledward used to run down Mr Stewart to staff in the Obstetric and Gynaecology division and that he openly stated that Mr Stewart was trying to poach his private practice.

10. EVIDENCE OF CONSULTANT COLLEAGUES - OTHERS

10.1. We were told that the General Surgeons had continuing concerns from the beginning of 1986 about Rodney Ledward's care of his patients, in addition to their concerns before the end of 1985. We heard evidence that the gossip about Rodney Ledward continued and that whenever he was asked by one of his surgical colleagues about a complication that had arisen in his patient, he was always supremely confident and never acknowledged that there was anything wrong with his practice. We were told that by the end of 1990 the general surgeons all felt that Rodney Ledward was a "bad penny". They were also well aware that after Mr Stewart and Mr Davies joined the Obstetric and Gynaecology unit, it was unhappy and divided, split between Mr Ursell and Rodney Ledward on the one hand and Mr Stewart and Mr Davies on the other.

Mr McPartlin

10.2. Mr McPartlin told us that Rodney Ledward was generally regarded as being "not frightfully good" by the Consultant General Surgeons. He said it was difficult to do anything about because almost every case they came across was a complication that could be explained. However he felt that it was the number of complications that made Rodney Ledward's practice out of the ordinary. He told us that he had to deal from time to time with complications from the other gynaecologists, but it was "the

number of problems" from Rodney Ledward that was the cause of concern.

Mr Girling

10.3. As we have already said, Mr Girling, Consultant Surgeon told us that he was increasingly aware between 1980 and 1989 that there were problems with Rodney Ledward and his practice. Mr Girling said he recalled that someone had described Rodney Ledward as "a disaster waiting to happen".

Mr Bates

10.4. Mr Bates, Consultant General Surgeon, told us that there was a great deal of concern about Rodney Ledward which ranged over a large number of issues including: that Rodney Ledward parked in the disabled parking space at the hospital; the financial terms behind the arrangement whereby students came from Ross University in the West Indies to be taught by him and then were left to be taught by others; cash being brought in by private patients for private care; his attitude to terminations of pregnancy.

Dr Bradfield

10.5.1. Dr Bradfield, a Consultant Anaesthetist, gave evidence to us that when things went wrong with Rodney Ledward's surgery it was not his reaction to try to do better. He said that the District General Manager, Mr Russell, knew of all the concerns about Rodney Ledward but nothing was done. It was felt that there was no proper system to monitor Rodney Ledward's practice so that there was little anyone could do. He told us that on one occasion he had been given cash by Rodney Ledward for anaesthetising a patient who was undergoing a termination of pregnancy although the patient was on a NHS list. The Consultant was highly critical of this and said so to Rodney Ledward. He stopped anaesthetising for Rodney Ledward's private practice. He told us that sometimes Rodney Ledward made facetious remarks about patients in the operating theatre. Dr Bradfield had felt that Rodney Ledward did not like women and thought they were inferior, and he also told us that Rodney Ledward tended to treat his overseas students in a demeaning way.

10.5.2. Dr Bradfield told us "Everybody thought everybody else was going to do something about it". He also told us that "... before Trusts, there was no real mechanism for getting to grips with this [a problem doctor] and no person who really was interested in keeping consultants in line...". This view was echoed by a GP from whom we heard evidence that there was no easy mechanism for GPs to make complaints about a Consultant, and from another GP that the District Management Team felt helpless because contracts of employment were held by the Region.

Dr Padley

10.6. Dr Padley, Consultant Pathologist, told us that Mr Russell was well aware that Rodney Ledward did not attend clinics as he should have done. He recalled an occasion when Mr Russell had told him that he had tried to contact Rodney Ledward in a particular clinic 5 weeks running but he had never been there. Dr Padley thought that Mr Russell had not monitored Rodney Ledward's attendance at clinics.

The Hospital Three Wise Men Committee

10.7. Mr Girling told us that the committee of three wise men remained the same between 1986 and 1989. In 1989 Mr Girling retired and Mr Griffiths, Consultant General Surgeon, took his place. We were told that before Mr Girling retired, one matter had been referred to the committee, but that no one had ever raised any concerns about Rodney Ledward with the three wise men. We remind ourselves that the role of the three wise men was to investigate any concern about the risk of harm to patients as a result of physical or mental disability, including addiction, of a doctor.

11. EVIDENCE OF JUNIOR DOCTORS

Dr Ahmed

11.1. Dr Ahmed, who is now a Consultant Physician, wrote to us to say that he had been Rodney Ledward's SHO between October 1987 and November 1988. He said that Rodney Ledward was the only Consultant in the Obstetric and Gynaecology division who took an interest in the clinical and academic work of junior staff. He said that Rodney Ledward was particularly interested in teaching and he felt that he

had been instrumental in junior staff achieving their examinations for Membership of the RCOG.

Dr Ameh

11.2. Dr Ameh, who now practises in Nigeria and Tanzania, also wrote to us to tell us that he had been Rodney Ledward's Registrar between August 1985 and February 1987. He said that Rodney Ledward had provided much teaching support and help to him and many other junior staff. He said he was the most "approachable" of all the Consultants and passed on his surgical skills to his juniors effectively. He wrote: "he was a constant source of encouragement and inspiration particularly to the foreign doctors." Dr Ameh praised Rodney Ledward's medical education of junior staff through the auspices of TSI and he told us that the South East Kent Health Authority benefitted greatly from the fact that Rodney Ledward could attract to their meetings respected lecturers and also pharmaceutical companies. He commented favourably about Rodney Ledward's medical publications. He went on to say that Rodney Ledward "worked tirelessly to relieve illness and bring succour to the patients." Dr Ameh readily accepted that he did not know about the details of the cases before the GMC and said he was not challenging the decisions. However in his view any deficiencies could only be mistakes made "in his [Rodney Ledward's] desire and eagerness to relieve the sick and render help to the needy."

Mr Ogunsanya

11.3. We have already referred to the fact that Dr Ogunsanya wrote to us to tell us that Rodney Ledward had been his Consultant when he was a Junior Doctor at the WHH between 1985 and 1986 and that he had considered that Rodney Ledward was a good teacher whose care of patients was exemplary.

Dr Agbaje

11.4. We have also referred already to the written evidence of Dr Agbaje who said he had been Senior House Officer and locum Registrar under Rodney Ledward between 1985 and 1987 and wrote in the most complimentary terms about Rodney Ledward.

Mr El-Lakany

11.5. Mr El-Lakany, now Consultant in Obstetrics and Gynaecology, wrote to us to say that he had first worked for Rodney Ledward in 1987. He wrote, "I could not imagine how much he was supportive and helpful to every junior doctor in the department." Mr El-Lakany told us that he soon became aware that things were not right between Mr Stewart and Mr Ledward. He told us that he had heard Mr Stewart on more than one occasion run down Mr Ledward to his patients.

Another Junior Doctor, now a GP

11.6. We heard evidence from another junior doctor who is now a GP. She told us that Rodney Ledward's ward rounds were very rapid and that she often had to go back to patients to explain matters to them. Although she had found him personally supportive, she considered that he was not someone it was easy to challenge and she thought that patients were in awe of him, possibly even intimidated by him. She said he did not expect patients to question him. After she became a GP she told us that she referred her patients to Rodney Ledward but that some of them did not wish to go back to see him; she said that Rodney Ledward was not the most popular consultant.

12. EVIDENCE OF THE NURSING STAFF

Theatre Sister

12.1.1. We heard evidence from an operating theatre Sister who had assisted Rodney Ledward at the WHH during this 5 year period. She said that he had 2 operating lists running simultaneously on Wednesday mornings, one which he carried out, and the other was carried out by the Registrar. She told us that Rodney Ledward did not always stay in theatre for the duration of the operating session but would invariably go back to his office, leaving a junior doctor to finish the operation and sometimes to start the next. It was the Sister's impression that he was doing administrative work between operating. She commented that the other consultants did not leave the operating theatre in the same way. She had found that his absences from theatre became more frequent as the years went by.

12.1.2. She also told us about problems she encountered with Rodney Ledward's lack of hygiene. She said that sometimes he did not put on surgical gloves before examining a patient and she had to stand over him to ensure he washed his hands afterwards. She spoke to him on the occasions when he failed to wear gloves, but he was blase and said "Oh I am just going to have a look". Thereafter when she observed that he was about to repeat the practice she would rush up to him with some gloves and he would laugh at her, but he put them on. She also had to insist that he removed his operating gown and gloves if he was going into the second operating theatre. The Sister said that she had complained to her line manager and two of the other consultants about this matter. She told us that Rodney Ledward knew that she had complained about him but she said it did not seem to worry him.

12.1.3. She also told us that she felt Rodney Ledward's surgery was too fast to be safe. She said sometimes he took 10-12 minutes carrying out a vaginal hysterectomy and that it was not possible for a junior nurse to keep up with him. She said that for vaginal hysterectomies he rarely tied 3 pedicles; usually he tied 2 pedicles but occasionally he tied only one. She described to us how he only made a single tie to each pedicle. *We understand that it is normal practice for a gynaecologist to tie 2 or 3 pedicles and that many gynaecologists double tie.*

12.1.4. The Sister recalled that Rodney Ledward often did not attend the patient if there was a problem after he had been operating. She remembered an occasion when Mr Derry was dealing with a patient whose bowel had been damaged by Rodney Ledward. Mr Derry insisted that Rodney Ledward attend the further surgery and he had done so, but had merely commented: "Oh, at least you are sorting it out now." He was not concerned by his mistakes or the anxieties of the nursing staff. She told us that she felt that Rodney Ledward was not concerned for his patients and nor was he concerned when she raised a matter about his practice with one of the other consultants. She said that he did not act as part of a team.

12.1.5. She also said that there were times when Rodney Ledward removed a patient's ovaries although the patient had not consented. She asked him whether he had explained to the patient before the operation that he might remove the patient's

ovaries. Sometimes he had not, but he did not desist from carrying out the procedure. The Sister said that she told him "to make sure you go and let the patient know afterwards." She said all she could do was then speak to another Consultant about this, as she had done. She told us that there was no way of indicating on the theatre record that a procedure was being carried out without the patient's consent. The Sister told us that Rodney Ledward's view was that he was the Consultant and that if he considered the operation was necessary, then the wording of the consent form where a patient agreed to "such further or alternative operative measures as may be found necessary" covered his action.

Ward Sister

12.2.1. We heard evidence from a ward sister who told us that she had worked on the gynaecology ward as a Staff Nurse from 1985. She said that Rodney Ledward only came to the ward once a week on a Tuesday lunchtime when he saw patients pre-operatively for the next day's list and also saw the patients he had operated on the week before. She said that other Consultants visited the ward more often. She described Rodney Ledward conducting a whistle stop tour with his entourage, which included his secretary. She had felt this was inappropriate for a gynaecological ward round. She said that none of the entourage was introduced to patients.

12.2.2. She also told us that she tried to be on duty on Wednesday evenings so that she could deal with any problems after Rodney Ledward's surgery. She said that he always left the hospital promptly once he finished his operating list and that he did not come back to the ward until the following Tuesday. She said that she had begun to realise that there were problems for patients after his surgery which she felt was rushed, and therefore she always watched his patients very closely, for example carrying out observations of their vital signs and vaginal loss, every half hour for 3-4 hours not just for the normal 2 hours. She said that the nursing staff often could not contact Rodney Ledward if there was a problem with one of his patients. Her impression was that the most frequent complications for his patients were tied ureters and bleeding pedicles. She said that the other Consultants did not have anything like so many such complications. It was her impression that his complication rate increased over the years. She told us that the nursing staff tried to overcome any

problems from Rodney Ledward's surgery by putting the most practical and capable staff on duty on the Wednesday day and night shifts.

12.2.3. The nurse told us that when she had begun working on the gynaecology ward, the prevailing culture was that nurses did not complain about consultants. She said that she had spoken to other nurses about her concerns about Rodney Ledward. However she said that as a nurse, "you did not complain to another consultant or question that consultant's ability. You did not do it. It just was not done."

Staff Nurse

12.3. We heard from a Staff Nurse who had worked on the gynaecology ward from 1989. She said that soon after she was appointed she was present at Rodney Ledward's ward rounds on a Tuesday. She said that the nursing staff dreaded the ward round. She said that his examinations of patients were very quick, he did not give the nurse time to cover the patient, and patients did not have a chance to ask questions. She felt that patients were intimidated by the whole experience, and he had moved on before the patient had recovered sufficiently to ask questions. She told us that when a patient had suffered a complication after his surgery, he did not return to see them until his ward round the following week.

Out-patient Sister

12.4.1. An out-patient Sister told us that she had been in charge of outpatients at WHH from 1980. She said that problems with Rodney Ledward began to arise in the mid 1980s. Patients complained that he treated them like slabs of meat and taught his students over them. She said they were often in tears. She commented to us "Gynaecology is a very emotional subject [for patients] at the best of times so they were ending up in tears and my nurses were having to sort them out."

12.4.2. She told us that Rodney Ledward had an outpatient clinic on a Tuesday afternoon between 2 and 5pm. He always finished the clinic by 4pm. She said that sometimes he arrived on time, particularly if he had a private patient, but that on other occasions he went to see his secretary first and did not arrive until 2.30pm. He would then "breeze through" but never apologised to the patients for his lateness.

She said that sometimes a private patient came to see him at his NHS outpatient clinic and he would insist on seeing that patient first and the NHS patients would have to wait.

12.4.3. The Sister told us that he asked his students to go and examine patients without a doctor or nurse being present. She had not approved and had expressed her views to him but said it was difficult to persuade him. She said that he very selective and judgmental as to which people he would offer a termination of pregnancy. She said he carried out terminations on private patients at the WHH and that occasionally he would offer to carry out a termination privately on a patient from France. She said that it was her impression that he had invited such patients to come to see him.

12.4.4. She told us that she had spoken to Rodney Ledward about some of her concerns, for example, when a patient was upset. He would say that this was a matter for the nursing staff to deal with. She had suggested that on occasions he should do things differently, and although he seemed to agree, nothing changed. She felt that she was banging her head against a brick wall. She also told us that she knew Rodney Ledward tried to persuade patients to become private patients by telling them there was a long waiting list but that they could have the proposed procedure done privately very quickly. He would ask them to bring cash. Sometimes the emphasis was so great she had felt that the patient would do their utmost to try to pay. She told us that he also exaggerated the waiting list times to patients and in her view, by doing so, increased the pressure they were put under.

12.4.5. She said that she informed the senior nurse of her concerns but the response tended to be "what do I do now?". She said that the Chief Nursing Officer had her hands full managing a busy hospital. She told us that the other consultants knew what was happening but she felt they were powerless to do anything to stop it.

12.4.6. The Sister told us that she had a serious concern about a doctor whom Rodney Ledward had arranged to do a particular clinic on a regular basis. She said that the doctor was not liked by the nursing staff. She had attended 2 or 3 of his sessions and told us that he examined some patients inappropriately. She spoke to

Rodney Ledward about the nurses not being willing to chaperone the doctor and complained that he was not good to the patients. She said that Rodney Ledward did nothing to stop the doctor's contract from being renewed. The Sister told us that she had then spoken to Mr Lowe, the Deputy Unit Administrator, and that the hospital eventually terminated the doctor's contract.

Midwifery Sister

12.5. A Sister in Midwifery told us that after the team approach to Obstetrics was started in the division as a pilot scheme in 1985, she had become Rodney Ledward's Team Leader. She said the scheme was subsequently adopted for the whole of the division. She remained as midwifery sister until 1989. She said that between 1985 and 1989 she hardly saw Rodney Ledward because he left Obstetrics to his Registrars. She had felt that expectant mothers should have a Consultant available to them. She had not felt, however, that care had been compromised save for one memorable occasion. She said that Rodney Ledward had come to the hospital one night when he was not on call. He asked if there was anywhere he could sleep. He had gone into the on call Registrar's room. During the night the labour ward was very busy and the Registrar and SHO were in theatre when a lady with a breech presentation was about to deliver. She asked Rodney Ledward if he would attend the patient and he agreed to do so. The Sister told us that during the delivery Rodney Ledward appeared to be worse the wear for drink. She said the delivery was "brutal" and she wished she had never asked for his assistance. She said the baby was in good health but the patient was very traumatised by the delivery and the Sister reported the matter the next morning. She said that nothing was done about this incident. Miss Watkins, who was Nursing Officer for Midwifery from 1984 to 1991, confirmed that she had been told about this incident on the following morning.

A Nurse

12.6. One nurse told us that she did not think Rodney Ledward was a good surgeon. She said to us, "I would never, ever, ever have chosen Mr Ledward [to operate on me] and if a friend of mine was coming into theatre to have gynae surgery I would never have suggested Mr Ledward."

13. EVIDENCE OF GENERAL PRACTITIONERS

13.1.1. A GP told us that within a year or so of his starting practice as a GP in 1987, he had become concerned at the care given to his patients because a number had complained to him about Rodney Ledward, after they had been referred to him. The GP discussed matters with his partners, some of whom also expressed concern that Rodney Ledward was using improper pressure to persuade patients to go privately. The GP thereafter referred his patients to other Consultants and he thought his partners did likewise.

13.1.2. The same GP told us that he felt that Rodney Ledward had little insight and did not recognise that he had a problem. Without such recognition, he said, Rodney Ledward would never change. He told us that, "he could be charming when he wanted to be and bullying when that failed.' He considered that Rodney Ledward's personality was such that he would "always work around" any criticism.

13.2. Another GP who had worked in the Kent area since 1985 told us that he did not feel that as a GP he was in a position to question or challenge a Consultant. He said that he had some concerns about some of his patients who were treated by Rodney Ledward, namely that there seemed a few more complications than he would have expected, and private patients were having too many surgical procedures. However he felt that he just did not have the authority to challenge Rodney Ledward but he reduced his referrals to him. Another GP told us that "it is difficult for a GP to criticise a specialist." He also said that Rodney Ledward had great prestige and presence which added to the difficulty for a GP.

13.3. We were told by another GP that in the early years after Rodney Ledward's appointment, "it became increasingly apparent that there were problems in relation to his practice, and to a large extent I stopped referring to him." He pointed out that Rodney Ledward used improper pressure to persuade patients to become private patients and the GP was concerned that a number of operations carried out on private patients were unnecessary. He discussed the matter with his colleagues who voiced similar concerns.

13.4. Another GP told us that he used to assist Rodney Ledward with his operations at St Saviour's Hospital from about the mid 1980s for which Rodney Ledward would pay him.

13.5. Another GP, who began to practise in Kent in 1986, told us that he also acted as an assistant to Rodney Ledward at St Saviour's but he had only done 2 or 3 sessions and then had been unwilling to do any more because he was not happy with Rodney Ledward's care. He told us however that many patients were happy to be cared for by Rodney Ledward.

14. EVIDENCE OF NHS MANAGEMENT AND ADMINISTRATIVE STAFF

Miss Watkins

14.1.1. Miss Watkins, Nursing Officer for Midwifery, told us that Rodney Ledward was known to be very fast and that he was described as "the Ledward express". She said that his maternity ward rounds were whistle stop tours. She said that he was very quick and flippant in dealing with patients. She had spoken to him about her concerns and he told her that patients do not want a chat, they want to be examined and in and out as soon as possible. She had been upset by his attitude. She told us that she had complained to Rodney Ledward about his being rough when examining a patient and his response was that the patient was a "softie". She said that he did nothing to put women at their ease before he examined them, and that his approach made things very difficult for the midwives. She said she had spoken to him on a number of occasions but that he was a law unto himself. She had also raised with him the fact that he did not mention the presence of students to the patient before he saw and /or examined the patient.

14.1.2. She told us that at his antenatal clinics he would only see 2 patients himself, so she and the midwifery staff devised a strategy where they had a list of a number of patients and as each was dealt with they would then introduce another to him. That way he stayed longer and saw more patients.

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14.1.3. Miss Watkins also told us that she was aware that his secretary would collect cash from patients, often for terminations. She had also been aware that Rodney Ledward often failed to attend his clinic at the Royal Victoria Hospital in Folkestone. She had reported this matter to Miss Kennett and Mrs Darling. She said that it was difficult to speak out about a Consultant at the time because "they were treated as gods."

Mrs Darling

14.2. Mrs Darling told us that she had been assistant director of nursing between 1984 and 1989, when she then became director of nursing services for the Dover, Deal and Folkestone hospitals from 1989 until April 1990. Mrs Darling told us that Rodney Ledward had been extremely helpful in setting up a pilot study for midwifery in about 1985. She said that he was the only Consultant in the Division who would entertain the idea at the time. However she suggested to us that over the years Rodney Ledward had lost interest in his NHS work and that he was increasingly not present in the hospitals. She felt he had outside interests such as his private work and his teaching post at the London Hospital. She had been told that he was not always willing to discuss matters at Divisional meetings. She had felt that a major concern was his lack of availability.

Mr Lowe

14.3. Mr Lowe told us that he had been the Deputy Unit Administrator at the WHH from March 1987 until 1990 but he had no concerns about Rodney Ledward or his practice during that time.

Mr O'Neill

14.4. Mr O'Neill was Assistant General Manager at the WHH from 1986 to 1990. He told us that he was unaware of any problems with Rodney Ledward's practice during those years. He knew about the legal claims made against Rodney Ledward but said that the claims against him were no different from those made against other Consultants. Mr O'Neill said that there was nothing to bring to his attention that there was a problem with Rodney Ledward's practice. However he told us that Rodney Ledward was very arrogant and he described an occasion when he had "towered

over" Mr O'Neill who had "quaked". He also knew that Rodney Ledward was interested in fostering his private practice but he considered that this was no different from the other consultants. He said that Rodney Ledward was commercially orientated.

Mr Grimoldby

14.5.1. Mr Grimoldby was the planning administrator at the Health Authority from about 1983. He said that data was sent to him from the different Units within the Authority, about numbers of admissions and discharges, and the data also covered the work of certain departments such as pathology and radiology. The data provided to him was concerned with out-patients. All information about inpatients (whether on a day or longer basis) was sent by each Unit direct to the Regional Health Authority. Mr Grimoldby said he had access to the regional data via his computer. He told us that the computer files which he accessed were an auditing tool for quantities and were not concerned with quality of patient care.

14.5.2. From the data provided and available to him he was able to pick up patterns of practice and differences from the norm and then reported to management. For example, he found that Rodney Ledward kept NHS patients in hospital for 2 days when they had undergone termination of pregnancy, but that his private patients who underwent terminations at the WHH were admitted as day cases. He said that this matter obviously affected resources and it was raised with Rodney Ledward. He said the discrepancy subsequently changed and that there was not a difference thereafter in length of stay for private and NHS patients. He said that he also became aware that the Obstetric and Gynaecology division had much longer waiting lists than other divisions.

14.5.3. Mr Grimoldby told us that Mr Russell was an easy man to get on with, and that the whole of the Management Team were approachable. He said there was a lot of goodwill and people worked together well. He said that they were all committed to improving matters within the NHS. He told us that the system was based on the assumption that everyone who worked within the various hospitals was pulling their weight. He felt that this explained how Rodney Ledward was able to work within the

system without concerns being raised about him.

Mr Girling

14.6.1. Mr Girling, Consultant General Surgeon, was appointed the General Manager of the William Harvey Hospital from 1986 to 1989. He was also a member of the District Management Team. We have already mentioned that he told us that, as a general surgeon, he had been increasingly aware between 1980 and 1989 that there were problems with Rodney Ledward and his practice. He said that when he was General Manager there had been additional concerns about Rodney Ledward's poor time-keeping and about his failing to turn up to clinics and operating lists. He recalled an occasion when a clerk had mentioned that Rodney Ledward was using the hospital franking machine to send post to the Isle of Man. He accepted that Management knew of the problems and also accepted that something should have been done by them. He said "it was overdue".

14.6.2. He told us that Mr Russell had looked into the question of Rodney Ledward's poor attendance at clinics and operating sessions and had asked him to explain. He understood that Rodney Ledward had not been best pleased; as Mr Girling told us: "surgeons do not like being carpeted by administrators." Mr Girling could not recall himself ever having raised his concerns with Rodney Ledward. He said that there was no clear mechanism in place to be followed if there was anxiety about a Consultant's practice. He now considered that probably the correct route would have been to speak to the Regional Director of Public Health as a Consultant's contract was held by the Regional Health Authority. *We were of the impression that Mr Girling regretted not having done something about Rodney Ledward before he retired in 1989.*

Miss Kennett

14.7.1. Miss Kennett became the General Manager of the WHH between 1989 and 1990, in addition to her role as Chief Nursing Officer. She told us that during the 1980s she had become generally aware of concerns about Rodney Ledward. She said that she had felt there were times when he was less than honest and that he was someone you had to keep your eye on. She said she was aware that he parked in one

of the hospital parking bays reserved for disabled persons; she had concerns about the financial implications of his connection with Ross University and she was aware that he used the hospital system for overseas postage. Miss Kennett told us that she was concerned that private patients treated by Rodney Ledward within the NHS hospitals were not always dealt with under the hospital procedures. She was concerned that he was always in a rush and she was aware that his attitude to patients left something to be desired.

14.7.2. She expanded on these concerns for us. Miss Kennett said that she recalled that Rodney Ledward failed to turn up from time to time at clinics and that this was an ongoing problem. She said: "he hated being in one spot more than 2 seconds". She told us that he found it difficult to talk to patients, "he could not relate to them somehow." In the Out Patient clinic at Folkestone the nurses told her he was arrogant and used "to frighten the patients to death". Miss Kennett told us that he was very difficult. She said, "he somehow could not talk to patients about their conditions, their illnesses, but he produced a lot of written information for them to take away - booklets, leaflets and so forth - and he was very good at doing that. He was actually a very good teacher."

14.7.3. Miss Kennett told us that she was always very concerned at the way he handled terminations and said that he pushed patients into private sector whenever he could. She was aware that money was collected for private procedures on the ward. She had tried to investigate these matters but told us that she could not obtain hard evidence. She said that she understood that she needed to have clear evidence in the form of a patient's written complaint or a patient's willingness to give oral evidence about a matter before it could be reported to the Regional Health Authority. She said she had never been able to obtain such evidence despite making considerable efforts to do so.

14.7.4. She said that she always tackled problems that arose and felt that Mr Russell had listened to her concerns. She told us that Mr Russell had spoken to Rodney Ledward in his office about various matters. She said that one of the difficulties facing Management was that the Regional Health Authority employed Consultants.

She did not know if anyone reported Rodney Ledward to Region, but she had not considered that she had the evidence to do so. She was unaware of any problems about Rodney Ledward's clinical practice apart from hearing that he was too fast, that he was a bit rough with vaginal examinations, and that his attitude to patients was not all that it might have been. It was her recollection that Rodney Ledward was not formally mentioned at the Management meetings, but that there was chatter about him. She said that each member of the team tried to tackle the bit that concerned them but she said there was no concerted effort, " it was not joined up." She also told us that in the climate of the time it was very difficult for anyone to take effective action against a consultant. Miss Kennett told us that Mr Russell was a very good manager. He handled the medical profession with a softly, softly approach. He was their friend; he was gentle and kind and a good leader.

14.7.5. Miss Kennett told us that Rodney Ledward "could be exceedingly charming and very, very nasty." He was not somebody she would go to chat to unless there was a specific reason, because he was not an easy man and he did not want to know about any problems. She said, "he really did not want to know about the health service." She reminded us that the Health Authority had gone through a number of reorganisations and that Management were so stretched it was her impression that they tackled the easy problems rather than those where it was felt they would not have much effect.

Mr Cain

14.8. Mr Cain told us that he remained responsible for the financial affairs of the Health Authority and was a member of the Management Team during this 5 year period between 1985 and 1990. He could recall a problem about a patient, who was undergoing termination of pregnancy, being asked to provide cash when she was in the hospital, and he understood that Mr Russell had "a quiet word" with Rodney Ledward about the matter to say that, if this were true, it was not acceptable. Mr Cain also expressed concern to us that it would not meet the approval of the Inland Revenue. He agreed that it was a serious matter which had been left to Mr Russell to sort out. He believed that this was the only occasion when Rodney Ledward had been discussed by the Management Team. He had not been aware of any queries

about travel expenses and told us that these would have been paid by the Region and any irregularities picked up there. They had mentioned nothing to him about any concerns. He was never aware of any concerns about Rodney Ledward's clinical practice or that he was being paid for a session that he in fact fulfilled at the London Hospital. He said that Consultants' annual and study leave was a matter sorted out by the Medical Staffing Officer at the Buckland which would only have been referred to him had a problem arisen.

Mr Russell

14.9.1. As we have already indicated in the course of the narrative above, Mr Russell, District General Manager, was unable to recall particular events or complaints about Rodney Ledward. He simply had a general recollection that Rodney Ledward encouraged patients to become private patients, asked to be paid in cash, sometimes did not attend clinics and was a poor time keeper. He said that he had no proof that Rodney Ledward was pressurising patients to become private patients. He had also felt that there was a problem ensuring that Rodney Ledward gave enough of his skill and time to his NHS patients. However he considered that he had insufficient rapport with the Obstetric and Gynaecology division to know what was really going on. He said that he considered that the appointment of new consultants to the division would alleviate the problem.

14.9.2. Mr Russell told us that he had spoken to Rodney Ledward from time to time and that he had tried talking to him in order to influence him not to continue following the practices about which Mr Russell was concerned. He also mentioned the problems to Dr Rideout, Assistant to the Director of Public Health. However he said there were no sanctions that could be used against a Consultant and that there was no disciplinary procedure for failure to comply with his contract. He said that he was aware of this because he had previously raised the issue with the Regional Health Authority and the Department of Health about another consultant, and had been informed that there was no action available to discipline a consultant. Mr Russell told us that the only way to persuade a consultant to leave was to make a payment of money. We remind ourselves that in March 1990 the Department of Health circularised new disciplinary procedures for consultants (to which we refer in more

detail below) and by Annex D a procedure was set out for repeated failure to fulfil the terms of the doctor's contract.

14.9.3. Mr Russell also told us that he was completely unaware that any consultant colleagues or anyone else had any concerns about Rodney Ledward's clinical practice during this 5 year period.

15. EVIDENCE FROM THE REGIONAL HEALTH AUTHORITY

Dr Forsythe

15.1.1. We heard evidence from Dr Forsythe who remained Director of Public Health at the Regional Health Authority during the years 1986 to 1990. He said that all Consultants were employed by the Regional Health Authority, and that he had been the accountable officer for hiring and firing them. He said that he had quite frequent contact with Mr Russell. He told us that about this period of time there had been a problem in the radiology department of the South East Kent Health Authority which the Region helped to resolve, but he could not recall being aware that the Obstetric and Gynaecology division was polarised or in any way dysfunctional. He accepted that he had spoken to Mr Davies on his appointment in 1988 and was happy to accept Mr Davies' word that he had spoken to him about Consultants in the division being keen to foster their private practices. However Dr Forsythe himself had no recollection of this conversation and he had no recollection of any discussion about the division being polarised. Had there been multiple legal claims against Rodney Ledward Dr Forsythe said he would have picked this up and gone to see Rodney Ledward for an explanation. *In fact it appears that no claims involving Rodney Ledward had been settled by the Health Authority before the end of 1990 or indeed before Dr Forsythe left the Region in 1992.* Dr Forsythe said that he had no substantial evidence to work on. He had not picked up a problem as a result of patients complaints since only rarely did he become involved by appointing an independent review body.

15.1.2. He was aware, but he could not recall how, that there was some concern

over Rodney Ledward pressurising patients to become private patients and some concern about Rodney Ledward's attitude to patients. He told us that he was having to rely on his memory because, as we have already mentioned, the Regional Health Authority has destroyed all files, including Dr Forsythe's confidential files.

15.1.3. Dr Forsythe told us that after the introduction of the three wise men committees he became concerned that local panels were not functioning properly or were not published in any way, and he therefore wrote annually to the manager of each hospital or District Health Authority within the Region, asking them to confirm the names of the panel members.

16. EVIDENCE FROM PRIVATE HOSPITALS WHERE RODNEY LEDWARD WORKED

The Chaucer Hospital - Mr Gough

16.1. Mr Gough was the Chief Executive of the Chaucer Hospital in Canterbury from October 1990, and he told us that by the time he was appointed, the theatre and nursing staff at the Chaucer Hospital were concerned about Rodney Ledward's practice and were generally uneasy about him. They voiced their concerns to Mr Gough soon after he arrived. Their concerns were about his lack of skill in operating. However he had not been told anything adverse about Rodney Ledward's manner or attitude to patients; he understood that his patients thought Rodney Ledward was charming.

St Saviour's Hospital - Mr Tempest

16.2.1. We also heard from Mr Tempest who was the General Manager at St Saviour's Hospital from 1990. He told us that soon after he arrived he was aware that the nurses did not consider Rodney Ledward to be their preferred Consultant, because patients needed to stay in hospital longer to recover after his surgery (when compared to other Consultants) and they did not like his attitude. He said that there was an ingrained culture in the nursing staff that they did not at that time question the consultants. He said that the culture at the time was that clinical care of patients and the service they

received was consultant led, that is, the consultant was in charge of the patient.

16.2.2. Soon after he was appointed, Mr Tempest told us that he became aware that Rodney Ledward had 2 sessions a week allocated for operating lists but was not using them to the full. Mr Tempest decided within 6 months of his arrival to re-allocate one of the sessions, which he then transferred to another, younger Consultant who had no operating list at all. He told us that Rodney Ledward had not liked that and was cross. He said that there was always a degree of rivalry and jealousy between consultants about their private practices. He told us that his decision to remove a session from Rodney Ledward had coloured their relationship from then on.

16.2.3. Mr Tempest told us that Consultants, who were sued by private patients, were not obliged to inform the private hospital about any claim arising from treatment given in that hospital. He therefore did not know if St Saviour's was aware of all the claims brought against Rodney Ledward. He had not considered that the numbers of claims about which he was aware, singled Rodney Ledward out from the other Consultants who worked at St Saviour's.

17. EVIDENCE BY AND ON BEHALF OF RODNEY LEDWARD

Rodney Ledward

17.1.1. Rodney Ledward stated in his written evidence to us that no one had ever raised concerns about his clinical practice with him at any time before he was suspended. He did not mention whether members of the nursing staff spoke of their concerns to him and we have not been able to pursue that point with him. He told us that Mr Stewart was not a "team player" and that Mr Stewart had always been "keen to report to Management". He strongly believed that Mr Stewart used to run him down to patients and members of staff and he said that this had been reported to him by one of his Registrars. He was also of the view that, after Mr Davies was appointed, the division had been divided between himself and Mr Ursell on the one hand, and Mr Stewart and Mr Davies on the other.

17.1.2. He said that on Mr Stewart's appointment as Consultant, Mr Stewart had

asked to be given Rodney Ledward's operating list at the Buckland Hospital without any reference to himself. He said that the list was given to Mr Stewart and therefore he accepted the post of Senior Teaching Fellow at the London Hospital. *We remind ourselves that Mr Stewart was appointed a Consultant at the WHH on 1st February 1987 and that Rodney Ledward was not offered the post of Senior Teaching Fellow until May 1990.*

17.1.3. We have been told that Rodney Ledward became Director of Medical Audit in the Obstetric and Gynaecology division in 1989. However as far as we have been able to discover, no systematic audit of the Division was carried out after the 3rd Biennial Audit which was published in 1986. Rodney Ledward wrote to tell us that he had wished such audit to be carried out but that this was opposed by Mr Stewart and Mr Davies. However Mr Stewart told us that Mr Ursell and Rodney Ledward were the Consultants who were unwilling to carry out audit within the division. Having spoken to Mr Ursell our impression is that he carried out his own audit on topics that he felt justified such audit. He did not say that Mr Stewart and Mr Davies opposed a team approach to audit. *As Rodney Ledward was Director of Audit, we find it surprising that he was not able to ensure that audit was carried out. If any of the Consultants opposed audit of the division, he should have spoken to Mr Russell, the District General Manager about the problem, or indeed Dr Forsythe at Region. It does not appear that he ever did so. Audit therefore seems to have been left to each indvidual consultant to carry out. We are unsure what audit Rodney Ledward carried out himself, save that we have been told that he used interesting cases for teaching purposes. He does not seem to have picked up any problems with his own practice.*

Miss Harris

17.2. During this 5 year period from 1985 to 1991 Miss Harris told us that she continued to work as Rodney Ledward's secretary for his private practice and to organise his accounts for him. She said that nothing had appeared wrong during that time.

Mrs Woodcock

17.3.1. Mrs Woodcock was appointed Rodney Ledward's NHS secretary in April 1988. She remained in that position until she resigned in March 1996 after Rodney Ledward was suspended. She told us that she loved her work and that she had always got on very well with Rodney Ledward. She said that he was very easy going, a very nice person who never got cross. She said that he was a charming person. It is our impression that he was very reliant on her and that she was most efficient.

17.3.2. She told us that TSI meetings took place approximately once a month and that she worked from home setting up a number of the meetings and lecturers. She told us that she had accompanied him on ward rounds so that she could put a face to patients to whom she had spoken on the telephone and that she attended with the students. She said he always asked patients whether they had any questions before he passed to the next patient.

18. DEPARTMENT OF HEALTH CIRCULARS 1985 - 1990

Hospital Complaints Procedure Act 1985

18.1.1. In June 1988 the Department of Health published a circular regarding complaints made pursuant to the Hospital Complaints Procedure Act 1985. It was stated in this circular:

> **"It is important that no one (staff or patient) should be inhibited from making valid complaints and that there is full confidence that these will be given full, proper and speedy consideration."**

18.1.2. The Circular gave Directions which provided for a Designated Officer to be appointed and put in charge of minor complaints which he or she would be bound to investigate. The Health Authority was directed to monitor such complaints. However complaints relating to clinical judgment, serious untoward incidents, disciplinary proceedings, physical abuse of patients or which involved a criminal offence were not covered by this procedure.

Working for Patients

18.2. In January 1989 the Department of Health published a White Paper entitled **Working for Patients**. This reflected the Government's new policies that some hospitals should have self governing status within the NHS and that quality of service within the NHS should be audited. It was stated that patients were to be put first with the best treatment available being offered throughout the NHS. Resources were also to be used in the best way to provide the best service for patients. It was envisaged for the first time that there would be some degree of cooperation between the NHS and the independent health sector. A programme was set out which proposed the creation of the first Hospital NHS Trust in 1991. It was also proposed that prior to NHS Trusts being established, District Health Authorities would act as agents for Regional Health Authorities in agreeing with Consultants the scope and arrangements of their NHS duties. *We understand that this change related to the creation of job descriptions for Consultants, but did not deal with problems of clinical competence*

which remained the responsibility of Regional Health Authorities.

Medical Audit

18.3.1. In early 1989 the Department of Health published a circular on Medical Audit. It followed the White Paper Working for Patients referred to above. It was intended as a discussion document and it was planned to complete discussion by May 1989. Medical audit was defined as "the systematic, critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources, and the resulting outcome and quality of life for the patient." It was said that effective medical audit was central to the provision of good quality care.

18.3.2. In essence it proposed that audit needed to be developed in hospitals, and outcome of care needed to be assessed. It recognised that medical audit should not act as a brake on the development of medicine in difficult cases.

18.3.3. The discussion paper proposed that medical audit needed to be undertaken by doctors themselves with a doctor in charge. However management was to be responsible for ensuring that an effective medical audit system was set up and reviewed, and for initiating where necessary an independent audit. Confidentiality was stressed. The Government recognised that doctors would have to be allowed time to carry out such audit and would need good record keeping and secretarial facilities.

18.3.4. For hospitals it was envisaged that a system of medical audit would be in place by April 1991 and to that end that a district medical audit advisory committee should be set up to ensure that medical audit was in place each year, and would report annually. Independent peer review could be initiated at the request of the District General Manager. Each Region would have an Audit Advisory Committee to organise audit for small specialties, to organise independent peer review as necessary and to advise generally on audit across the Region. It envisaged that once arrangements were in place for medical audit there would be a need to amend all Consultants' job descriptions to reflect the requirement for medical audit.

The Bevan Report

18.4. The Bevan Report, commissioned by the NHS Management Executive, on The Management and Utilisation of Operating Departments was published in December 1989. The following were amongst its recommendations:

(a) theatre managers and clinicians should maintain a continuous review of emergency operations performed outside normal working hours;

(b) each theatre should maintain a record of all operative procedures undertaken;

(c) records kept should reflect the activity undertaken.

Disciplinary Procedures for Doctors - HC(90)9

18.5.1. In March 1990 the Department of Health a circular entitled: DISCIPLINARY PROCEDURES FOR HOSPITAL...STAFF. This document divided concerns about a doctor's practice into 3 areas: personal conduct, professional conduct and professional competence. The circular set out a number of different procedures to be followed where disciplinary action was contemplated against a doctor. Serious disciplinary action which might involve dismissal of the doctor was to be governed by Annex B. The procedure was set out in detail. It required investigation by the Chairman of the Health Authority as to whether there was a prima facie case, then a full investigation by a disciplinary inquiry which was to be chaired by a lawyer, provision for the Inquiry team to report within 32 weeks and provision for the Health Authority to make a decision about any disciplinary action within another 4 weeks. *The procedure is on any view complex and cumbersome*. Annex C set out the procedure for doctors to appeal and provided for the doctor to be paid his or her salary while the appeal was pending.

18.5.2. Annex D set out the procedure to be followed where a Consultant had failed repeatedly to fulfil the terms of his contract. Annex E was an intermediate procedure whereby independent assessors would advise on a specific allegation of conduct or

competence against a Consultant, or where there was a difference of professional view within a department. It could not be used where the doctor might be dismissed.

19. Professional Conduct and Discipline Pamphlets published by the General Medical Council (GMC) known as "The Blue Books"

Pamphlet published in June 1990

19.1.1. The only new blue Book published by the GMC during the period 1986 to 1990 was that published in June 1990. It repeated earlier Books but envisaged that disciplinary proceedings might follow from improper arrangements calculated to extend or benefit a doctor's practice. This was said to include pressurising a patient to accept private treatment in reliance on representations about the relative comparative availability of treatment under the NHS and privately.

19.1.2. It also set out the duty of a doctor to inform an appropriate body about a colleague whose behaviour might have raised a question of serious professional misconduct, or whose fitness to practise might be seriously impaired through a physical or mental condition. It also permitted a doctor to comment when giving a reference for another doctor on the professional performance of a colleague.

19.1.3. Other changes to the pamphlets do not appear to be relevant for the purposes of our Inquiry.

20. *Our Commentary on Rodney Ledward's practice during the period 1st January 1986 and 31st December 1990*

20.1.1. *It has been difficult always to give a date to the factual evidence we have heard. Often witnesses could not recall dates or put a year on the facts they were describing. We have done the best we can, on the information before us, to give a date as to when the events took place. It is clear that much of what we heard did not fall neatly into the periods of time into which we, for the purposes of this report, have divided the 16 years that Rodney Ledward was a Consultant. There was clearly a good deal of overlap. We have continued to use such medical records and other documents as are available to us as landmarks in establishing a chronology. However we have found that many witnesses were unable, for the understandable reason that their memories have faded with the passage of time, to give us exact dates when they noticed failings in Rodney Ledward's practice. This is particularly so of those failings which in their view continued for a considerable period of time. It is our impression that many of these failings became more obvious at some time during the period 1985 to 1990 but we cannot be more precise as to when they emerged.*

20.1.2. *Rodney Ledward's poor record keeping continued throughout this period and also hampered us in trying to establish what events took place during this time.*

20.1.3. *We point out that once again during the period from the beginning of 1986 to the end of 1990, an almost equal number of Rodney Ledward's NHS and private patients brought their treatment to our attention.*

20.1.4. *Therefore the only person who would have had full information about his practice from both NHS and private patients would have been Rodney Ledward himself. It seems from all we have read and heard that he continued to show no insight into the problems and concerns about his practice. We consider that he shut his eyes to problems and tried to cover up his mistakes. The lack of explanation to patients and the inaccuracy of letters to their GPs continues to point to that conclusion. We consider that the culture of Consultants who could do no wrong was very slowly beginning to change. It did not change overnight and those who had*

practised within the NHS for a number of years were probably the most reluctant to countenance or recognise this change. However some consultants were by the late 1980s more open and ready to explain matters to patients. We are satisfied that the change of culture did not embrace Rodney Ledward. We have heard that a surgeon was still treated as a god whose word was not questioned. We have also heard that some nurses raised issues with Rodney Ledward, and reported him to their seniors and we are aware that the 2 more recently appointed Consultants had a different approach to clinical practice from that of Rodney Ledward. Any attempts by management to alter his views or his practice seem to have been met by the suggestion that things would change; but in reality nothing did.

20.1.5. *We accept that Rodney Ledward continued to raise the academic profile of both himself and the William Harvey Hospital, for example through TSI lectures and by his appointment at the London Hospital. We accept that he was continuing to teach his students and junior staff and that many of his junior staff are very grateful to him for his encouragement and teaching.*

20.1.6. *We have seen the report (published in 1986) of the audit of the Obstetric and Gynaecology division which covered the period 1984-1985. However that appears to be the last audit of the division ever carried out and thereafter it seems that there was no systematic audit of the division or of an individual's work. Since Rodney Ledward was himself appointed Director of Medical Audit of the division in 1989 he bears considerable responsibility for the failure to carry out any such audit. However under the Department of Health Circular "Medical Audit", management was to be responsible for ensuring that an effective medical audit system was set up and reviewed. We have seen and heard nothing to indicate that management began to take steps to ensure that there was an effective system in place in the Obstetric and Gynaecology division by April 1991, as the Circular envisaged.*

21. *Rodney Ledward's Competence*

21.1. *From our review of Rodney Ledward's patients' cases that have been brought to our attention, it appears that a number of them suffered ureteric, urinary tract and bowel damage during the 5 year period ending 31st December 1990. It also seems that a number suffered from surgical complications. We are also concerned that in some cases he appears to have followed unacceptable medical practice. We have been very concerned at the repeated and apparently unnecessary surgery which Rodney Ledward carried out on private patients. Our impression is that he worked too fast both in the operating theatre and when he saw patients in out-patient clinics or on ward rounds, so that mistakes and upset were caused. We consider that there was probably stronger evidence of Rodney Ledward's lack of competence during this 5 year period, than there had been in the period until the end of 1985, which we have discussed in the previous section of the Report.*

22 *Rodney Ledward's Conduct*

22.1. *We have been concerned that throughout this 5 year period we have heard clear evidence that Rodney Ledward continued to pressurise patients to become private patients, and we express particular concern that some of those patients were especially vulnerable as they were seeking termination of pregnancy. We have also heard clear evidence that he failed to attend some clinics and failed to carry out some operating lists. We were most concerned to hear that he attended and treated a patient while he may have been worse the wear for drink. It appears that he continued to carry out surgery on some patients without having obtained their proper consent. We have also been told that he did not always maintain proper standards of hygiene and that on occasions he could not be contacted when he was on call. It also appears that he showed no concern when matters were raised with him and we have seen little evidence that he ever changed his practice in the light of concerns that were raised with him. It seems that his conduct in this 5 year period was below that which his patients and the Health Authority were entitled to expect.*

23. *Rodney Ledward's Attitude and Manner*

23.1. *We have heard much evidence that Rodney Ledward continued to be arrogant and uncaring in his attitude to patients and that on occasions his internal examinations could be rough and painful. It appears that he failed to provide proper explanations to his patients sometimes before he operated and sometimes after they suffered complications.*

23.2. *Overall it is our strong impression that during the period from 1985 to the end of 1990 Rodney Ledward showed much less interest in his NHS practice and spent much of his time fostering his private practice and his outside medical interests. We consider that there is substantial evidence before us to point to that conclusion in that he routinely did not attend out-patient clinics, he left his junior staff to carry out his operating lists and he left the operating theatre when he was operating, to carry out administrative work.*

24. *The Three Wise Men Committee*

24.1. *We can understand that since there was never any suggestion that Rodney Ledward was ill, concerns about Rodney Ledward were not raised with the committee. However it was an avenue that might have helped pick up that there were problems of personality and attitude, if nothing else.*

25. *Should Rodney Ledward's failings have been noted and acted upon by the South East Kent Health Authority or by the South East Thames Regional Health Authority ?*

25.1. *We are satisfied from all we have read and heard that some medical, nursing and management staff at the NHS hospitals where Rodney Ledward worked were well aware of concerns about him and his practice during this 5 year period. We accept that it was difficult for nursing staff to complain, although some did so and raised concerns with their superiors. It is clear to us that some members of the Management*

Team were aware of concerns about his practice and indeed some had concerns of their own. We accept that certain individuals tried to take steps to deal with a number of problems but our strong impression is that there was no concerted effort, no one took charge of the problem and each concern was dealt with on an ad hoc basis.

25.2. *From 1985 the District General Manager, Mr Russell, had overall responsibility for the running of the South East Kent Health Authority. He told us that he was unaware of any concerns about Rodney Ledward's clinical practice. If that is so then he should have been. Although he worked from an office in Folkestone, we consider that it was his job to ensure that the care being provided to patients at the various hospitals within his remit, was of a proper standard. Mr Russell told us that in his view there was no system in place to identify and deal with problems involving a consultant. It is our impression that everyone hoped that someone else would deal with Rodney Ledward. They knew that he was not responsive to being challenged and our view is that most took the line of least resistance. It required leadership and direction to investigate the problems and deal with them properly. In our view this required that management should talk to consultant colleagues, nursing and theatre staff, in short investigating whether there was a problem with Rodney Ledward's practice. Had that been done we consider that real concerns would have been picked up and if management were unable to deal with them, or felt inhibited from doing so because consultant contracts were held by Region, the problem should have been raised with the Regional Director of Public Health.*

25.3. *We were not impressed by the way a number of serious complaints about Rodney Ledward were dealt with by management. We accept that Rodney Ledward could be intimidating and frightening. We accept that some people who worked within the NHS remained of the view that Rodney Ledward was a good consultant and that some took the view that consultants were beyond challenge. However that can be no excuse when serious concerns are raised, for senior management failing to take steps to protect patients and professional colleagues.*

25.4. *We also express our concern that the Regional Health Authority was so little*

aware of the problems about Rodney Ledward. The Region held his contract of employment but it appears that concerns were only brought to the Region's attention on an informal basis. Indeed if Mr Russell, the District General Manager, was unaware of problems concerning Rodney Ledward it is not surprising that Region knew little.

25.5. *A number of Consultants told us they had concerns about Rodney Ledward's practice in the years up to 1990. Our impression is that they understood that the District Management team, including Mr Russell, knew of their concerns, and considered that it was up to management to deal with the problem. They may well have felt, if they considered their professional obligations as set out in the Blue Books, that since their concerns were known by management, they had complied with the duty to inform "an appropriate body". We also accept, as we have been told, that at the time it was a major step for one doctor to report his colleague to the GMC.*

26. *Should Rodney Ledward's failings have been noted and acted upon by the the private hospitals where he habitually worked?*

26.1. *We are also clear that by the end of 1990 concerns were being raised about Rodney Ledward's private practice in that the private hospitals where he habitually worked had become aware of problems with his work. We accept however that quality was still not the major remit of private hospitals at that time; there was still the culture that the provision of care to a private patient was a matter between the patient and her consultant. We have the impression that things were beginning to change over this five year period but we do not consider that we can properly criticise the private hospitals' management for failing to deal with their concerns about Rodney Ledward in the climate that then existed in the private sector.*

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PART V

RODNEY LEDWARD'S PRACTICE 1991 - 1996

1. INTRODUCTION

1.1. We have continued to try to place events in chronological order. The dates are likely to be more accurate for this period of time since recollections are fresher. However we are aware that considerable time had passed before we started our Inquiry and there is no doubt that national publicity about Rodney Ledward and his practice has coloured some recollections. Therefore even for this period of time for which we have considered Rodney Ledward's practice, we acknowledge that we may not have obtained a full picture.

2. THE HEALTH AUTHORITY ORGANISATION

2.1. The South East Kent Health Authority continued in being at the start of this 5 year period. Mr Russell continued as the District General Manager and headed the Management Team. He remained answerable to the Board of the Health Authority. In July 1993 the East Kent Commissioning Agency was established which was a joint body comprising the South East Kent Health Authority and the Canterbury and Thanet Health Authority. The Agency remained in place until the merger of the two Authorities was complete on 1st April 1994 and the East Kent Health Authority was formed. Three NHS Trusts were created under the new Health Authority, of which the South Kent Hospitals NHS Trust was one. It was responsible for the hospitals where Rodney Ledward worked. Thereafter the divisions in the various hospitals were formed into Clinical Directorates with a Clinical Director appointed, on a rotating basis, from amongst the Consultants within the Directorate.

2.2. This re-organisation was planned for some considerable time and the Trust was run in shadow form for over 6 months before April 1994, during which time it was

largely autonomous. Mr Addison, who had been employed as Unit General Manager for the WHH unit in 1991, led the hospitals in South East Kent into Trust status and in 1993 became the acting Chief Executive until the Trust was created in April 1994. He then became the Chief Executive of the new Trust. Mr Russell retired in March 1994 just before the Trust was set up and told us that until that time Mr Addison had been accountable to him. However he said that in reality, for some time before he retired, he had been winding down his role as District General Manager and that he had therefore left many matters to Mr Addison. Dr Padley was appointed as the first Medical Director of the Trust in June 1994. We have been told that a great deal of time and effort was expended by a whole range of staff in the build up to obtaining Trust status. When the Trust was created in April 1994, consultant contracts were henceforth to be held by the Trust and no longer by the Region.

2.3. *We comment that major re-organisation, although intended to be for the benefit of patients and the NHS as a whole may, while the reorganisation is taking place, paradoxically adversely affect patient care.*

2.4. The South East Thames Regional Health Authority merged with the South West Thames Regional Health Authority to become the South Thames Regional Health Authority in 1993. At the same time, regional offices of the NHS Executive were established and took over the functions of the Regional Health Authorities in April 1994. The South Thames Regional Health Authority therefore became the South Thames Regional Office of the NHS Executive.

1991

3.1.	The Patients' Charter
In 1991 the Patients' charter was published. It described the NHS as "a service that always puts the patient first, providing services that meet clearly defined national and local standards...."	

3.2. On **1st January 1991** Mr Davies became Clinical Director of the Gynaecology and Obstetric Division. He remained Director until 31st December 1992.

3.3. In **January 1991** a NHS patient underwent an abdominal hysterectomy which was advised and carried out by Rodney Ledward for early signs of cancer. The patient told us that she had found Rodney Ledward rude and abrupt and said he had told her that unless she had the hysterectomy she would have cancer or be dead within 5 years.

3.4. We were told by the Community Health Council that in **early 1991** Rodney Ledward advised one of his patients, whom he had previously persuaded to become a private patient, that she needed surgery to remove an ovarian cyst. During the course of the operation Rodney Ledward damaged the patient's bowel, which he recognised at the time and attempted to repair. We were told that he did not make a note of this in her records nor did he tell his patient what had happened. She then became seriously ill and began to drain faeces through the abdominal wound. The hospital staff were not able to contact him. He did not attend the patient until 5 days later when he told her and her family what had occurred at the operation. She had a faecal fistula through the abdominal wall and she remained in hospital for 2 months. Her problems continued so that she was referred in July 1991 to a Consultant General Surgeon, as a NHS patient for further surgery. We have not seen this patient's records nor have we heard direct evidence from her.

3.5. A NHS patient told us that in **early 1991**, when she had been expecting a baby, she was advised that she needed to have a caesarean section. She was reluctant to undergo the procedure and spoke to Rodney Ledward who agreed that she should wait to see if she went into labour spontaneously. She told us that this decision was not communicated to his junior staff and that she was operated on against her wishes. After the baby's birth she complained to the hospital and she and her husband were seen by Rodney Ledward in February 1991. She told us that he had been "rude and arrogant". The patient was not satisfied with the response from the Health Authority to her complaint.

3.6. Another NHS patient told us that in **early 1991** she had seen Rodney Ledward for a consultation after abnormal cells had been found at a smear test and she had been advised to have a cone biopsy by a Clinical Assistant. Rodney Ledward told her that she had cancer and he advised a hysterectomy without carrying out a cone biopsy first. She told us that he had said: "I will do you a favour, I will do the hysterectomy through your vagina so you will have no scars". The patient told us that she had not liked Rodney Ledward at all because he was arrogant and she had felt intimidated by him. He had treated her "as if she had no brains at all". She had therefore asked her GP to refer her elsewhere. Her GP said "that was not the done thing". The operation was carried out by Rodney Ledward in March 1991 and afterwards she suffered a major haemorrhage. He could not be contacted and another Consultant Gynaecologist attended her and took her back to theatre. The patient told us that she had been very frightened and thought she was going to die, particularly as she was asked to telephone her next of kin at midnight. On the following afternoon Rodney Ledward came to see her with a number of medical students. The patient said that he had not spoken to her, but addressed the students who were with him. He said, "This is the woman that caused all the trouble last night." The patient was very upset and was reduced to tears. She felt that she herself had been the cause of the problems. The patient told the nurses that she never wanted to see Rodney Ledward again and it was arranged that she should be looked after by the Consultant who had re-operated on her during the night. The patient required further treatment and has continued to suffer from serious problems. *We express our concern that the original hysterectomy may have been inappropriate for the condition from which this patient was suffering.*

3.7. We were told that in **April 1991** Rodney Ledward incorrectly informed a NHS patient that HRT was unavailable on the NHS and that it was only available to private patients.

3.8. Consultant contracts continued to be held by the Regional Health Authority but after **April 1991** the management of consultants' personal files was devolved to District Health Authorities.

3.9. **In May 1991** Rodney Ledward performed a biopsy of the bowel at laparotomy on a NHS patient and caused a perforation to her bowel. He did not ask for assistance from Mr Bates, Consultant General Surgeon, although he was operating in the next theatre. The surgeon told the GMC that he would have been available to assist Rodney Ledward had his help been requested. Rodney Ledward accepted before the GMC that his notes about this procedure were "weak" as he had not mentioned the nature of the tissue removed at biopsy. The Professional Conduct Committee of the GMC found that Rodney Ledward had been guilty of serious professional misconduct in relation to this patient.

3.10. In **May** 1991 Rodney Ledward damaged a patient's bladder during surgery, which he recognised and repaired. She said that she was not given any information about the surgical mishap by him or any member of his team, nor any explanation of the fact that she had to stay in hospital longer than she had expected. The patient said that she continued to suffer from incontinence.

3.11.1. Mr Bates, Consultant General Surgeon, told us that he had become very concerned about Rodney Ledward's patients by **early 1991**. Apart from the case mentioned above which went before the GMC in which Mr Bates was involved, he told us about a patient in whom, he said, Rodney Ledward had damaged the iliac vein and had asked Mr Bates for assistance. Mr Bates said it took him a whole day to do a vein graft on the patient. He also recalled one of Rodney Ledward's private patients, who was being cared for at the WHH, who was having a 5th laparotomy. He told us that Rodney Ledward went through a loop of the patient's bowel and she had

developed a fistula. Mr Bates said that Rodney Ledward did not come to see the patient once during the 5 weeks that she remained under Mr Bates' care.

3.11.2. Mr Bates said that in about **July** 1991 he went to see Mr Addison, then Unit General Manager of the William Harvey Hospital, about other matters, but at the same time mentioned his concerns about Rodney Ledward. He said he made no note of the meeting and nothing happened as a result of the meeting. However he had felt so concerned about Rodney Ledward's patients that he had also raised his concerns with Dr Forsythe, Regional Director of Public Health, who said unless Mr Bates was able to prove chapter and verse he could do nothing.

3.11.3. Dr Forsythe told us that he recalled Mr Bates speaking to him in 1991 about Rodney Ledward's professional competence and that he had asked Mr Bates to collect hard evidence together about Rodney Ledward, to see whether there was a prima facie case which would justify bringing disciplinary proceedings against him. He told us that in the early 1990s a pattern of poor performance was not sufficient to start disciplinary proceedings; he said that he needed hard evidence of a handful of examples of serious incompetence. He said that Mr Bates had come to see him about other matters but while talking had raised the question of Rodney Ledward's competence. Dr Forsythe did not feel it was his job to go into the division and investigate. He said that it was only from the conversation with Mr Bates in 1991 that he ever had any knowledge that there was a query over Rodney Ledward's competence. He told us that he had subsequently spoken to Mr Russell about the matter and had also asked him for hard evidence of a few examples of serious incompetence, but that he had heard nothing more.

3.11.4. During the course of our Inquiry we asked Mr Addison, who was then Unit General Manager at the WHH, what he could recall of the conversation he was said to have had with Mr Bates in 1991. He told us that he had no recollection of any discussion about Rodney Ledward. He said that after he was appointed Unit General Manager he made a point of seeing every Consultant and he accepted that it was during the course of such a meeting that Mr Bates must have spoken to him about Rodney Ledward. However he had no recollection about any such discussion. He

certainly had no note.

3.11.5. Mr Russell, who was the District General Manager in 1991, told us that he recalled Dr Forsythe telephoning him as a result of a discussion with Mr Bates. Mr Russell thought this was in about 1993 but from the evidence we have heard we believe it must have been a conversation which took place in 1991. Dr Forsythe apparently told Mr Russell that the general surgeons had concerns about Rodney Ledward's complications after surgery. Mr Russell told us that he understood that the surgeons were to monitor the position closely and Dr Forsythe was simply alerting Mr Russell to the problem. Mr Russell thought that he would have spoken about this to the District Management Team but he could recall nothing else about the matter. It does not appear that he discussed the concerns with Mr Bates.

3.12.	**The Health of the Nation**
In **June** 1991 the Department of Health published a discussion paper entitled The Health Of the Nation. It set out the Government's proposals for the development of a health strategy.	

3.13. In **July** 1991 Rodney Ledward carried out a laparoscopy on a private patient, as well as a D & C. Rodney Ledward then advised her to undergo hysterectomy which was carried out in September 1991. She told us that as he was the expert, she had put herself in his hands. The patient continued to suffer from problems but it was her impression that Rodney Ledward felt she was making a fuss. After he was struck off she contacted the WHH and further minor surgery was carried out which resolved her problem.

3.14. In **July** 1991 Rodney Ledward carried out a laparoscopy on a private patient and told her that he had found fibroids. In August 1991 the patient was advised by Rodney Ledward to undergo vaginal hysterectomy "straightaway". She underwent the surgery but fibroids were not confirmed at histology. Post operatively she suffered a deep vein thrombosis. Rodney Ledward stated at the time that she had

been given heparin as a prophylactic measure. We could find no record of his ordering such treatment or that it had been given. The patient had believed that she was to be treated as a NHS patient for the hysterectomy and was very surprised when she received an invoice from the hospital and she complained. This was resolved by the WHH and she did not pay for that surgery.

3.15. We were informed by a NHS patient that in **August** 1991 she had been referred to Rodney Ledward by her GP for specialist care after 10 years of infertility. The patient told us that Rodney Ledward had carried out an internal examination but that no chaperone was present. She told us that she was very upset by what Rodney Ledward had done and what he had said at the appointment but she had not felt able to complain at the time. Subsequently she agreed to undergo laparoscopy as advised by Rodney Ledward. *We express concern that a vaginal examination may have been carried out in the absence of a chaperone. We also comment that this patient appears to be another example of a vulnerable woman who felt unable to tell her husband or her GP or anyone else about her concerns.*

3.16. We were told that Rodney Ledward carried out a hysterectomy on a patient in **August** 1991. She was treated privately at St Saviour's Hospital under the auspices of the St Saviour's Charitable Trust. The patient suffered a primary haemorrhage and was taken back to the theatre for re-operation. She then suffered a wound abscess. The patient told us that Rodney Ledward did not come to see her to explain what had happened.

3.17. In **October** 1991 Mr Addison received a complaint from the mother of a patient about Rodney Ledward's arrogance, his lack of compassion and poor bedside manner which had reduced her daughter to tears. The patient's mother also commented that she too had also been subjected to Rodney Ledward's arrogance when she had undergone a hysterectomy some time previously. She complained that it seemed to be beneath him to deal with NHS patients. A meeting was suggested but the patient's parent was unable to attend. It was suggested that a further appointment be made for them to meet Rodney Ledward but neither the patient nor her family pursued that suggestion. The file was closed.

3.18. In **December** 1991 a patient complained that she had been referred to Rodney Ledward for termination of pregnancy but, after asking her for her name and age, and without any further discussion or examination, she said that he told her the procedure could not be carried out on the NHS. The patient therefore paid for the operation privately. A Senior Nurse for Quality Assurance replied to the patient's complaint and said that the reason the patient had not been examined was that she had been unwilling to accept earlier advice about contraception. The patient replied in some distress and anger. She repeated her complaint that Rodney Ledward had simply asked her 2 questions and then said "No". She also said she had followed the contraceptive advice given but that there was a fault in the device used. She asked for an apology from Rodney Ledward. She finally met the Director of Nursing Services who wrote thereafter and apologised "that you were upset by Rodney Ledward when you visited his clinic." No comment from Rodney Ledward was recorded about this complaint.

3.19. In **1991** Rodney Ledward advised and carried out a bladder repair on a private patient during which he made a hole in her bladder which he repaired at the time. Her incontinence deteriorated and he carried out a further operation in 1992 which again did not resolve her problem. She said that he told her she had suffered problems because her bladder was small and thin. Finally she was referred to a urologist and had further surgery. The patient told us that she thought it was "her fault" that she had such problems. She also told us that Rodney Ledward had given her regular HRT implants on a private basis.

3.20. Mrs Watts, Business Manager, told us that soon after her appointment in **1991** there was a problem one evening with lack of staff at the Buckland Hospital, Dover. She had considered that the Obstetric and Gynaecology Division at the Buckland had to be closed to emergency admissions and she tried to contact Rodney Ledward who was on call. She could not contact him until after 9pm that evening and by then she had already taken the decision to close the Division, without any clinical input. She had not wished to do so but since she could not contact Rodney Ledward she felt she had no alternative. She told us that when she was finally able to contact him, it was her view that he was not wholly coherent.

1992

4.1. In **January 1992** Rodney Ledward carried out a cystoscopy on a private patient. *We are concerned that we have found nothing in the patient's records to indicate that she was suffering from any symptoms which warranted that procedure. We also comment that Rodney Ledward had carried out a number of surgical procedures on this patient between 1981 and 1983 and we have already expressed our concern as to whether all those procedures were medically necessary.*

4.2. On **2nd March 1992** a patient complained that she had attended an appointment to see Rodney Ledward but that he was not there. The matter was investigated and it was said that Rodney Ledward apologised to the patient when he saw her in clinic some 2 weeks later. There is no record of any response from the hospital to the patient.

4.3. In **March** 1992 Rodney Ledward carried out a Caesarean section on a patient during the course of which he made a hole in her bladder.

On 12th **June** 1992 a patient complained about her treatment by Rodney Ledward after she had suffered the tragedy of a stillbirth. Her postnatal appointment was arranged to be with Rodney Ledward because of the difficulties she had experienced, but the original appointment was cancelled without any reason being given. On arrival for the rearranged appointment Rodney Ledward was not there and another doctor (who did not have all her notes) asked her whether she was breast feeding. She was very distressed. As a result of her complaint Rodney Ledward saw the patient on 30th June 1992 and advised her about any future pregnancy. A fulsome letter of apology was sent to the patient by the Director of Nursing Services.

4.4. On **13th August 1992** a patient made a formal complaint about Rodney Ledward to the hospital. She complained that Rodney Ledward had inserted an instrument into her vagina without informing her what he intended to do. She said

that she had also been examined by students while she was on her side although she had not been asked to agree to students being present or examining her. She complained that the insertion of the instrument and its extraction had been rough and that Rodney Ledward had been curt and had given her little or no explanation of his findings or his proposed treatment. The patient said she was in tears as a result of the consultation and in pain. She complained to the nursing staff immediately about her treatment. Her written complaint, made within days of her seeing Rodney Ledward, is in the most graphic and distressing terms. A meeting was arranged with Rodney Ledward and the patient was accompanied by a friend (who was a legal executive) when she saw him on 25th August 1992. Although a junior doctor made a statement at the time that the examination had been carried our properly, Rodney Ledward wrote to Mr Addison stating that he had carried out cauterisation "to save time", had apologised that he had not lived up to the patient's expectation, and said that he had been "less than perfect on this occasion". The patient was not fully satisfied but she was assured by the Director of Nursing Services that she would look into the matter of quality of service. The patient wrote finally to say that her care had now been transferred to another gynaecologist about whom she had nothing but praise.

4.5. A patient told us that in about **October** 1992 she had undergone a laparoscopy under Rodney Ledward at St Saviour's. She had been a NHS patient but he had suggested she take advantage of the St Saviour's Charitable Trust which, he said, would pay for the operation. She had never heard of the Trust before. Afterwards Rodney Ledward suggested that she had a total hysterectomy again using the funds of the St Saviour's Charitable Trust. This was carried out in December 1992.

4.6.1. In **October** 1992 Rodney Ledward carried out hysterectomy on a private patient at St Saviour's Hospital and also removed her ovaries. He had not previously discussed with the patient that he might remove her ovaries and she did not consent. Subsequently she learned that her ovaries had been removed. She suffered a haemorrhage after the surgery but Rodney Ledward could not be contacted. He came to see her on the following day and then re-operated. She was given a number of blood transfusions. She went on to develop urinary incontinence and Mr Derry, Consultant General Surgeon, was asked to see her. He re-operated and found that

sutures had been placed round and through the ureter. She consulted her solicitor and brought a claim against Rodney Ledward which was settled.

4.6.2. This patient's case was one of those brought before the GMC and in respect of which Rodney Ledward was found guilty of serious professional misconduct. He told the GMC that he had discussed removal of the patient's ovaries but had failed to ensure that this was written on the consent form. He said that the pedicle had probably slipped causing the haemorrhage and that the nick to the patient's bladder had probably occurred at the re-operation. He accepted that he had sent a letter to the patient's GP saying that her surgery had been "uncomplicated". He said he had written it immediately after the original surgery. However he agreed that he had signed the letter 8 days later by which time he was aware that the patient had suffered serious complications. He also accepted that he had gone to London for a meeting after he had carried out the hysterectomy and had not arranged Consultant cover for her that evening.

4.7. The Community Health Council told us about one of Rodney Ledward's former NHS patients who was referred to Rodney Ledward by her GP in **1992**. We were told that Rodney Ledward advised her to undergo hysterectomy but said that there was a 12 month waiting list. He said that she could have the operation done privately at St Saviour's immediately or she would have to undergo regular D&Cs requiring time off work for each procedure until her name reached the top of the NHS waiting list. The patient had felt that her only course of action was to agree to pay for private treatment and she paid £3,340. She consented to hysterectomy but after the operation Rodney Ledward told her that he had also removed her ovaries as "you won't be needing them any more will you?" He also said to her: "it saves going back in, if there are problems." In fact the patient had signed the consent form for oophorectomy but we were told that Rodney Ledward had not explained that he intended to remove her ovaries, and no one else had explained the word to her.

4.8.1. In **December** 1992 a GP complained that a patient, whom he had referred for termination of pregnancy, had been told by Rodney Ledward that no bed was available at the Buckland Hospital before January 1993 when she would be 16 weeks

pregnant. He had said that if she went to the hospital with £600 in cash he would find her a private bed. She agreed and Rodney Ledward had carried out the procedure in December 1992. Mr Russell passed the complaint to the Chairman of the Medical Staff Committee who set up a Professional Review Panel for 10th February 1993 to discuss the matter with Rodney Ledward. At the last minute Rodney Ledward sent a message to say that he could not attend. However later that day he told the Chairman of the Committee that no NHS bed had been available but that when the patient had been prepared to go privately a bed had been found. Rodney Ledward suggested that this was a contrivance by the Hospital to generate funds. Mr Russell then carried out his own investigation and came to the view that there was no truth in Rodney Ledward's suggestion. He put the matter before Mr Addison, Unit General Manager.

4.8.2. Mr Addison told us that he had investigated the matter and had learned that a NHS bed had been available on the day in question. He then spoke to Rodney Ledward and told him that there was no question of this being a contrivance by the hospital to generate funds, and told him that his conduct was unacceptable.

1993

5.1. On **1st January 1993** Rodney Ledward was appointed the Clinical Director of the Obstetric and Gynaecology Division. He held this post until 31st December 1994.

5.2. It was also on **1st January 1993** that an agreement between the South East Kent Health Authority and TSI Ltd came into force, whereby TSI agreed to pay to the Health Authority £500 per annum for the use of Rodney Ledward's office at Folkestone Ward in the WHH and for secretarial services. Telephone calls and postage within the UK were also to be provided by the WHH, but calls and postage outside the UK were to be covered "by arrangement". It appears that the Health Authority wished to regularise the use of the WHH for TSI business and this

agreement was reached. *We have not seen any evidence to suggest that any arrangement was ever made for the cost of overseas calls or postage. The Health Authority seem to have had some concerns that the agreement was being abused but we could find no evidence of any investigation having been carried out. Eventually the agreement was terminated in 1995 by Mr Addison, then Chief Executive.*

5.3.1. In **January** 1993 we were informed that there was a long waiting list for gynaecological operations within the Division. Mrs Watts, the Business Manager, told us that she had proposed a waiting list initiative on Saturday mornings to the Consultant Gynaecologists, to try to reduce the backlog of operations. Rodney Ledward was one of those who expressed an interest. She had made it clear that only 3 major operations were to be carried out at a session with a fee fixed for each operation. It was agreed that Rodney Ledward should carry out an operating list on a Saturday morning in January 1993 between 8am and 12 midday. However he carried out 7 major operations.

5.3.2. From theatre lists and other documents produced to us it seems that Rodney Ledward carried out the following procedures on that Saturday morning:

	Start	**Finish**	**Operation**
Operation 1	0755	0830	Abdominal hysterectomy
Operation 2	0833	0900	Total abdominal hysterectomy
Operation 3	0908	0950	Total abdominal hysterectomy
Operation 4	0955	1020	Vaginal hysterectomy
Operation 5	1021	1040	Vaginal hysterectomy
Operation 6	1040	1120	Total abdominal hysterectomy
Operation 7	1122	1200	Total abdominal hysterectomy + Marshall Marchetti Kranz

5.3.3. Mrs Watts told us that when she discovered what Rodney Ledward had done, he was not permitted to take part in the waiting list initiative again. She became aware from the other Consultants soon after the list had been carried out, that 3 of the patients had suffered complications and that their GPs had been called to attend them.

Mr Stewart and Mr Davies confirmed what Mrs Watts had told us. Mr Davies said that as the Consultant was to be paid a fee for each procedure, the more Rodney Ledward did, the more he was paid. Mr Stewart said the number of major procedures had been limited to 3 and it was his view that Rodney Ledward had carried out too many procedures too quickly.

5.3.4. We were told that those 3 patients subsequently brought claims in negligence in respect of their operations and the Health Authority settled each claim. The first claim was notified on 11th February 1993. The patient suffered a haemorrhage and required further surgery. The Health Authority accepted that the vaginal hysterectomy had been carried out negligently and probably too quickly. Her claim was settled in 1997. The second claim was made in April 1994. The patient had undergone a hysterectomy during which it was alleged that the blood vessels were nor properly tied, and the patient suffered a vault haematoma. Her claim was settled in 1997. The third claim arising from this operating list was notified to the Health Authority in October 1994. It was alleged that the wrong ovary had been removed, the patient had suffered post operative infection and she suffered from bladder problems. Her claim was settled in 1997.

5.3.5. Mr O'Neill, then Business Director of the Health Authority, told us that he knew by October 1994 that 3 claims had been notified by patients operated on by Rodney Ledward during that morning. He said that Rodney Ledward's reaction to each allegation was that there was nothing to answer. Mr O'Neill had discussed the complaints with the person who had been theatre manager in January 1993. He told us that the view was that Rodney Ledward had done too much on that day.

5.3.6. Mr Addison told us that he became aware of the claims as they were being dealt with, when he was Chief Executive of the Trust, but he could not recall when he had become aware that all 3 claims arose from one operating list.

5.4. In **February** 1993 judgment was given in the High Court in a claim brought against Rodney Ledward by a patient, to which we have already referred. The Judge held that Rodney Ledward was not liable.

5.5. In **March** 1993 a NHS patient informed us that Rodney Ledward "had treated me as one of the herd". We were told that he spent no more than 2 minutes with the patient at consultation when he advised her to undergo hysterectomy and the patient felt that he was not in the least caring. She was very upset by his lack of interest and communication.

5.6. It was also in **March** 1993 that Rodney Ledward carried out a total abdominal hysterectomy and removal of ovaries on a NHS patient. The consent form signed by the patient made no mention that her ovaries were to be removed. After the surgery she suffered a primary haemorrhage and had to be taken back to theatre.

5.7. A patient also complained to us about Rodney Ledward's flippant attitude to her when she suffered haemorrhage after undergoing a hysterectomy as a NHS patient in **March** 1993. On one occasion when Rodney Ledward came to see her, he slapped her stomach on top of her incision and told her that she would soon find a boyfriend. She told us that she had been very upset by his attitude.

5.8. On **21st and 22nd March** 1993 Rodney Ledward could not be contacted about one of his private patients when she developed a pelvic abscess after he had operated to remove an ovary at St Saviour's Hospital. He then attended her and drained the abscess but her bowel had been damaged and she developed a colo-vaginal fistula and he referred her to Mr McPartlin, a General Surgeon. Mr McPartlin carried out a colostomy on the patient and she told us that while she was in hospital Rodney Ledward put his head round the door and told her to "keep her chin up", but otherwise he had not spoken to her or given any explanation for her problem. She told us that Rodney Ledward never spoke to her again despite her continuing problems and further major surgery. She said that his attitude was totally different when she had been a private patient to that when she was a NHS patient.

5.9. In **April** 1993 Rodney Ledward delegated the operation of vaginal hysterectomy to his Registrar when the patient had a double uterus and a complicated gynaecological history. This NHS patient's case was one of those brought before the

GMC. Rodney Ledward was found guilty of serious professional misconduct in that it was held inappropriate for him to have delegated this surgery to his registrar. He had not read the patient's notes before delegating the surgery. At operation the registrar removed one uterus but did not remove the other. In August 1993 Rodney Ledward carried out a further vaginal hysterectomy to remove the other uterus. The patient suffered a severe post operative haemorrhage but Rodney Ledward was unavailable to attend her.

5.10. We were informed about a patient whom we were told was persuaded by Rodney Ledward to become a private patient. He carried out surgery on her in **April** 1993 and transferred her back to the NHS as a result of his findings at surgery. He could not be contacted post operatively when she became seriously ill and another Consultant had to be asked to attend the patient.

5.11.	**Guidance for Staff on relations with Public and Media**
In **June** 1993 the Department of Health published guidance for staff encouraging openness and dialogue within the NHS. It was stated that the NHS exists to meet the needs of patients and went on to say that all NHS staff have a duty to draw to the attention of managers any matter they consider to be damaging to the interest of a patient.	

5.12.	**Reporting Adverse Incidents**
Also in **June** 1993 the Department of Health published guidance to ensure the prompt reporting of adverse incidents in particular in relation to medicines and defective equipment.	

5.13.1. In **July** 1993 we were told that a Locum Consultant was covering for Rodney Ledward who was away on leave. A gynaecology clinic was booked for 27th July 1993 starting at 0830. 9 patients were booked in at 5 minute intervals finishing at

0910. In addition a further 2 patients were double booked. The Locum arrived at 0850. The Out Patient Sister told us that the Locum took 15 -20 minutes for each patient, unlike Rodney Ledward, who only allowed 5 minutes or less for each patient. *We comment that allowing only 5 minutes for each patient in a gynaecology outpatient clinic does not seem sufficient to talk to the patient, examine her, and explain the findings and treatment proposed. It seems unsurprising that the Locum was not able to work within the 5 minute time allotted for each patient.*

5.13.2. The Out Patient Sister told us that she contacted the Director of Nursing and suggested that if the locum doctor was still to be employed at the WHH, then different arrangements should be made for appointments and that only 6 new patients should be given appointments for his clinic. The Director of Nursing spoke to Rodney Ledward about the matter. The Sister told us that when Rodney Ledward heard what she had done he had been furious with her. He had shouted at her and criticised her for going behind his back. She said that he "tore her apart" when she told him that she had been acting as the patients' advocate. She was reduced to tears and was very angry and upset. Thereafter the Sister said she did not accompany Rodney Ledward when he came to clinics because their working relationship had broken down.

5.14.1. On **16th July 1993** a GP wrote to Mr Addison,Unit General Manager, regarding a patient. The patient had been expecting a baby and Rodney Ledward advised her to have a caesarean section. She and her husband asked that she be given an epidural anaesthetic for the caesarean. Rodney Ledward told them that this was not available on the NHS but that if she was insured he could arrange for the procedure to be carried out privately. She agreed to become a private patient and her insurance company paid for the caesarean section and the epidural anaesthetic to which she contributed £90 by way of excess. The whole procedure was carried out at the WHH. Mr Addison spoke to Rodney Ledward about the matter. Rodney Ledward said that he had felt he needed to treat the patient privately because he required confidence in the anaesthetist. The NHS anaesthetist told Mr Addison that he had special skills in giving epidurals in Obstetrics. Mr Addison then wrote to Rodney Ledward on 26th August 1993 asking him why he had no confidence in his NHS anaesthetist. A meeting was

arranged for 17th September 1993 to discuss the matter.

5.14.2. Mr Addison told us that at the meeting Rodney Ledward had agreed that there was a NHS anaesthetist employed at the WHH who had the expertise to give an epidural, but said that the anaesthetist was not always available and that therefore he had mentioned the private sector to the patient. Mr Addison had said to Rodney Ledward that if he felt that there were shortcomings in the provision of anaesthetic care he should discuss the matter with the Director of that division and the anaesthetist who had expertise in epidurals.

5.15.	**Clinical Audit**
In **July** 1993 the Department of Health published a document entitled Clinical Audit. The purpose of the circular was to review the process started in 1989 pursuant to the document entitled "Working for Patients" and set out the Department's policy for development of multi-professional clinical audit.	

5.16.1. We were told that a GP arranged for one of his patient's to have an urgent appointment to see Rodney Ledward in his outpatient clinic on **17th August** 1993. The patient arrived for the appointment in time, she saw Rodney Ledward come out of his room and leave the clinic area. The patient was then told that Rodney Ledward had left the clinic for the afternoon and she was asked if she would see his registrar or come back to see Rodney Ledward the following week. She decided that since her appointment was urgent and she had taken a day off work, she would see the registrar. She made a formal written complaint in strong terms. Rodney Ledward was asked about this matter, and stated that the patient's notes had not been brought to his attention and therefore he could "understand the patient's irritation." The Unit General Manager, Mr Addison, apologised to the patient about the failure of the nurses to bring her notes to Rodney Ledward's attention while he was in clinic.

5.16.2. The patient then wrote to say that she knew Rodney Ledward had been contacted by the nursing staff while she was in clinic but he had refused to return and had himself suggested she was seen by his Registrar. The nursing staff subsequently

learned that they had been blamed for the patient's complaints. The Out-patient Sister wrote to Miss Kennett, Chief Nursing Officer, on 26th November 1993 to say that Rodney Ledward's assertions were a "total fabrication" as the patient had been seen by the Registrar on Rodney Ledward's instructions. The Sister was upset that her staff had been wrongly accused. This was confirmed to us by the Sister when she gave oral evidence to us. She told us that it was not that unusual an occurrence that Rodney Ledward left a clinic when someone wanted to see him. Miss Kennett told us that she had no recollection of the incident.

5.17.1. Mrs Watts, Business Manager, told us that in **August** 1993 she discovered by chance that drug representatives were making payments to Rodney Ledward in connection with the Tuesday educational meetings which he ran for the junior staff. She told us that his secretary, Mrs Woodcock, was not there for one Tuesday meeting and that Mrs Watts had been given an envelope from a drug company containing a cheque made payable to the Unit Teaching Fund. She said that she knew there was no such fund but learned that Rodney Ledward asked drug companies to pay for the Tuesday meetings. Mrs Watts raised this matter with one of the Consultant Gynaecologists and she understood that a letter was sent to Rodney Ledward about the matter.

5.17.2. Mr Stewart, Consultant Gynaecologist, said that he had received a cheque (probably from Mrs Watts) for a teaching fund which the directorate did not own. He discovered that this was a private fund held by Rodney Ledward, into which money went from drug companies who attended the Tuesday lunchtime clinical meetings. Rodney Ledward was asked about it and promised to produce audited accounts but Mr Stewart said that they never were produced. The account was closed. Mr Stewart then set up a teaching fund under the hospital auspices for the Tuesday meetings and he became aware that there was always a surplus after the meetings. Mr Stewart told us that he was concerned as to how the surplus had previously been used.

5.18. At the beginning of **September** 1993 a NHS patient was admitted for the birth of her baby by caesarean section. 6 days later the wound became infected and Rodney Ledward came to see her. She told us that she was very upset by his attitude

and what she felt was his lack of compassion or care. She told us that he said "it was a bit of a bore" and she had been made to feel that it was she who was the bore. She had made a formal complaint to the Community Health Council shortly thereafter. Rodney Ledward was contacted about the matter and suggested that the patient should come to see him. She was unwilling so to do. Mr Addison wrote to the patient apologising for Rodney Ledward's attitude.

5.19. In **September** 1993 a NHS patient was admitted to the WHH at 38 weeks for induction of her baby as she had undergone a caesarean section with her previous child. She was examined and advised by a junior doctor that she would again need to have a caesarean section. She explained that she was unhappy about this and Rodney Ledward came to see her. After the birth of her baby she complained in a letter dated 16th October 1993 that Rodney Ledward had not examined her but told her she had to undergo a caesarean as her baby was too big. Rodney Ledward responded to the complaint by saying that a caesarean section had been correct in the baby's and mother's interests. A reply was sent to the patient on 22nd December 1993 from Mr Addison, Unit General Manager, in which reliance was placed on the fact that the mother suffered from gestational diabetes, the baby felt large on examination and the baby's head was not in the pelvis. *Whilst we have no concerns about Rodney Ledward's clinical care we are concerned that the patient's complaint of failure by Rodney Ledward to examine her was never properly addressed.*

5.20. In **September** 1993 Rodney Ledward removed the ovaries of a patient at St Saviour's Hospital. The patient was able, at Rodney Ledward's suggestion, to obtain funds from the St Saviour's Charitable Trust. She was discharged home but 4 days later was admitted to the WHH with a large haematoma. Her problems continued but she refused the undergo the further surgery that Rodney Ledward advised. She then saw another Gynaecologist. The patient remains concerned that her left ovary was not in fact removed.

5.21. Rodney Ledward (and others) published an article in the Journal of Obstetrics and Gynaecology in **September** 1993 entitled: "Vaginal Hysterectomy - Study of Early Discharge and Implications". The article stated that, "Early discharge

following vaginal hysterectomy is safe and economical." This paper, based on the work of Rodney Ledward's team, provided evidence that the technique was safe and of benefit to patients. The paper discussed 20 patients who had vaginal hysterectomy of whom the only complications referred to were one patient who suffered a deep vein thrombosis after discharge from hospital and another patient who suffered a vaginal cuff infection and was treated with antibiotics. *We do not know how the patients were selected for this study. From what we have seen and heard about complications that arose after Rodney Ledward had carried out vaginal hysterectomies, we are concerned as to whether the article accurately reflected his work in this specialist area.*

5.22. A patient, who had undergone hysterectomy as Rodney Ledward's private patient in 1988, and who had been followed up by him every 6 months thereafter, told us that in **October** 1993 Rodney Ledward advised her to have a bladder repair operation. She was unaware of problems before the operation and told us that she was worse after the operation. Rodney Ledward told her she had to give it time. Her post operative problems did not resolve and she then went to see another Gynaecologist. He advised physiotherapy which was of some help. She told us that she considered that Rodney Ledward had only carried out the bladder repair "for financial gain as BUPA paid all the bills." She also said to us: "It is not easy for ordinary people to question the opinions of consultants - we go to them because we assume they know what they are doing. I wish now I had never had the bladder repair. It clearly was not necessary."

5.23. Mr Bates, Consultant General Surgeon, told us that in **October** 1993 he recalled that Rodney Ledward had carried out a laparoscopy on a patient during which her bowel was injured. Mr Bates told us that Rodney Ledward asked for assistance from a surgical Registrar from the outpatient department although 2 consultant surgeons were operating in nearby theatres at the time. The Registrar had complained to Mr Bates about the matter. He told us that the Registrar had complained that Rodney Ledward had entered a patient's bowel and that after the Registrar arrived in the theatre Rodney Ledward left. However he had not removed the ovarian cyst for which the patient was being operated, so that the Registrar had to

carry out that procedure too.

5.24. In **November** 1993 Mr Addison, Unit General Manager, wrote to a patient after she complained that she had suffered haemorrhage after Rodney Ledward had carried out a vaginal hysterectomy. In the letter Mr Addison stated that the patient had suffered a rare complication. Mr Addison also accepted that the patient had found her subsequent meeting with Rodney Ledward unsatisfactory.

5.25. In **November** 1993 Rodney Ledward carried out a vaginal hysterectomy on a NHS patient after which she suffered a primary haemorrhage. Rodney Ledward did not then attend his patient because he said he was attending an audit meeting. She was therefore taken back to theatre by his Registrar who found that haemostasis had been inadequate at the original operation in that she had bled from both pedicles. This case was considered by the GMC and Rodney Ledward was found to have been guilty of serious professional misconduct. He told the disciplinary committee that he had not been able to attend the patient when she haemorrhaged as he had been at an audit meeting with his colleagues and that his registrar was sufficiently experienced to carry out the re-operation. He said that bleeding from pedicles is a recognised complication of vaginal hysterectomy. Rodney Ledward wrote a letter post the hysterectomy to the patient's GP but did not mention that the patient had suffered any complications.

5.26. It was also in **November** 1993 that Rodney Ledward delegated laparotomy, to remove the ovaries of a NHS patient, to his Registrar. The surgery was likely to be difficult because the patient was obese, and had pelvic adhesions from a long surgical history. This patient's case was also considered by the GMC. Rodney Ledward told the GMC that he had been operating in the opposite theatre at the time, doing a D&C, and the Registrar could have called him in if necessary. The patient subsequently developed a large haematoma and abscess. Rodney Ledward was then not available to attend the patient but he arranged for antibiotic cover and for a consultant colleague to cover for him while he was in London. The Staff Nurse told us about this patient and said that the nurses had all been aware that the abscess needed to be drained, but Rodney Ledward failed to come to see her. The abscess burst. The

Staff Nurse said that when the abscess burst it had been traumatic for the patient and for the nursing staff. Mr Derry, Consultant General Surgeon, was then called to see her. He arranged for her to have urgent surgery for faecal peritonitis. The patient had required nursing on the Intensive Care Unit. Rodney Ledward was found to have been guilty of serious professional misconduct in respect of his care of this patient.

5.27.1. Mr Bates, Consultant General Surgeon, told us about 2 cases which occurred in **November** 1993 where each patient had suffered haemorrhage after a vaginal hysterectomy which had been carried out by Rodney Ledward. We have been unable to discover if the NHS patient concerned was the same patient to whom we have just referred. Mr Bates also told us that one patient was operated on at St Saviour's and one at the WHH. Each patient had to be returned to theatre. Mr Bates wrote to Mr Addison on 11th November 1993 about his concerns regarding Rodney Ledward's practice. He wrote in the letter:

> "I have today been asked to see a patient of Mr Ledward by one of his gynaecological colleagues. Complications may follow any operation but you are aware that there is grave concern amongst his surgical colleagues that the frequency with which these occur puts his patients in danger.
>
> Regretfully, the problems continue and I am therefore putting my concerns to you in writing."

5.27.2. As a result a meeting was held in **December** 1993 which Mr Bates, Mr Addison, Mr Davies and Mr Stewart attended. Mr Derry knew about the meeting and discussed matters with Mr Bates and Mr Addison both before and after the meeting took place. He was unable to attend himself.

5.27.3. Mr Bates told us that at the meeting it was agreed that there were concerns about Rodney Ledward's surgical competence, about the financial aspects of TSI, about his steering patients towards private practice and his approach to terminations of pregnancy. It was decided that there should be an audit. This would cover all surgical specialities not just the 3 Consultant Gynaecologists, so that proper comparisons could be made. It was also decided to contact both the St Saviour's and Chaucer Hospitals. However Mr Bates told us that this did not happen.

5.27.4. Mr Davies, Consultant Gynaecologist, told us that he went to the meeting and that the surgeons had raised a number of serious concerns about Rodney Ledward with Mr Addison. Mr Davies was under the impression that Mr Addison was also concerned but felt that good, hard evidence needed to be obtained. Mr Davies had understood that, as a result of the meeting, an audit was to be set up which would cover all surgical specialities and all consultants, and that the Health Authority would be asked to carry it out. He had understood that the audit would be set up and would run from about April 1994 -April 1995. However he told us, nothing happened.

5.27.5. Mr Stewart also recalled that at the meeting it was suggested that there should be an external audit across all surgical specialities. However he said it did not happen. He told us that he and the others spoke to Mr Tempest at St Saviour's Hospital about carrying out an audit there. Mr Stewart told us that it was his greatest regret that no audit was in fact carried out in 1993. He felt that the surgeons should have pushed Mr Addison when no audit was organised, and he felt that they all shared the blame for not carrying their plan into effect.

5.27.6. Mr Addison, who was then Unit General Manager, told us that he remembered receiving the letter dated 11th November 1993 from Mr Bates, who had then come to see him to express further concerns about Rodney Ledward's clinical competence. He had a meeting in December attended by Mr Bates, Mr Stewart and Mr Davies. He told us that he could not recall the meeting well, but accepted that probably concerns were expressed about the quantity of problems and the quality of Rodney Ledward's practice. Mr Addison told us that it was most unusual to have general surgeons and gynaecologists raising an issue about a colleague's practice.

The meetings was not minuted. He accepted that the outcome was a decision that some kind of audit was needed of the surgical practice of all the Consultant Gynaecologists and also, in order to be fair, of all the General Surgeons. However this was not done. Mr Addison was not clear why he had not done so and he had felt that he had overlooked the matter. However he said that at the time he had been dealing with a serious problem in another division of the WHH, which was not functioning properly, and he also said that much of his time was taken up in dealing with arrangements for the transition to Trust status. Mr Addison also told us that had an audit been undertaken he doubted whether there would have been sufficient cooperation from all the consultants to provide a useful conclusion.

5.27.7. Dr Farebrother, Director of Public Health for the South East Kent Health Authority recalled that in about 1993 a suggestion was made to her by Mr Stewart and Mr Davies that Rodney Ledward had a higher complication rate for taking patients back to theatre for re-operations than his consultant colleagues. She said they realised they could not obtain information about this unless each patients' notes were gone though individually, and that it was an exercise that would have to be undertaken in respect of each of the four Consultants to provide a proper reference point. She said that she was aware that it was also suggested that this sort of exercise should be carried out across the whole Consultant body and that this had been a daunting prospect. She said that it was "such an enormous exercise that we did not in fact do it." She accepted that the theatre register might have shown the return rate to theatre. However she felt that at the time the proposed audit had not been feasible.

5.27.8. Mr Russell, District General Manager, told us that he knew nothing about this meeting or the concerns of the surgeons.

5.27.9. Mr Bates told us that after the meeting in December 1993, he had, when looking through a patient's notes, by chance come across a letter written by Rodney Ledward on 11th September 1985 to Professor Blandy at the London Hospital. We have already referred to this letter in Part IV of our Report. In the letter Rodney Ledward had referred a patient to Professor Blandy as she had a vesico-vaginal fistula. He had written:

"I have to despair, and ask your forgiveness for sending you the third and almost certainly final case of vesico-vaginal fistula."

Mr Bates told us that he sent a copy to Mr Addison who said he would follow up the matter, but Mr Bates said that this did not happen.

5.27.10. Mr Addison gave evidence to us that he had not told Mr Bates that he would follow up the letter. He did not consider that this letter, which had been written in 1985, supported the concerns Mr Bates had in 1993.

5.28.1. On **20th December 1993** Mr Addison wrote to Rodney Ledward about a meeting which Miss Kennett had also attended at which a number of concerns had been raised. The letter stated that it had been agreed: "that it might be sensible not to make reference to the possibility of private patient treatment as an option in the course of your first consultation with a patient." The letter went on to note that a particular locum consultant was no longer to be used by Rodney Ledward and also referred to the fact that it had been agreed that "there might be benefit to be gained in obtaining a specialist psychology opinion on how best to defuse difficult situations which inevitably crop up in the course of caring for patients." It also suggested that complaints should be discussed at divisional meetings to avoid repetition of problems and emphasised the importance of receiving replies to complaints within 2 weeks.

5.28.2. Miss Kennett recalled the meeting between herself, Mr Addison and Rodney Ledward in December 1993 when they had raised a number of concerns with Rodney Ledward. She recalled that she had terrible trouble trying to set up the meeting. She said that nailing Rodney Ledward to a meeting was an art form. She told us that although the letter stated that the meeting had been constructive she had not been convinced that things would change. She accepted that with hindsight the letter which was sent subsequently to Rodney Ledward should have been more frank.

5.29. Mr Stewart told us that in about **1993** Miss Kennett had raised with him the question of Rodney Ledward's practice of steering patients to become private

patients. Mr Stewart raised the issue at a meeting of the Consultants Gynaecologists. They all, including Rodney Ledward, agreed that patients should not be pressurised.

5.30. A GP told us that in **late 1993,** at a meeting of the South East Kent General Practitioner Committee, Rodney Ledward's competence was raised. The GP had told the Committee that he had been informed that Rodney Ledward's admitting rights to the Chaucer Hospital had been withdrawn. Although the meeting was confidential this got back to Rodney Ledward who wrote to the Chairman of the committee stating that there was no truth in the allegation and asked for an apology. The GP wrote to Rodney Ledward and apologised. However, we have learned that at about this time Rodney Ledward's practice at the Chaucer Hospital diminished due to problems in his finding an anaesthetist willing to work with him.

5.31. A Staff Nurse told us that in about **1993** a patient came in to the WHH with post partum bleeding and blood pressure at 40 over 0. She told us that the patient had been transfused, there was blood everywhere and she bled so much that the internal pack floated out. A junior doctor came to see her and then Rodney Ledward had attended. The Staff Nurse told us that Rodney Ledward was red in the face and was obviously drunk. It was about 5.30pm. Rodney Ledward told the junior doctor not to take the patient to theatre until the locum Registrar arrived. The junior doctor pushed Rodney Ledward against a wall, said that he had obviously had a liquid lunch and that he, the junior doctor, was going to take the patient to theatre at once or she would die. Mr Stewart's registrar then arrived and dealt with the patient. The Staff Nurse said that the whole incident had been terrible. She said that Rodney Ledward had been the Clinical Director at the time so that there was nothing the nursing staff could do.

1994

6.1. A patient complained to the Unit General Manager, Mr Addison, on **6th January** 1994 that a hysterectomy, which she had been advised to undergo by Rodney Ledward, would not be carried out for some 13 months when she had been told there was only a 6-9 month waiting list. Mr Addison had grounds for understanding, as he noted at the time, that the patient required treatment within 6 months. He asked Rodney Ledward to review the patient who indicated that he would do so. On 10th January 1994 Rodney Ledward wrote to the patient's GP to say that on review of her notes he could find no reason to advance her on the waiting list. On 13th January 1994 Mr Addison wrote to Dr Padley, Consultant Pathologist, asking whether there was any histological information about this patient which was relevant to her place on the waiting list. Dr Padley replied on 13th January saying that a biopsy in September 1993 showed that the patient had a pre-malignant condition of the cervix which, in Dr Padley's opinion, required treatment within 6 months of diagnosis. However he suggested that, since treatment and timing were outside his field, Mr Addison should raise the matter with "the other Gynaecologists". In a letter dated 1st February 1994 Rodney Ledward said that there was no evidence of pathology to require immediate surgery and that he was doing further investigations. The patient had a hysterectomy on 15th May 1994.

6.2. **In February** 1994 Rodney Ledward carried out a hysterectomy on a patient and she subsequently suffered a severe haemorrhage. Mr Stewart was asked to see her and advised that she be given a blood transfusion. She was given 6 pints of blood. Mr Stewart also advised that Rodney Ledward should re-operate on the patient the following day when she was fit for surgery. However before Rodney Ledward attended his patient Mr Derry was asked to see her and he took her back to theatre and re-operated. He found a large pelvic abscess, as well as the haemorrhage. The GMC found that Rodney Ledward had been guilty of serious professional misconduct in relation to this patient.

6.3. In **March** 1994 Rodney Ledward advised a patient to undergo a total abdominal hysterectomy and removal of both ovaries and then permitted a junior doctor to carry out the procedure. Rodney Ledward had previously carried out 7 operative procedures on this patient as a private patient and further surgery as a NHS patient. *In those circumstances we understand that Rodney Ledward should have been aware that hysterectomy might not be straightforward and that it was inappropriate to delegate the surgery to a junior.*

6.4. Mr Davies, Consultant Gynaecologist, told us that in **early 1994** concerns were raised that Consultant Gynaecologists were not on call after they had operated and it was decided that each Consultant would be on call during the night after his operating list.

6.5. On **1st April 1994** the East Kent Health Authority and the South Kent Hospitals NHS Trust were created. After April 1994 consultant contracts were the responsibility of the NHS Trust.

6.6. In **April** 1994 Rodney Ledward delegated a total abdominal hysterectomy and removal of both ovaries on a NHS patient to his registrar, although at earlier laparoscopy she had been shown to have extensive endometriosis. She subsequently developed a uretero-vaginal fistula. *We understand that as a general principle delegation of such major surgery in the presence of endometriosis is inappropriate.*

6.7.	**Codes of Conduct and Accountability for NHS Boards**
In **April** 1994 the Department of Health set out Codes with which Members of Trust Boards were required to comply so as to ensure effective running and management of NHS Authorities and Trusts.	

6.8.1. In **May** 1994 a NHS patient made an oral complaint to the hospital about Rodney Ledward and on 31st May 1994 put her complaints in writing. She said that she had asked Rodney Ledward to treat her privately for a laparoscopy in early 1994

for which he charged her £800. The operation was to be carried out at the WHH. He asked her to take the money in cash 2 days before the operation as the hospital did not take credit cards or cheques. After the laparoscopy, Rodney Ledward advised her that she had polycystic ovaries and fibroids and he advised hysterectomy for which the NHS waiting list was 6 months. He said he would not remove her ovaries as she was too young which she questioned as she felt that her ovaries were causing her the problems. He told her that once her womb had been removed her ovaries "would quieten down". He said he would carry out a vaginal hysterectomy so that she would not have a scar.

6.8.2. She said that Rodney Ledward than carried out the hysterectomy, that she had suffered a severe bleed after the operation and she told us that she had been very frightened. The patient told us that a number of doctors attended her and one took her back to theatre where she underwent laparotomy. As a result she had a large abdominal incision. She had asked the doctor, who had re-operated on her and had assisted Rodney Ledward at the original hysterectomy, how large her fibroids had been. He told her that she had no fibroids. She complained that Rodney Ledward did not attend her at all after her re-operation. She told us that Rodney Ledward finally visited her a week after her surgery and said "Didn't you cause me a lot of trouble last week!" in a patronising tone. He said that because she was obese, "you have to expect these things." The patient said that she was furious at what he said and the way he had said it. She said that the staff knew she was very cross and his registrar came back to see her later.

6.8.3. The patient complained that she had never been warned that her obesity was an added risk prior to surgery, that if she had no fibroid the hysterectomy had been unnecessary, and she also complained that she had not been sutured properly at the hysterectomy. These complaints were all made in May 1994 and the patient asked for answers to all her questions.

6.8.4. Rodney Ledward was asked by Mrs Davidson, Senior Nurse Patient Liaison, for his comments and he wrote on 10th June 1994 in reply. He stated: that he had advised vaginal hysterectomy "in view of her obesity"; that he was not contacted

when she haemorrhaged; that he rang the ward after her return from theatre "and was told the patient was perfectly well" and that he would see her on his normal ward round; no surgery is without complication; and that "a fibroid disappears as soon as you ligate the vessels". Rodney Ledward then saw the patient and although she was not entirely satisfied she wished to "let sleeping dogs lie." This patient's case was one considered by the GMC where Rodney Ledward was found to have been guilty of serious professional misconduct.

6.8.5. The doctor who had re-operated on the patient gave evidence to the GMC. He said that he had been called to see her when he had found the patient in a state of shock with severe gross intra-abdominal bleeding. He had been unable to contact Rodney Ledward that evening but said that since the patient was an acute emergency he proceeded to operation without discussion with Rodney Ledward. He had found severe blood loss, that the patient was bleeding from the pedicles and that the tying of the pedicles was loose. The doctor had told Rodney Ledward the next day about the patient and expected him to visit as soon as he could. 2 experts informed the GMC that a fibroid does not disappear when vessels are ligated at hysterectomy.

6.8.6. *We comment that this patient had complained at the time and in clear and graphic terms about a whole range of matters concerning Rodney Ledward's care. His written answers to the patient's complaints were taken at face value by Mrs Davidson and no investigation was carried out.*

6.9. In May 1994 Rodney Ledward carried out a ventrosuspension on one of his private patients at the Cromwell Hospital in London after performing a laparoscopy on her in April 1994. In August 1994 he carried out another laparoscopy on the same patient at the Portland Hospital and in March 1995 another laparoscopy and D&C at the WHH as a NHS patient. She therefore underwent 4 surgical procedures in just under 12 months. *We express our concern as to whether all these procedures were medically necessary.*

6.10. Mr Blakey, Chairman of the Trust, told us that in **June** 1994 Rodney Ledward invited him to attend a meeting of TSI at a local restaurant. Mr Blakey said he went to the meeting to talk to local GPs and he had found it interesting. He described it as a "lavish affair" which he was told by Rodney Ledward was paid for by drug companies. He had subsequently attended other meetings.

6.11. A NHS patient complained to us about Rodney Ledward's manner and attitude in consultation, when she had gone to see him in **June** 1994. She said that almost at the outset of the consultation he had asked her whether her financial situation would allow her to have private treatment because she needed a hysterectomy as soon as possible. He said that he could do the operation privately at St Saviour's Hospital for £5,000 the following week. Alternatively he told her she would have to wait between 6-10 months for the operation as a NHS patient. She told us that he had been arrogant and off-hand. She could not afford private treatment and the operation was carried out in May 1995. The patient told us that a few days after the operation Rodney Ledward had come to see her, looked at her notes but said nothing to her, did not examine her and began to walk away. The patient then asked him whether all was well and he replied "of course" and walked out of the room. The patient told us that she continued to suffer problems and she had felt she was just unlucky.

6.12. In **June** 1994 Rodney Ledward and one of his junior staff, Dr Kumi, published a document entitled "Educational Package" as a training manual for junior doctors at the WHH and the Buckland Hospital. It included an educational contract as well as examples of appraisal forms. The Package asked for corrections and constructive criticisms from recipients. *In our view this was a most useful document for junior doctors which enabled them to understand the training programme they would follow and the integral parts of the programme. We consider that it demonstrates Rodney Ledward's interest in education and training.*

6.13. In **August** 1994 Rodney Ledward delegated the surgery on a NHS patient (who was then aged 32 years old) to his registrar for removal of both ovaries although she had no significant pathology and she was known to have diabetes and serious adhesions.

6.14.1. In **September** 1994 a NHS patient complained about Rodney Ledward's care of her during her pregnancy. He had advised that she needed to have a Caesarean section to which she agreed but asked for it to be carried out under epidural and for her husband to be present. Rodney Ledward said that she could have the operation under epidural if she had private insurance but probably would not be able to on the NHS and that her husband could not be present. He also said that her baby would have to be admitted to the Special Care Baby Unit for 24 hours. Her husband had remonstrated with Rodney Ledward who simply got up and left the consulting room without saying anything further to the patient or her husband. They had been devastated and the patient was reduced to tears. The patient asked her GP to refer her to another Consultant which he did. Her baby was born in the WHH by Caesarean section under epidural with her husband present. She had nothing but praise for her new Consultant, his team and the nursing staff.

6.14.2. Rodney Ledward was asked about the complaint. He wrote in reply by letter sent on 26th October 1994. He stated that epidurals cannot be guaranteed on the NHS; that sometimes patients are unsuitable for epidurals; that husbands are not actively encouraged to be present and the decision is left to the surgeon and anaesthetist; that when patients are treated privately they can choose their surgeon and anaesthetist and decide whether an epidural can be carried out and whether they are happy to have the husband present. *We express our concern that Rodney Ledward did not deal with the particular complaints by the patient about his manner and attitude. In our view his response evaded the real issues.*

6.14.3. Mr Addison replied to the patient apologising for Rodney Ledward's attitude and explaining that the issue of whether fathers were to be allowed at Caesarean sections was to be discussed by the Obstetric and Gynaecology Division. It does not appear that he spoke to Rodney Ledward about the complaint. *We are concerned that Mr Addison did not link this complaint with the complaint made 13 months earlier by GP in September 1993 (to which we have referred above) in which a similar allegation was made.*

6.14.4. This patient's case was considered by the GMC. Rodney Ledward in evidence to the GMC denied that he had suggested that all babies delivered by Caesarean Section under epidural had to spend the first 24 hours in the SCBU. He said he did not try to persuade the patient to become a private patient. He said that he never allowed husbands to be present at such procedures whether they were carried out on the NHS or privately. Rodney Ledward was found guilty of serious professional misconduct in that he gave misleading information to the patient and sought to encourage her to become a private patient.

6.15.1. On **8th October 1994** the husband of a patient wrote a formal letter of complaint about his wife's treatment. She had been advised to undergo hysterectomy and bladder repair. She was admitted to hospital for the proposed surgery when hysterectomy was carried out, but not a bladder repair. She had questioned why this had not been done and was told by the nursing staff that the doctors cannot have considered that it was necessary. She went to see Rodney Ledward for an out-patient check up afterwards when he advised her to have a bladder repair operation. He had left the room to make a personal call which the patient was able to overhear and did not return to speak to her so that she was unable to ask him why this had not been done at the same time as the hysterectomy.

6.15.2. Mr Addison asked Rodney Ledward to comment about this complaint and he did so in a letter dated 27th October 1994. He stated that it was normal to assess a patient for incontinence as a second stage procedure to see whether the hysterectomy had helped the symptoms. As in her case it had not, she was then advised to undergo a bladder repair and placed on the waiting list. An appointment was arranged for the patient to see Rodney Ledward in November 1994 to discuss her queries. We have been unable to discover whether her questions were answered satisfactorily but it appears that no further step was taken by the hospital. *We express our concern that this patient's proposed surgery was changed without full discussion and explanation with her before the surgery was carried out.*

6.16. In **October** 1994 Rodney Ledward carried out a vaginal hysterectomy at St Saviour's Hospital on a private patient, who was then only 27 years old. *We have not*

been able to discover the medical reason why such a procedure was necessary. From the records we have seen Rodney Ledward carried out 2 surgical procedures on this patient in 1993, 2 procedures (including the hysterectomy) in 1994, and a further 3 procedures in 1995. All the procedures were done privately and Rodney Ledward therefore carried out 7 operations on this patient between July 1993 and November 1995. *We express our concern as to whether all these procedures were medically necessary.*

6.17.		**Disciplinary Procedures for Hospital Staff**
In **October** 1994 Guidance was published by the Department of Health as to suspension of staff and stated that immediate suspension might be appropriate to protect patients.		

6.18. One of the Consultant General Surgeons at the William Harvey Hospital told us that **in about 1994** he learned that Rodney Ledward had carried out a D&C on the daughter of a local GP, after which she suffered complications from which she nearly died. He told us that Rodney Ledward had been flippant about the problem.

6.19. Mrs Sidwell, Director of Nursing Quality, told us that **in 1994** she had received a letter from a patient complaining about being asked to bring cash for private care. The patient had said that she was alarmed to be asked to bring in £500 in cash for Rodney Ledward when she came for surgery. Mrs Sidwell told us that she took the letter to Mr Addison whom, she had understood, dealt with the matter.

6.20.1. Mrs Watts, Business Manager, said that one of the things she had looked at soon after the Trust was created **in 1994**, was the regrading of secretaries in the Trust. She said that Rodney Ledward wanted to upgrade his NHS secretary, Mrs Woodcock. Mrs Watts had the impression that he wanted Mrs Woodcock to have Mrs Watts' job. Mrs Watts said that there was one evening in 1994 when Rodney Ledward had called her into his office and said that his secretary was to account to him and not to her. Mrs Watts had refused and said that Mrs Woodcock had to be

treated in the same way as all the other staff. She said that Rodney Ledward was very intimidating and very arrogant. He told her that she was not to interfere with his secretary. She said he was very, very aggressive, he shouted and she had thought he was going to hit her. She told us that she had stood up to him and told him she would tell Mr Addison, the Chief Executive. He then inferred that she would be wasting her time as he knew people in high places. She told us that the meeting lasted nearly 3 hours. She had raised during the course of this meeting the question of the collection of cash from patients and she had told him that she would also speak to Mr Addison about that matter. He said that she would not have a future in the Trust. He was quite different from "the affable, kindly, rogue character" he had been before. She told us that she had been very upset by the confrontation.

6.20.2. Mrs Watts said that she went to see Mr Addison the next day and that he was very supportive. She then had to attend a meeting with Rodney Ledward but he did not mention the matter. She said that thereafter they worked together and it was never mentioned again. She had thought his behaviour and attitude was bizarre. She did not know if Mr Addison ever raised the matter with Rodney Ledward. Mrs Woodcock continued to report to Rodney Ledward, but Mrs Watts had decided "not to rock the boat", and so said nothing.

6.20.3. During the course of our Inquiry we asked Mr Addison about this matter but he could not recall Mrs Watts speaking to him about the incident.

1995

7.1. On **1st January 1995** Mr Stewart became the Clinical Director of the Obstetric and Gynaecology Unit and has continued to hold that position ever since. The Chief Executive, Mr Addison, and the Medical Director, Dr Padley, told us that they had decided that the Clinical Director of the Unit should be a permanent, non-rotational post and Mr Stewart had been chosen by them as Clinical Director. Mr Stewart said

that when he became Clinical Director at the beginning of 1995 the Directorate was dysfunctional, in that it was a divided department. He also said that there continued to be a large imbalance in the Consultants' workload.

7.2. We were told that in **January** 1995 a private patient had laparoscopy and urethroplasty under Rodney Ledward, but that he failed to obtain her consent to the urethroplasty. We note that Rodney Ledward had carried out 3 previous surgical procedures on the same patient in 1993, namely laparoscopy, removal of an ovary and removal of a cyst. He had then carried out a further laparoscopy on the patient in June 1995 and then a laparotomy in August 1995. She had therefore undergone 3 operations in 1993 and a further 3 in 1995, all carried out by Rodney Ledward privately. *We express our concern as to whether all these procedures were medically necessary.* The patient had been content to be referred back to Rodney Ledward in 1995, but she was not happy that he did not obtain her consent to the whole of the surgical procedure which he then carried out.

7.3. In **February** 1995 a NHS patient had a vaginal hysterectomy carried out by Rodney Ledward and his Registrar during the course of which the Registrar damaged the patient's bladder. The Registrar recognised the problem and Rodney Ledward repaired the bladder. The patient began to bleed in recovery and the Registrar discussed the problem with Rodney Ledward. It was agreed that she should re-operate and pack the patient's vagina. She sutured the point of bleeding. The GMC considered this patient's case and found that Rodney Ledward had been guilty of serious professional misconduct in carrying out the repair incompetently and in delegating surgery to his registrar when the patient suffered post operative complications. The patient told us that she had suffered serious incontinence after the surgery and that she was referred back to Rodney Ledward. He told her he could find nothing wrong and there was nothing he could do. She was then referred by her GP to Mr Deane, Consultant Urologist, who diagnosed a vesico vaginal fistula. She subsequently underwent further surgery for incontinence.

7.4. It was also in **February** 1995 that a NHS patient underwent an examination under anaesthetic and hysteroscopy after which Rodney Ledward advised her to have

a hysterectomy. The patient accepted Rodney Ledward's advice although she was only 26 years old. On admission she was told that the operation was to be carried out vaginally but she told the locum consultant, who was to carry out the procedure, that she had bad adhesions and he decided to carry out the hysterectomy abdominally.

7.5. In **March** 1995 a NHS patient was referred to Rodney Ledward for a termination of pregnancy. She said that he persuaded her to undergo sterilisation at the same time. She was then 24 years old. *We point out that a consultant gynaecologist would have been paid an extra sum by the NHS for the sterilisation.*

7.6.1. On **13th April 1995** the Finance and Commercial Director of the Trust wrote to the Divisional Audit Manager expressing concerns about contributions (over and above the costs of catering) made to an Obstetric and Gynaecology Teaching Fund by various pharmaceutical companies for the lunchtime meetings organised by Rodney Ledward. In her handwritten notes she indicated that the name of the fund was misleading as it suggested that the Fund was administered by the Trust whereas it was administered by Rodney Ledward. She noted that requests for contributions to the companies, which were sent on Trust notepaper by Rodney Ledward's NHS secretary, confirmed that impression. This also raised the question of abuse of Trust property and employees time. She was very concerned about the legality of the fund and suggested that it should in future be run as a charity by and for the Trust. She also suggested that Rodney Ledward be asked to produce the accounts of the Fund.

7.6.2. As we have said previously the existence of this fund had been discovered in 1993 and the account had been closed. We have seen a letter dated 19th September 1995 from Rodney Ledward to Mr Addison in which he stated that the existing fund had been closed and that Mr Stewart had agreed to a departmental teaching fund being established and monitored by the Clinical Director. Rodney Ledward said that he had not kept bank statements relating to the Fund and that the cost to duplicate them would be £120 or more. He suggested that the Trust pay for the cost of obtaining the statements if they wished to do so. It was decided not to take the matter further.

7.7. Mr O'Neill, who was then Trust Director of Corporate Affairs, told us that the Clinical Negligence Scheme for Trusts was introduced to the Trust in **April 1995** and that risk management had thereafter become part of his remit.

7.8.	**Code of Practice on Openness in the NHS**
In **April** 1995 the Department of Health published a Code on the provision of information to the public. It was stated that Trusts and Authorities must provide information about how to contact the Community Health Council and Health Ombudsman and how to gain access to personal medical records.	

7.9.	**Guidance on Implementation of the Code on Openness**
This guidance on the Code mentioned above was published in **May** 1995.	

7.10. In **May** 1995 a NHS patient underwent hysterectomy under Rodney Ledward after which she suffered a pelvic haematoma. From her records it seems that the operation was carried out within 25 minutes. The patient told us that Rodney Ledward only went to see her on the day she was discharged from hospital, 7 days after the operation. She described him as arrogant and said that he showed her no pity and offered no apology. She also told us he was abrupt.

7.11. Mr Addison told us that in **May** 1995 he had become concerned about the arrangement whereby Rodney Ledward was using the services of WHH in return for a payment of £525 per annum to run TSI Ltd. He said that he felt that Rodney Ledward was abusing the services of the WHH. Dr Padley, Medical Director, told us that he was aware that TSI had virtually taken over much of Rodney Ledward's NHS time. He said that he had concerns about the financial implications of TSI, but he told us that he had never been able to discover chapter and verse about the organisation. The arrangement was brought to an end. Rodney Ledward then removed all files and documents relating to TSI from his office at the WHH.

7.12. In **June** 1995 Rodney Ledward operated on a private patient at St Saviour's Hospital upon whom he had previously performed a D&C. The histology from the D&C showed that the patient was suffering from cancer. Rodney Ledward failed either to obtain or read the histological findings before carrying out abdominal hysterectomy on the patient. He accepted when giving evidence to the GMC, that he should have read the histological findings before operating, and that the surgery he carried out was inappropriate in the light of the histology. Dr Coltart, Consultant Oncologist, told the GMC hearing that Rodney Ledward had written a letter to the patient's GP after the hysterectomy stating that histology suggested a malignant focus. Dr Coltart said that this was inaccurate as in his view the histology clearly showed malignancy. This was confirmed by Dr Padley, Consultant Pathologist. The GMC found that Rodney Ledward had been guilty of serious professional misconduct in relation to this patient.

7.13. In **July** 1995 Rodney Ledward carried out an operation to insert a sling in a NHS patient's bladder for urinary incontinence. After the procedure the patient developed infection and was unable to pass urine. Mr Derry, Consultant General Surgeon was asked to see her and he decided to re-operate. The patient's case was considered by the GMC and Mr Derry gave evidence. He said to the GMC that when he had operated he had found that the sling had been placed through the bladder. Rodney Ledward told the GMC that he did not accept that he had placed the sling through the bladder. The GMC found that Rodney Ledward had been guilty of serious professional misconduct in respect of this patient.

7.14. We were told that it was also in **July** 1995 that one of Rodney Ledward's private patients returned to see him because of problems of frequency and urgency of micturition, although he had previously carried out a repair operation. He then advised and carried out a repeat repair operation but he did not ask for urodynamic studies before operating. *We understand that to carry out a second repair operation for frequency and urgency without doing urodynamic studies in advance is not good practice.*

7.15. In the same month, **July** 1995, a NHS patient was advised by a locum consultant to have her left ovary removed as a cyst was present. She was admitted to hospital where she saw Rodney Ledward. She told us that he had said that her left ovary was ominous and nasty and suggested to her that her right ovary be removed at the same time, since he said it was likely that if one ovary was diseased the other would become diseased. The patient said that Rodney Ledward was in a hurry, he was surrounded by a group of people whom the patient assumed were students, and she felt pressurised to sign the consent form. The patient was then 41 years old. She suffered a haematoma after the surgery and she recalled being given a blood transfusion. She said that she had suffered considerable pain during the week following the surgery and had asked to see Rodney Ledward but he did not visit her until a week later, was offhand and showed her no concern.

7.16. In **July** 1995 a private patient told us that Rodney Ledward had carried out an anterior repair upon her at St Saviour's Hospital. He had previously carried out a vaginal repair operation on her privately in November 1988 and another in 1992. After her discharge from hospital in July 1995 she suffered from bleeding and infection but was unable to contact Rodney Ledward. She then saw Rodney Ledward for a post operative check and he subsequently wrote to her GP stating that she was very happy with the results of his surgery. The patient told us that she had not been happy with the results and she was sure that she had not told Rodney Ledward that she was happy. She told us that she has continued to suffer from incontinence.

7.17. A private patient told us that in **August** 1995 Rodney Ledward had advised her to undergo a vaginal hysterectomy. She told us that she felt intimidated by Rodney Ledward and was concerned that he had not discussed matters fully with her. She said the consultation lasted about 10 minutes and she considered that since she was paying for his services, he should have devoted more time to explain matters to her and answer her concerns. The operation was carried out in October 1995 at St Saviour's Hospital and during her stay Rodney Ledward simply put his head round the door on 2 occasions and she had not been able to ask him anything about her operation.

7.18. We were told that in 1995 Rodney Ledward saw a NHS patient in consultation and advised her to have a total abdominal hysterectomy. She said that he told her that she had enough fat on her tummy to feed Oxfam for 3 months, which she had found very upsetting. The operation was carried out in **August** 1995 at the Buckland Hospital and from the records it appears that the operating time was only 15 minutes. The patient suffered a haemorrhage after the procedure and a urinary infection. She said that Rodney Ledward told her this was normal. After discharge from hospital she developed a pelvic haematoma and had to be readmitted to hospital.

7.19.1. Mr Blakey, Chairman of the Trust, told us that he had attended a meeting of TSI in **September** 1995 at Rodney Ledward's invitation. He told us that the speaker was a Judge of the Irish Supreme Court. Mr Blakey said that Rodney Ledward gave a speech during the course of the meeting when he said that the Trust was more concerned with profits than patients. Mr Blakey was appalled by this pronouncement. He told us that the Trust's objective had always been to put patients first. He spoke to Dr Padley, Mr Addison and Mrs Sidwell about the matter and then decided to raise it with Rodney Ledward. He did so and told him that such behaviour was not acceptable.

7.19.2. Rodney Ledward also referred to this incident in his written evidence to us. He said that as Chairman of the meeting, he had referred to a letter published in the national press from the then Chairman of the Hospital Consultants' Association in which he had stated that "increased throughput had the potential for increased complications and increased litigation." Rodney Ledward said he made no reference to the Trust or any of its hospitals. He said that Mr Blakey who was in the audience had taken no part in the discussion, but had approached him afterwards and accused him of making derogatory remarks about the Trust. He told us that he was later asked to attend a meeting with Mr Blakey (Chairman of the Trust), Mr Addison (Chief Executive), Dr Padley (Medical Director) and the Quality Control Director. He was challenged about what he had said and told the meeting that he had not made derogatory remarks about the Trust. He had not apologised as he had felt there was nothing to apologise for. The meeting then ended but he told us that he had subsequently understood that Mr Blakey wanted to remove Rodney Ledward from his

consultant post in the Trust.

7.19.3. Miss Harris, Rodney Ledward's private secretary also attended that meeting of TSI. She told us that Rodney Ledward had not spoken in derogatory terms about the Trust. She said he had simply referred to a published letter in which reference was made to the need for hospitals to "balance the books" and the possibility of this increasing litigation.

7.20. In **September** 1995 Rodney Ledward carried out a laparoscopy on a private patient when he found a cyst on her left ovary. He requested a scan but no evidence of a cyst was then demonstrated. Despite this, in October 1995 Rodney Ledward performed a laparotomy to remove the left ovary of the patient. It appears from the records that the procedure was carried out in less than 10 minutes. Rodney Ledward then re-operated on the patient a week later to explore a wound haematoma. On histology the ovary was normal.

7.21.1. On **11th October 1995** the mother of a patient wrote to complain about Rodney Ledward's treatment of her daughter. The patient had been referred to Rodney Ledward for abdominal pain and possible ectopic pregnancy. He saw her on 14th September when no urine sample was taken. The patient's mother wrote as follows:

> "...we were both shocked by his manner and professional conduct. Apart from being late for the appointment, he did not, we believe, pay sufficient attention to [her] presenting symptoms and medical history, preferring instead to concentrate on her responsibility regarding birth control and making inaccurate and offensive social judgements."

Rodney Ledward had advised her to come into hospital the following week for "a bit of a clean up" and to have a coil fitted. The patient's mother wrote that later that day her daughter's condition deteriorated and she was admitted to the Buckland Hospital early the next morning when ectopic pregnancy was diagnosed and she underwent emergency surgery.

7.21.2. Dr Padley, Medical Director, and Mrs Watts, Business Manager, arranged for the patient to be seen by Mr Stewart and to attend a meeting with Mrs Davidson, Senior Nurse Patient Liaison Officer. Mrs Davidson went to the patient's home on 26th October 1995 when the patient and her mother complained about Rodney Ledward's attitude and arrogance, which they described as "appalling".

7.21.3. Rodney Ledward was asked about the matter and in a letter dated 16th November 1995 said that his treatment had been appropriate, and that "ectopic pregnancy is a great mimic." The patient's mother was informed of Rodney Ledward's response. The patient's mother had commented that it was "no more than she expected." The complaint was closed.

7.22. A NHS patient told us that at the end of **October** 1995 she had undergone a vaginal hysterectomy and that afterwards she suffered a vault haematoma. She was given a blood transfusion and was discharged from hospital by Rodney Ledward although she was still suffering from considerable pain. A week later she had to be readmitted and was given further blood transfusions followed by a further operation. The patient told us that although it had been suggested to her by one of the hospital staff that she should complain, she had not wished to do so because she wanted to go home and she felt that complaining would affect that. *We express our view that this patient is but one example of a patient who did not wish to complain in case her complaint affected her medical management. Patients have real fears that if they question, challenge or complain, their treatment and care will be adversely affected.*

7.23. Another NHS patient told us that in **November** 1995 she had seen Rodney Ledward who advised her to undergo surgery and asked her whether she or her partner had private health insurance. When she replied in the negative he said that there was a long waiting list and suggested that she seek financial assistance from the St Saviour's Charitable Trust, about which she should ask her GP. She told us that the consultation was very quick and lasted no more than 5 minutes. She obtained financial help from the charity and Rodney Ledward carried out tubal surgery at St Saviour's Hospital. The patient told us she was unhappy with the appearance of the

scar after surgery. She said that she went to see Rodney Ledward for a post operative appointment and that he had carried out an internal examination in the absence of a chaperone. She said that she had been very upset by what Rodney Ledward had done and what he had said at that appointment.

7.24. We were told that in **November** 1995 Rodney Ledward delegated a laparotomy on a NHS patient to his Registrar. The patient said that he should have known, by virtue of her long surgical history which he had carried out, that it was not appropriate to delegate this surgery. She told us that she had been his private patient since 1979 and that he had carried out 9 previous operations on her privately. The Registrar created a hole in the patient's bladder during the course of this difficult surgery. *We express our concern as to whether it was appropriate to delegate this surgery to a registrar.*

7.25. A former patient of Rodney Ledward wrote to us during the course of our Inquiry to say that Rodney Ledward had carried out a hysterectomy on her some years ago. She wrote that "he treated me with kindness, courtesy and expertise." She thought there would be very many patients who shared her views.

1996

8.1. A patient told us that she had been given a hysterectomy by Rodney Ledward in May 1995 as an NHS patient and that he subsequently advised her to have (a) a laparoscopy which was carried out as a private patient at St Saviour's in December 1995, and (b) removal of an ovary which was also carried out privately at St Saviour's in **January 1996.** She suffered from wound infection after the last operation. The patient therefore had 3 surgical procedures within the space of 8 months. She expressed concern to us as to whether all 3 operations were necessary and told us that she had found Rodney Ledward arrogant.

8.2.1. In **January** 1996 Rodney Ledward carried out a total abdominal hysterectomy on a private patient at St Saviour's Hospital during the course of which the patient's bladder and ureter were damaged. After the surgery Rodney Ledward asked for an investigation to be carried out in the X-ray department but the radiologist could not contact him with the result. The Sister at the Hospital could not contact Rodney Ledward on his mobile telephone and nor could the Trust. She spoke to the Matron, Mrs Biddle, about her concerns who advised her to call another Consultant Gynaecologist to attend. The Sister asked Mr Davies to attend the patient. He called in Mr Deane, Consultant Urologist, who arranged for the patient to be transferred to the WHH as a NHS patient. At operation Mr Deane found that the patient was suffering from peritonitis and 2 urinary tract injuries, namely a large hole in her bladder and obstruction of a ureter. Mr Deane gave evidence to the GMC about this patient. He said that in his view the damage to the bladder should have been recognised by Rodney Ledward at the time he was operating. It was suggested by an expert Consultant Gynaecologist, who gave evidence to the GMC, that the procedure had been carried out too quickly as the original operation had lasted only 35 minutes.

8.2.2. Rodney Ledward told the GMC that he had not realised that he had damaged the patient's bladder at the time of his surgery. He had left the hospital to attend a medical meeting in Hastings and he said his mobile telephone had not worked. He had told the radiologist he would return to see the patient after he came back from Hastings. He said that by the time he went home after the meeting the patient had been transferred to the WHH. He told the GMC that he went to see the patient 5 days later and apologised. The GMC found Rodney Ledward guilty of serious professional misconduct in respect of this patient's care.

8.2.3. Mr Davies, Consultant Gynaecologist, told us about this patient whom he had been asked to see as Rodney Ledward could not be contacted. Mr Davies said that he had been very concerned about the case and had spoken to Mr Deane who was responsible for transferring the patient to the NHS. Mr Davies said that he had rung his defence organisation to ask for advice as to how to contact the GMC about the matter.

8.2.4. Mr Deane told us that he had been called in to see the patient at St Saviour's Hospital and he had thought it was unacceptable that Rodney Ledward could not be contacted by St Saviour's when he had 3, or possibly 4, patients who had undergone major surgery in the hospital at the time. Mr Deane told us that he went to see Mr Addison and said he thought this was unacceptable and that he was no longer prepared to support Rodney Ledward.

8.2.5. Mr Bates told us that he became aware at the end of January 1996 about this patient because his operating list had to be cancelled as Mr Deane was operating on the patient. He told us that he went to see Mr Addison and wrote to him about his concerns.

8.2.6. Dr Padley, Medical Director, told us that Mr Bates had spoken to him about this patient. He had then spoken to Mr Deane, Mr Davies, and then to Mr Addison and Dr Kenwright. He also went to see the patient. The patient had told him her story and had complained that Rodney Ledward had pressurised her to become a private patient. Dr Padley said that what he learned was "awful" in that Rodney Ledward could not be found after the operation, he had ligated the patient's left ureter and she was suffering from septicaemia. Dr Padley said that as a result of what he had been told he was very concerned about Rodney Ledward's clinical competence. He had felt that Rodney Ledward had to be stopped from operating until the case had been fully investigated.

8.2.7. Mr Addison told us that he had been informed about this patient and he had decided that Rodney Ledward had to be suspended forthwith and that disciplinary proceedings should be instituted against him.

8.2.8. Mr Blakey, Chairman of the Trust, told us that at the beginning of February 1996 he had been informed about this patient. He told us that he went to see the patient in the WHH and had been told that her treatment at St Saviour's Hospital had been paid for by the St Saviour's Charitable Trust. Mr Blakey spoke to her husband who said that Rodney Ledward had rung him about his wife and had apologised.

8.2.9. Mrs Davis, a non executive director of the Trust who is a solicitor, told us that Mr Blakey had telephoned her in February 1996 and informed her about the patient. She had advised that the Trust contact their solicitors for advice.

8.2.10. Dr Padley, Medical Director, said that the Trust obtained advice from the Trust's lawyers as to how Rodney Ledward's suspension should be carried out. Dr Padley said that the Trust followed their recently published disciplinary procedures, (which largely followed the Department of Health 1990 circular about disciplinary proceedings). He said that he and another Trust employee had spoken to Rodney Ledward about the matter and informed him he was being suspended. He said that Rodney Ledward became cross and angry at the meeting and he had felt that Rodney Ledward might strike one of them. Dr Padley said that Rodney Ledward had shouted and was intimidating. He told us that he had found Rodney Ledward's explanation about why he had not called into the hospital on his return from a medical meeting very weak, if not devious. He said that the Trust notified the Chaucer Hospital and the St Saviour's Hospital that Rodney Ledward had been suspended and also wrote to all the GPs in the area. On 29th March 1996 Dr Padley also wrote to the Royal College of Obstetricians and Gynaecologists.

8.2.11. Mr Addison, Chief Executive, told us that he and the Trust then spent considerable amounts of time and effort preparing the case for the Disciplinary Inquiry set up by the Trust. He thought that by then he had been made aware of all the complaints which had been made about Rodney Ledward. He said that the disciplinary proceedings against Rodney Ledward were discussed at Trust Board meetings and Clinical Board meetings.

8.2.12. Mr Addison told us that most clinicians in the hospitals where Rodney Ledward had worked, although by no means all, were supportive of the fact that Rodney Ledward had been suspended. He also said that some GPs were critical of the Trust's action and told us that a number of eminent Consultant Gynaecologists from around the country voiced their criticisms of the steps the Trust were taking. He felt that he received no support from the Regional Health Authority.

8.2.13. Mrs Watts, Business Manager, told us that she had thought it was very brave of Dr Padley and Mr Addison to suspend Rodney Ledward since if it had gone wrong it would have been disastrous for the Trust and for them. Many witnesses from whom we heard echoed her concerns. They had felt that bringing disciplinary proceedings against Rodney Ledward and suspending him was a momentous step, because he was powerful and intimidating. We were told that there was deep anxiety amongst many Trust employees as to what steps Rodney Ledward would take to prevent such proceedings succeeding and to harm or destroy the careers of those who spoke against him.

8.3. Trust Disciplinary Procedures for Medical and Dental Staff

8.3.1. New disciplinary procedures for doctors employed by the Trust were adopted and published by the Trust on **30th January 1996**. The procedures followed substantially the Department of Health Circular on disciplinary procedures published in 1990, to which we have already referred in the previous section of our Report. They were said to be designed to consolidate and improve upon the procedures set out in that Circular. One of its provisions was that a doctor should remain on full pay, save in a case of personal misconduct, until the outcome of any appeal. *In our view it is subject to the same criticism as that we made in respect of the DoH Circular, namely that where dismissal of a doctor might be involved the procedure was complex and cumbersome.*

8.4. For the sake of completeness we mention that in **February** 1996 the Audit Commission reported to the Trust on the staff review audit it had carried out for the period from February to July 1995. The Gynaecological and Obstetric services were reviewed. The Audit Commission noted the significant variations in the workload of the consultants in the Obstetrics and Gynaecology Directorate. They advised the Trust to consider (a) the number of fixed commitments for each consultant, (b) the attendance level of each consultant and (c) how long the session lasted. It advised that each of these factors should be monitored.

9. *Our Concerns about the Care of those Patients to whom we have referred above.*

9.1. *From a consideration of those patients who received care under Rodney Ledward between the beginning of 1991 and the beginning of February 1996 and whom we have considered above, we express the following concerns:*

* *a number suffered ureteric, urinary tract or bowel damage.*

* *a number suffered from haemorrhage, haematoma, infection or pelvic abscess.*

* *a number seem to have been pressurised by Rodney Ledward to become private patients and/or were asked to make payment in cash.*

* *a number of private patients seem to have been subjected to repeated and unnecessary surgical procedures.*

* *a number seem to have been given unconventional medical treatment or did not consent to all the surgery carried out.*

* *a number told us that he was unkind and uncaring and that he did not provide full explanations of their treatment or subsequent complications.*

* *in a number of cases we have been concerned that he failed to give full information to patients' GPs.*

* *in a number of cases he delegated surgery to junior doctors when it may have been inappropriate to do so.*

* *in a number of cases it seems that Rodney Ledward could not be contacted when on call or when emergencies arose, and*

failed to attend his patients.

* *on occasions we have been told that Rodney Ledward examined patients internally in the absence of any chaperone.*

We comment that many of these concerns echo our concerns about Rodney Ledwards' practice between 1980 and 1990.

10. RODNEY LEDWARD'S COMPLAINTS AGAINST MR STEWART IN 1995

10.1.1. On **3rd February 1995** Rodney Ledward wrote to Mr Addison, Chief Executive, about a decision made by Mr Stewart to transfer a staff grade doctor from Rodney Ledward's Friday morning operating list to help Mr Stewart run an antenatal clinic. He put forward some suggestions as to how the matter might be resolved. He expressed criticism of Mr Stewart's behaviour which he described as egocentric and "for his own personal gain". He expressed his belief that Mr Stewart did not have the necessary qualifications for the post of Clinical Director. He called upon Mr Addison to replace Mr Stewart as Clinical Director. He copied the letter to Mr Blakey (Chairman of the Trust), Dr Padley (Medical Director), Dr Norris (Chairman of the 3 wise men committee) and Mr Ursell (Consultant Gynaecologist).

10.1.2. Dr Padley, Medical Director, wrote to Rodney Ledward on 6th February 1995 stating that in his view there was considerable overmanning of Rodney Ledward's operating list on a Friday morning since both Rodney Ledward and the senior fully qualified staff grade doctor, whom he described as the equivalent of a Consultant, were due to be present plus 2 senior House Officers. He stated that as this was a fixed session for Rodney Ledward, he would expect him to fulfil that commitment save for study or annual leave, illness or genuine emergencies.

10.1.3. Rodney Ledward wrote again to Mr Addison on 17th February 1995 to say that he did not agree with the comments made but that he was prepared to discuss the matter at the April meeting of the Directorate.

10.1.4. Mr Stewart, Consultant Gynaecologist, told us that although Rodney Ledward had an operating list at the Buckland Hospital in Dover on a Friday morning, he rarely attended the hospital and generally Rodney Ledward's Registrar or a senior House Officer carried out the list. Mr Stewart was aware of this because he was sometimes called in to assist in the operating theatre, despite the fact that they were not his patients and he had never seen them before. Mr Davies, Consultant Gynaecologist, also confirmed that Rodney Ledward monopolised the junior doctors at the Buckland Hospital on a Friday morning.

10.1.5. Dr Padley told us about this matter. He said that he attended a meeting with Mr Stewart and Rodney Ledward which he described as very acrimonious. He said that Rodney Ledward started shouting at Mr Stewart, that he got red in the face and was threatening and insulting. He said that Rodney Ledward lost all control and Dr Padley thought Rodney Ledward was going to hit him. Mr Stewart also told us about this meeting. He said that Rodney Ledward had repeatedly shouted "you're incompetent" at him during the course of the meeting.

10.2. On 7th February 1995 Rodney Ledward wrote another letter to Mr Addison, on this occasion complaining about Mr Stewart's management of 2 patients and asking that both matters be referred to the wise men Committee or a professional review body. He also said that the second patient had told him that Mr Stewart had never seen her to discuss her management. Rodney Ledward stated in his letter that both patients "are unhappy with their management and have asked me to bring this to the attention of the Chief Executive and would like a report".

10.3. On 9th February 1995 Rodney Ledward went to see Mr Blakey, Chairman of the Trust, about a whole range of issues but in particular complaining about Mr Stewart's management of the Directorate.

10.4.1. Mr Addison recognised that Rodney Ledward's complaints about Mr Stewart were very serious and investigated the allegations with Dr Padley, Medical Director of the Trust. Mr Stewart wrote a detailed letter in response to the allegations. Mr Stewart denied that he had been professionally incompetent in either case.

10.4.2. On 14th February 1995 the second patient and her husband were seen by a member of staff from the WHH. During the meeting they complained about Rodney Ledward's care at the Buckland Hospital. The patient said that she had full confidence in Mr Stewart and she had been happy with his advice about her labour. However after admission she was seen by Rodney Ledward who considered that she needed a Caesarean section because of her previous medical history. She and her husband complained that Mr Ledward had told them that her pregnancy had been badly managed and that he would complain about the matter and that there would be an inquiry. He then advised them to choose (i) to be delivered by Caesarean section at the Buckland that afternoon, or (ii) be transferred to the WHH; or (iii) be transferred to Kent & Canterbury. The patient and her husband complained that they had found Rodney Ledward patronising to them and said he had no bedside manner. The patient decided to go to Kent & Canterbury Hospital where her husband took her by car. She had a normal vaginal delivery of a healthy child later that day. However they were very unhappy with Rodney Ledward's care.

10.4.3. Mr Addison, Chief Executive, told us that he wrote to Rodney Ledward on 28th February 1995. In the letter he stated that he had been advised that the wise men procedure was not apt for a disagreement between colleagues. He said that both the patients concerned had been visited and expressed satisfaction with their care although the second patient had wished to complain about Rodney Ledward. He wrote that he found it regrettable "that you chose to write in such a way as to undermine a colleague with unfounded allegations." He suggested that Rodney Ledward should discuss with him the matters about which the patient complained about his conduct. He also suggested that the whole matter be discussed at a meeting to be attended by Rodney Ledward, Mr Stewart, Dr Padley and himself before pursuing more formal machinery.

10.4.4. Finally on 18th May 1995 Mr Addison wrote to both Rodney Ledward and Mr Stewart to set up a meeting to be attended by the 2 Consultants, Dr Padley and Mr Addison. The meeting was apparently arranged for 29th June 1995 but Rodney Ledward cancelled it because he was away on sick leave. We understand that a meeting took place later when we were told Rodney Ledward apologised formally. Subsequently Mr Addison wrote to the second patient to say that at the meeting "Mr Ledward retracted his allegations about Mr Stewart's professional incompetence and also apologised to him. Secondly, Mr Ledward told me he was very sorry for the distress he caused you both."

11. IMBALANCE OF WORK AND REFERRALS - 1995

11.1. In about the summer of 1995 the Trust produced data which showed an imbalance between the work done by the 4 Consultant Gynaecologists for the years 1993-1994 and 1994-1995. As we have already said, 2 of the Consultants were carrying out about two thirds of the work of the Directorate, and the other third was carried out by the other 2 consultants.

11.2. A GP told us that on **5th June 1995** there was a meeting of the South East Kent General Practitioner Committee, which Mr Stewart and Mr Davies attended. They informed the Committee that their waiting lists at the WHH were completely out of control because so many patients were referred to them rather than the other 2 Consultants. They asked the GPs to refer patients to all the Consultants equally so that there was a more even distribution of work. The GP said that there was a frank discussion at the meeting about Rodney Ledward and there was a general consensus by the GPs that they did not wish to refer patients to him. It was decided that letters would be written by the GP committee to the Chief Executives of both the East Kent Health Authority (Mr Outhwaite) and the South Kent Hospital NHS Trust (Mr Addison) setting out the reasons for the imbalance in referrals. Copies were also sent to the Chairman of the Trust and to the Chairman of the East Kent Health Authority.

11.3. The GP who was Chairman of the South East Kent District GP Committee told us that he had been present at the meeting on 5th June 1995 and as a result of the decision he had written as requested to the Trust and the Health Authority. We have a seen a copy of his letter dated 21st June 1995 in which he wrote:

> "I would urge both the South Kent Hospitals Trust and the EKHA to urgently examine this situation. The pattern of referral by General Practitioners whilst a coarse form of audit is also an extremely powerful one."

11.4. The GP told us that he had then met Mr Addison and Dr Padley, the Medical Director, and mentioned a number of the GPs' concerns about Rodney Ledward's practice, namely: (i) that Rodney Ledward was steering patients towards private practice; (ii) that he was leaving clinics to junior staff; (iii) that he had an excessive complication rate; and (iv) that his attitude to patients was not good. He said that he felt that Mr Addison and Dr Padley accepted that these were problems with Rodney Ledward's practice and they told him that they would raise the various matters with Rodney Ledward. No note of the meeting was kept by either Mr Addison or Dr Padley. However they were both sure that concerns about Rodney Ledward's clinical competence had not been raised with them by the GP at the meeting.

11.5. Mr Addison apparently met Rodney Ledward and some weeks later on 31st August 1995 wrote to him confirming the concerns raised by the GP Committee and suggesting that Rodney Ledward should speak to the Chairman of the GP Committee direct.

11.6. We were told that the GP was then telephoned by Rodney Ledward who suggested they go out together for a drink. The GP agreed and had met Rodney Ledward on 5th September 1995. He put many of the concerns of the Committee to him. He told us that Rodney Ledward was charming and amicable and put his side of things. However the GP was not persuaded by Rodney Ledward that the criticisms about him were unjust or unfair. He felt that Rodney Ledward had no insight into the

concerns that were being raised. He also told us that Rodney Ledward could be a bully when charm failed. The GP then wrote to Mr Addison on 13th September 1995 to tell him about the meeting. He said that Rodney Ledward had told him that (a) his contract did not allow him to attend antenatal clinics at Folkestone more than once a fortnight but that he was willing to attend every week from then on; (b) he did not accept that he had an attitude problem to patients but he would listen to any feedback from GPs; (c) he agreed that his approach to private work was "sailing close to the wind" and could be open to misinterpretation and that it would be better if he adopted a different approach in putting options to patients; (d) he was concerned that the Trust was interested in quantity not quality and had suggested an audit of the quality of consultations.

11.7. Mr Addison told us that he had felt that Rodney Ledward had responded appropriately to the GPs concerns but had felt that there was unlikely to be any change in his practice. He said that he later checked on Rodney Ledward's attendance at clinics which he was told had improved.

11.8. On 13th December 1995 representatives of the East Kent Health Authority attended a meeting with Mr Stewart, Mrs Watts and others which considered the reduction of waiting list times for the 2 senior consultants, Mr Ursell and Rodney Ledward. It was decided that Rodney Ledward would undertake only one obstetric clinic in Ashford allowing him an extra 2 gynaecology clinics a week. This was seen as a first step to ensuring that referrals from GPs would be spread evenly between the Consultants. *We comment that this step was unlikely to resolve the real issue namely that a number of GPs did not wish to refer their patients to him as the Trust and the Health Authority knew.*

12. DISCIPLINARY ACTION AGAINST RODNEY LEDWARD - AUGUST 1995

12.1. Dr Padley, Medical Director, told us that Rodney Ledward had not attended a meeting that had been arranged for 29th June 1995 (when he was due to apologise to Mr Stewart) as he was away on sick leave but that it had come to Dr Padley's notice that Rodney Ledward had, on the same day, treated a private patient at St Saviour's Hospital. He was aware of this because Rodney Ledward sent a histological specimen to Dr Padley from a private patient upon whom he had carried out a D&C on that day at St Saviour's Hospital. Dr Padley informed Mr Addison.

12.2. On 24th July 1995 Mr Addison, Chief Executive, wrote to Rodney Ledward about the fact that he had worked at St Saviour's Hospital on 29th June 1995 when he had a medical certificate that he was unable to work for a 2 week period from 17th June 1995. He also referred to the fact that he had cancelled a meeting at the Buckland Hospital with Dr Padley, Mr Addison and Mr Stewart on the morning of 29th June because he was ill. Mr Addison set up a formal disciplinary interview for **9th August** 1995. He also raised the question of Rodney Ledward's non attendance at ante-natal clinics at the Royal Victoria Hospital on Friday afternoons.

12.3. Dr Padley told us that when he became aware in June or July 1995 that Rodney Ledward was not attending his ante-natal clinic in Folkestone, he asked for an investigation to be carried out into Rodney Ledward's timetable and his attendances. He said it was clear that Rodney Ledward was not attending the clinic as he was required to do, and that this matter was therefore raised at the disciplinary hearing in August 1995.

12.4. Rodney Ledward attended the meeting on 9th August with a representative from the British Medical Association. He accepted that he had worked at St Saviour's on 29th June although he was away from work and certified medically unfit. He said that the patients had been booked in by St Saviour's without his knowledge and that he had reacted spontaneously when he had learned of this and gone to treat them. He said he did not consider he had done anything wrong but

accepted that he should have contacted the Trust the following day to say he was then fit for work. As to his attendance at the antenatal clinic, he said it was run by midwives and a Registrar with Consultant back up. He said that it was a happy clinic, that he popped in when necessary and that it was run efficiently. He said that only occasionally, about once in every 4-5 weeks, did a patient need to be seen by him and this was arranged for his Tuesday Gynaecology clinic. It was put to him that GPs were entitled to expect Consultant input when they referred their patients for Consultant antenatal care, and also that patients were entitled to be seen by their Consultant in an antenatal clinic.

12.5. At the end of the hearing Mr Addison issued Rodney Ledward with a formal warning about his attendance at St Saviour's hospital when he was signed off sick from his NHS work. Timetables for the antenatal clinic were to be reviewed and arrangements in respect of the clinic were to be clarified by Mr Stewart, Clinical Director and Miss Watkins, Director of Nursing. This was all confirmed by Mr Addison in a letter dated 10th August 1995 to Rodney Ledward in which he indicated that the formal warning would remain on his record for 12 months. He was notified of his right of appeal.

12.6. On 1st September 1995 Rodney Ledward wrote to Mrs O'Shea, Human Resources Director, to say that as the antenatal clinic on Friday afternoons was now weekly he would attend such sessions weekly. Mr Addison wrote to Rodney Ledward on 29th September 1995 regarding a meeting that had been held 2 days earlier. It stated that it had been decided that information leaflets for patients would be agreed by all the Consultants; that audit meetings would be attended regularly and minuted; that care pathways and protocols would be developed and that Rodney Ledward would endeavour to contribute to a better level of cooperation between the Consultants within the Directorate.

12.7. Dr Padley said that Rodney Ledward's attendance at the clinic was subsequently monitored and there was no problem.

13. EVIDENCE OF CONSULTANT COLLEAGUES - GYNAECOLOGISTS

13.1. Apart from the evidence we have already mentioned within the narrative above, we heard about other matters from Rodney Ledward's consultant colleagues in respect of his practice from 1991 to 1996.

Mr Stewart

13.2.1. Mr Stewart, Consultant Gynaecologist, told us that he believed that over the years Rodney Ledward ran a number of money making ventures, including fostering his private practice, working for TSI and establishing and encouraging the link with Ross University. Mr Stewart considered that all these interests allowed Rodney Ledward insufficient time to do his clinical work properly.

13.2.2. He told us that Rodney Ledward was unquestionably popular with the junior staff. Mr Stewart had been concerned that there was an element of patronage from Rodney Ledward to his junior staff as a result of TSI hospitality. He recognised that Rodney Ledward was doing the only consultant led teaching session at the time because, he said, his and Mr Davies' workload was so heavy.

Mr Davies

13.3.1. Mr Davies, Consultant Gynaecologist, said that people did not like Rodney Ledward because he could be arrogant and overbearing. Mr Davies was also aware that he pushed patients towards private practice. He said that Rodney Ledward tried to obtain a financial advantage whenever he could do so, and if one ruse failed, he simply tried another. Mr Davies, told us about a patient upon whom he had refused to carry out a termination of pregnancy in the early 1990s because he had considered that there were no proper grounds. He said that the patient was then treated privately by Rodney Ledward and that Rodney Ledward had come to speak to Mr Davies subsequently. Rodney Ledward had suggested that they should each turn down patients for NHS terminations, and should then refer the patients to the other for private care. Mr Davies was horrified by that proposal and had not agreed. Mr Davies told us that he did not feel able to tell anyone because it would have simply

been one consultant's word against the other, but he did ask Dr Farebrother (Director of Public Health for the South East Kent Health Authority) to reorganise the termination clinic.

13.3.2. He also told us that in the early 1990s when Rodney Ledward was on call, Rodney Ledward had insisted that the Registrar who was on duty at the WHH should travel to the Buckland Hospital some 23 miles away if a junior SHO at the Buckland asked for assistance. This meant therefore that Rodney Ledward was only called to the WHH in the unlikely event that there was an emergency while the Registrar was away at the Buckland. Mr Davies felt that Rodney Ledward's prime concern was to avoid having to attend the WHH when he was on call.

13.3.3. Mr Davies said that there was no audit of the division as a whole and that Rodney Ledward had only audited the occasional case to use it in a teaching session. *We remind ourselves that Rodney Ledward remained Director of Medical Audit for the Obstetric and Gynaecology Directorate during this time.*

Mr Ursell

13.4.1. Mr Ursell, Consultant Gynaecologist, gave evidence to us about the 5 year period from 1991 until Rodney Ledward was suspended in February 1996. He said that the Obstetric and Gynaecology Directorate held meetings which Rodney Ledward generally attended. He said that he also attended audit meetings. Mr Ursell told us that he considered that teaching was part of audit but the main purpose was to ensure that the Department's figures were not at variance. He said that the Consultants had never had a discussion about Rodney Ledward, or his complications or any other concern.

13.4.2. He accepted that the Directorate was geographically divided, in that the hospitals were at each end of Kent. He said that the plan was always to keep one Consultant at one end and another at the other of the area. He said that it was a distance of 50 miles across the area and 23 miles between hospitals. He told us that he did not like polarisation in the division and he tried to discourage it, although he considered that differences of opinion are not always a bad thing.

13.4.3. Mr Ursell told us that he was unaware of any concerns being raised by his consultant colleagues about Rodney Ledward's practice in 1993. He was unable to help us as to whether he had ever heard any adverse discussion about Rodney Ledward in the corridors. He said that he knew nothing about any queries over Rodney Ledward's competence, save that in 1995 he learned that people were unhappy with Rodney Ledward. He had noticed no complications when he was on call after Rodney Ledward had operated. He said that he had an open mind as to whether Rodney Ledward has been badly treated by the profession. He told us that Rodney Ledward published many articles, books and pamphlets, most of which, he said, were extremely good.

13.4.4. He said that in his view junior consultant colleagues sometimes took a patient back to theatre too readily whereas those with more experience would wait and see how things developed. He accepted that his patients may have had a longer stay in hospital longer than the patients of his junior colleagues. He said that he, like Rodney Ledward, came from an era when patients did stay longer.

13.4.5. He described Mr Stewart as an able administrator but said that he did not fit in as well in the division as some of the Consultants.

13.4.6. Mr Ursell told us that he had given evidence at the GMC. He was critical of the fact that the GMC Committee that heard the charges against Rodney Ledward, did not include a Consultant Gynaecologist in their number.

13.4.7. Mr Ursell also told us that he had felt that sometimes Rodney Ledward modelled himself on James Robertson Justice in the film "Doctor in the House". He said this was particularly apparent when he had seen Rodney Ledward at the GMC hearings.

Others

13.5. We heard evidence from another doctor who worked for the Trust between 1990 and 1996. He said that he knew in about 1993 that Rodney Ledward was

having problems with his practice. He said that it is very difficult for junior doctors to report on consultants because the consultant is responsible for the junior's training and for providing a reference at the end of such training. He also told us that Rodney Ledward was always in a rush and he gave an example. He said that on a particular day each week Rodney Ledward would do a clinic in Folkestone from 0830 to 0915, then go to St Saviour's Hospital in Hythe, then go to the WHH in Ashford to do an antenatal clinic at 11.30, then carry out a clinical meeting for junior doctors at 1300 and then do his weekly ward round finishing by 1530.

14. EVIDENCE OF CONSULTANT COLLEAGUES - OTHERS

Mr Griffiths

14.1.1. Mr Griffiths, Consultant General Surgeon, told us that from the early 1990s until 1995/6 he had been Chairman of the Audit Committee. He told us that he had been aware that Consultants in the Obstetric and Gynaecology division were split 2:2; he said they would not meet and they did not carry out audit. He told us that Rodney Ledward was primarily interested in doing private work and did not attend his NHS clinics. Mr Griffiths had spoken to the nursing staff who told him that Rodney Ledward either did not attend his clinics or left early, did not examine patients, and saw patients while he was dictating or on the phone. They also told him that Rodney Ledward tried to steer patients to have private treatment. He said that he had spoken to a number of GPs, when he met them socially or at medical meetings, about the comparative waiting lists for the Consultant Gynaecologists. They had told him that they would not refer their patients to Rodney Ledward.

14.1.2. He informed us that he and Mr Russell had taken Rodney Ledward aside in about 1992/1993 and raised these complaints with him and told him that this sort of practice had to stop. He said that Mr Russell followed up the discussion by a letter. Mr Griffiths told us that Rodney Ledward had a total lack of insight into their concerns and that he could not see anything wrong with his practice. He said that neither he nor Mr Russell received further evidence of Rodney Ledward trying to pressurise or encourage patients to go privately. He said that it was his impression

that Rodney Ledward's attendance at his NHS clinics improved, but he accepted that this was not monitored.

14.1.3. Mr Griffiths told us that although none of Rodney Ledward's surgical complications were ever referred to him, he was aware of them from his colleagues. He was also aware that legal proceedings had been brought against Rodney Ledward and that in one case at least he had not been found liable. He said that this had made him feel it would be difficult to take any action. He told us that there was no audit or system for reporting clinical incidents as they occurred at the time.

14.1.4. He told us that after Rodney Ledward was suspended a number of his colleagues including anaesthetists, a gynaecologist, and a number of the nursing staff continued to support Rodney Ledward. Some of the nursing staff seemed to want to protect him because he could show wonderful charm. There was a suggestion that the Trust was "out to get" Rodney Ledward.

Mr Derry

14.2.1. Mr Derry, Consultant General Surgeon, told us that he saw a number of Rodney Ledward's problem cases over the years and it was his impression that they became more frequent. He was generally aware that there was a problem with Rodney Ledward from gossip in the hospital. He recalled that during the 1990s he had been involved in the care of 2 patients from St Saviour's Hospital. He said that they had both suffered damaged ureters which, in his view, should not have happened. He was very concerned that nothing was being done about Rodney Ledward and so had suggested to the 2 patients that they should go to solicitors. He was told by the 2 patients that they had not been able to pursue matters. He had not felt there was much more he could do. He said that there was no system to report or investigate colleagues and told us that he had been reluctant to "stick my neck out and find myself sacked". He told us that one of the patients about whom he had been so concerned was one of the cases which was eventually found proved by the GMC.

14.2.2. Mr Derry said that after Mr Deane, Consultant Urologist, was appointed in 1989, Mr Deane had mentioned to him one or two of Rodney Ledward's patients who

suffered from incontinence. Mr Derry said that they each had concerns about Rodney Ledward as did Mr Bates. Mr Derry said that he had discussed the matter with Mr Addison, who asked him to find examples of cases which showed problems with Rodney Ledward's practice. Mr Derry said that he had found 3 or 4 such cases. He told us that it was very time consuming going though notes with nothing to guide you as to where to look. He said it had not been an enjoyable task, indeed he described it as a nightmare. He said it took a couple of years to collect this information from the time he was able to devote to the matter and from the notes available to him.

14.2.3. He said that Rodney Ledward could be very personable and charming when he wanted to be and told us that he had only ever seen the charming side. However he had been concerned at Rodney Ledward's casual approach because he felt that he was not meticulous. Mr Derry said that Rodney Ledward should not have had such a number of problems. He knew that the whole department was dysfunctional and was run badly and he gave as examples that the unit kept using locums in the consultants' absence and that Rodney Ledward was in charge of audit for the Directorate.

14.2.4. He told us that it was difficult for junior doctors to report on a consultant, as they were dependent on consultants for references. Mr Derry accepted that every surgeon probably had one bad case in their career but he felt that it was the numbers in Rodney Ledward's case that make his practice unacceptable.

Mr Deane

14.3.1. We also heard evidence from Mr Deane, Consultant Urologist, who was appointed in 1989. He told us that he had become concerned about Rodney Ledward's patients in the early 1990s. He could recall 2 patients with bladder fistulas and one with a damaged ureter. Mr Deane said that Rodney Ledward referred a number of his patients with continence problems to him. He said that the nursing staff had spoken to him about Rodney Ledward, as had his consultant colleagues. The nurses felt he had too many complications, that he operated too fast, and that his list was always finished at the same time whatever the number or type of operation.

14.3.2. He told us about his views of Rodney Ledward. He said that Rodney

[redacted]

Ledward was not a standard personality; he had found him a difficult man to cope with on a personal level. He said he was a frightening and intimidating man. He considered that much of the problem was Rodney Ledward's personality because people were frightened of him. He said, "I think people did feel physically threatened by him and would not stand up against him because of that." He said he had found it very distressing to report his colleague as he had done in 1996.

Mr Bates

14.4.1. Mr Bates, Consultant General Surgeon, said that he was aware of 2 ongoing problems in particular about Rodney Ledward: (i) a slow drip feed of a variety of allegations and (ii) patterns of injury. He told us that he recalled being asked by Rodney Ledward on occasions to cross the operating theatre corridor into the theatre where Rodney Ledward was operating, because he had damaged a patient's bowel. He discussed the problem with an anaesthetist colleague, Dr Lewis (now deceased), who had confirmed that there were problems with Rodney Ledward's practice.

14.4.2. He told us that people who worked with Rodney Ledward knew he was a problem and a danger to patients. He told us that in hospitals everyone in a hospital knows who is the bad penny.

Mr McPartlin

14.5. Mr McPartlin, Consultant Surgeon, told us that all the surgeons knew that Rodney Ledward pushed patients into private practice.

Dr Kenwright

14.6. Dr Kenwright, Consultant Physician, was Chairman of the Medical Executive Committee from 1990 until 1994. This committee was made up of a Consultant representative from each of the Directorates within the hospitals. He said that Rodney Ledward was only mentioned to the Committee once and that was about financial matters because he was pressurising patients to go privately. Dr Kenwright told us that Mr Russell dealt with it; he said that Mr Russell " had a word with Rodney Ledward". He said that Mr Bates had on one occasion mentioned a patient to him where there was a problem under Rodney Ledward but he said that he did not pay the

matter a great deal of attention.

Dr Padley

14.7.1. Dr Padley, who became Medical Director in June 1994, told us that he was aware soon after his appointment that the Directorate of Obstetrics and Gynaecology was divided. He also said that in about 1994 he had investigated Rodney Ledward's travel claims. However he said the problem was met by the finance department simply paying the accepted rate and not paying his claims in full. Dr Padley also found some claims for times when Rodney Ledward was away on leave. He said that when this was put to Rodney Ledward his reaction was that it was all a big mistake. Dr Padley said that Rodney Ledward was like Mr Toad and would agree to anything while he was being questioned but it was different once the confrontation ended.

14.7.2. He said that he and Mr Addison talked about all the various problems that arose. He said that sometimes they discussed the problems with Mr Stewart and sometimes with Mrs O'Shea, Director of Human Resources. They decided on a plan of action which was to deal with each problem as it arose. For example, he recalled that just before Rodney Ledward was suspended they had persuaded Rodney Ledward to write a letter dated 1st September 1995 (to which we have referred above) regarding his obligations to his clinical sessions. Dr Padley also told us that from the creation of the Trust in April 1994 he and his colleagues were criticised by some members of the medical profession, who went so far as to suggest that the Trust was enagaged in a witch hunt against Rodney Ledward.

14.7.3. Dr Padley told us that he had heard nothing significant about Rodney Ledward's clinical practice until February 1996 when he was suspended.

15. EVIDENCE OF OTHER DOCTORS

15.1. In relation to this 5 year period we heard from only one of the other doctors employed by the Trust.

Mr Ahmed

15.2. Mr Ahmed wrote to us to tell us that he had worked at the WHH as a locum consultant for short periods from the beginning of 1995. He told us that he had found Rodney Ledward a very knowledgeable Consultant whose clinical and operative skill was impressive. He spoke of Rodney Ledward's enthusiasm for teaching. He told us that the 2 younger Consultants in the Directorate and some of the Trust managers did not get on with Rodney Ledward.

16. EVIDENCE OF THE NURSING STAFF

Out-Patient Sister

16.1.1. An Out-patient Sister told us that Rodney Ledward had an out-patient gynaecology clinic at the Royal Victoria Hospital in Folkestone on a Tuesday morning. It was due to run from 0830 to 1200. However Rodney Ledward only attended between about 0830 and 0930. He had patients booked every 5 minutes and he saw them for 5 minutes or less. The last patient was booked for 0915. Subsequently he asked his registrar to conduct the clinic on alternate weeks so that thereafter he only attended once a fortnight, and then for only an hour.

16.1.2. She told us that Rodney Ledward's standards of hygiene were poor; sometimes he would throw dirty gloves on top of a sterile area. She said that sometimes his explanations to patients were brief or non-existent so that the nursing staff had to explain what was proposed to the patient. However if the patient asked to speak to him personally then he would see the patient and explain matters more fully. She said that in those circumstances he was usually very good. The Sister told us that Rodney Ledward appeared to be rough when he carried out vaginal examinations. She said: "He was very brief, with very little warning and it appeared rough. I would not have liked to be examined by him". She also told us that sometimes GPs referred their patients to Rodney Ledward for HRT implants. She had heard him say to such patients that implants were not available on the NHS as the Trust would not fund this. The Sister knew this was incorrect and sometimes told the patient to return

to her GP to discuss the matter further.

Theatre Sister

16.2. We have already referred to the evidence of a theatre Sister in the previous section. Her concerns about Rodney Ledward continued until 1996 when he was suspended. She did not feel things had changed although she had mentioned some concerns to Mr Stewart and Mr Davies.

Sister in Recovery

16.3.1. We heard evidence from a Sister in the Theatre Recovery Area, who had worked with Rodney Ledward in the Obstetric and Gynaecology theatre from 1993-1994, that she had several concerns about Rodney Ledward. One concern was the speed at which he operated. She said that sometimes he took 10 minutes for a vaginal hysterectomy. She felt that he did not always take proper care and that sometimes, for example, he did not tie the pedicles securely. She said he was extremely quick and slap dash and that his speed meant the nursing staff did not have time to do their jobs properly, nor did the anaesthetist. She also told us that he used to leave the operating theatre during operating lists and that sometimes he was difficult to find.

16.3.2. She said it became a matter of common gossip that patients would have problems in the evenings after Rodney Ledward's operating list on a Wednesday. She also criticised his hygiene, she said his scrub technique was perfunctory, and that when he crossed from one theatre to another he did not change his gown. She said that he failed to change gloves between examining patients or sometimes wore no gloves at all. When she raised the matter with him he told her to stop fussing. She said that Rodney Ledward sewed patients' abdomens with thick silk sutures which would not give a good cosmetic result and that he was not prepared to change or to use material that gave a better result. She felt that he had no compassion and if something went wrong he did not follow up the patient.

16.3.3. She recalled an occasion when she had queried the fact that Rodney Ledward tried to obtain a patient's consent to hysterectomy after a pre-medication had been given and while the patient was in the anaesthetic room. She told us that Rodney

Ledward had shouted and sworn at her, asking her who she thought she was in telling him what he could or could not do. She had called in another Sister. He did not go ahead with the hysterectomy but he said that if he had been in the private sector he could have done what he liked.

16.3.4. The Sister also told us about an occasion when Rodney Ledward left his Registrar to do a termination of pregnancy which was at an advanced stage. The fetus had to be removed in pieces and the nurses were all in tears. She had asked him to speak to them. Rodney Ledward had said, "Sister dear thinks I should apologise to you all". She told us that the nursing staff all felt humiliated.

16.3.5. She had felt that these concerns were generally known. She had spoken to one of the other Consultants from time to time and recalled his reaction being "Oh no, not again." She also spoke to her senior who had listened but she had not felt that anything changed.

Ward Sister

16.4. The concerns of a Ward Sister about Rodney Ledward (mentioned in our previous section) continued from 1991 to 1996. She told us that when Rodney Ledward was suspended the news was very welcome. She felt that it should have happened much earlier. She said that the nursing staff all felt pleased that matters had come to light and that something was being done about the problem.

Staff Nurse

16.5.1. A Staff Nurse told us that during this 5 year period she had to deal with many patients who needed a great deal of reassurance, after Rodney Ledward's surgery. When he came to see them the following week he would say: "I hear you have been a naughty girl". She said that he was blase and sometimes rude to patients. He had a number of stock phrases he used to patients and she said that the nursing staff were able to quote them before he even saw the patient. He used to say it was the patient who was to blame if they needed to be re-operated and she told us that upset patients a lot, as they could not understand how it could be their fault. She commented that Rodney Ledward always took the line that any problems were alway

somebody else's fault. He blamed the anaesthetist, he blamed the patient, never himself. She said that he only rarely came back to see his patients if they suffered post operative complications. She recalled that in about 1993 an SHO was in tears on several occasions when she had to explain to patients why they had been returned to theatre.

16.5.2. She told us that it was thought by the nursing staff that Rodney Ledward had a lot of power with the Royal College of Obstetricians and Gynaecologists and she said that he would speak about knowing people in the GMC. She was aware that he also had influence through TSI. She told us that in her view he was a bully but there was nothing the nursing staff could do. She said that some people respected him because of the people he knew.

16.5.3. She told us about one occasion when he had shouted at her on the ward, because she was looking after patients coming back from the operating theatre rather than presenting his patients at the ward round. She told us that he did not apologise for his behaviour and she had known that she was in the right. The Staff Nurse told the Sister in charge of the ward. However she said that the Sister had herself been intimidated by him and reduced to tears on an occasion when there were no beds for his patients.

16.5.4. The Staff Nurse told us that Rodney Ledward used to attend patients in inappropriate dress: sometimes in riding clothes and carrying a whip and sometimes in shorts.

Out-Patient Sister

16.6.1. Another Out-patient Sister gave evidence to us about the 5 year period before Rodney Ledward was suspended. She recalled a session when Rodney Ledward was in Folkestone attending an outpatient clinic, where he had spent much of the clinic telephoning all over the world, doing his administration and other matters when he was due to see patients. She had only discovered this as a result of a patient survey which the nurses ran. A considerable number of patients complained that they had overheard Rodney Ledward spending time on these other matters when

they were waiting to be seen in clinic.

16.6.2. She also told us that she had seen and heard Rodney Ledward being very cross sometimes with his junior staff. She said that another concern for her had been that Rodney Ledward would often see patients from abroad and would use an NHS bed and time for private work. She thought that this had not previously been agreed with the Trust.

16.6.3. She told us that in early 1996 she had assisted Rodney Ledward at an Outpatient clinic. She said that he had examined not one of the patients he saw, not even those patients whom he advised to undergo surgery. She said that she had been most concerned about Rodney Ledward's attitude, and that he ignored the nurses' and patients' views. She said it was all water off a duck's back.

Senior Midwife

16.7. A Senior Midwife was responsible for risk management in the Obstetric and Gynaecology Directorate from October 1995. She was answerable to Mr O'Neill who was responsible for the whole Trust's risk management procedures. She said that she began to have discussions with the staff at Directorate meetings which Mr Stewart and Mr Davies attended regularly. However she said that Rodney Ledward did not. She instituted, with the help of the Consultants and nursing staff, a number of joint protocols so that there was a uniform approach to care.

17. EVIDENCE OF GENERAL PRACTITIONERS

17.1. A GP told us that some of his colleagues from local medical centres had no criticism of Rodney Ledward and that one GP in particular had always expressed eloquent support for Rodney Ledward. However he said that he and many other GPs had concerns about Rodney Ledward which they mentioned to Mr Stewart and Mr Davies at the meeting in June 1995. He said that the GPs had been asked to provide Mr Addison and Dr Padley with chapter and verse about their concerns regarding Rodney Ledward. However they had not been able to provide that sort of detailed

information to take the matter further.

17.2. Another GP told us that neither he, nor his partners, had any concerns at all about Mr Ledward at any time before he was suspended, although he was aware of one case about which he had been concerned, which we have mentioned above. He had considered that Rodney Ledward's suspension was a "bolt out of the blue".

17.3.1. Another GP said that over the years he had realised that Rodney Ledward was obsessed with private practice and was pressurising patients to go privately. The GP considered that this was unethical as well as in breach of his contract. He had therefore stopped referring patients to Rodney Ledward and discussed the matter with his GP partners and other colleagues. He also mentioned the matter to Mr Bates, Consultant General Surgeon at the WHH, whom he said voiced his own concerns. Mr Bates had told him that he was trying to obtain details of cases about Rodney Ledward and the GP said that he was supportive of these efforts. The GP said that it was not easy for a GP to complain about a consultant.

17.3.2. The same GP told us that another of his concerns was that patients were persuaded by Rodney Ledward to receive HRT implants privately when the service was available free from GPs on the NHS. He also told us that he was concerned as to whether some patients ovaries had been removed unnecessarily. He recalled that Rodney Ledward removed the ovaries from a number of young women without their consent and then provided them with HRT implants for which they paid about £270 for each implant. He said that some insurance companies refused to pay for this repeated treatment and so the GP had simply taken over his patients' HRT care and given implants on the NHS.

17.3.3. The same GP told us about a particular patient whom he considered needed only minor surgery under local anaesthetic but that Rodney Ledward persuaded the patient to become a private patient and he then advised and she agreed to have 2 further surgical procedures as well. The GP considered that there had been no justification for all this surgery. He said that he thought this occurred in about 1994-1995.

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17.4. Another GP told us he had noticed that a number of his patients, who had been operated on by Rodney Ledward, suffered from perforations, for example to the bladder. He also told us that Mr Russell had told him in the early 1990s that he considered the obstetric department at the WHH to be a "disaster waiting to happen". During the course of our Inquiry we asked Mr Russell about this matter but he told us that he had no recollection of using those words and he did not think they would have reflected his feeling at the time.

17.5.1. Another GP told us that Rodney Ledward had attended his surgery to see patients at an outreach clinic. He said that the surgery was in the area serviced by the St Saviour's Charitable Trust. The GP said that he told patients occasionally about the existence of the Trust and that it might be able to help them. He said that Rodney Ledward was aware of this charity and he understood that several patients who were operated on by Rodney Ledward privately obtained funds from the charity. The GP also told us that after Rodney Ledward was suspended in February 1996 he had agreed that Rodney Ledward could see his private patients in the GP's clinic. He said that it was only for a few weeks from February 1996. The same GP had written a letter of support in respect of Rodney Ledward after he was suspended. A copy of the letter was sent to us by Rodney Ledward and we asked the GP about it. He said it was written when he had only learned Rodney Ledward's side of things. He accepted that he might have been too loyal to Rodney Ledward and too critical of the colleagues who had spoken out against him. He told us that he had heard rumblings about Rodney Ledward before he was suspended but it was no more than that and he had no concerns about Rodney Ledward or his practice. He said that after he was suspended Rodney Ledward had told him that his hospital colleagues "had it in for him".

17.5.2. Mr O'Neill, Trust Director of Corporate Affairs, told us that he knew that Rodney Ledward attended an outreach clinic but said that he had not set it up and had not authorised it. He said that it appeared to have been set up as a private arrangement between Rodney Ledward and the GP concerned.

18. EVIDENCE OF NHS MANAGEMENT AND ADMINISTRATIVE STAFF

Miss Watkins

18.1.1. Miss Watkins told us that after 1991 she took over responsibility for nursing in gynaecology. She was aware from gossip that some private patients brought in cash for Rodney Ledward and it was her recollection that this mostly occurred in relation to terminations of pregnancy. She said that one ward sister told her she felt "guilty by association". This was the position she had inherited when she started work on the gynaecology ward and so she did not question practices. Miss Watkins said that she would often go to the gynaecology ward on a Thursday morning to ask how many patients had been returned to theatre after Rodney Ledward had operated. She had been concerned about the number and had spoken to Mr Stewart and Mrs Darling about the matter. She said that she made sure she had skilled nurses on duty on Wednesday evenings after Rodney Ledward's operating list. She said the nursing staff told her of problems and she, in turn, told the Director of Nursing Services. However she said the nurses were reluctant to speak out about a consultant.

18.1.2. Miss Watkins also told us that on frequent occasions she reported Rodney Ledward's non attendance at clinics. However she had thought that if there was a good registrar available it was probably better for the patients to see the registrar rather than wait an hour to see Rodney Ledward and only have a minute of his time. She told us that she knew that Rodney Ledward was asked to see Miss Kennett and Mrs Darling on occasions, because he would complain to her that he had to go to see them. She did not know what happened as a result of those meetings.

Mrs Darling

18.2.1. Mrs Darling was the Director of Nursing Services from 1989 to 1993 and from 1991 she dealt with patients' complaints. She told us that she recalled that people were concerned about Rodney Ledward's attitude. She said she had spoken to him about some complaints but his response was flippant. She said that she had felt embarrassed to have to talk to a Consultant about common courtesy. She said that she could clearly recall 2 particular occasions when she had spoken to him. She told us that on the first occasion she had spoken to Rodney Ledward in front of the patient

and her relative because they wanted an apology. She told us that they were not satisfied with what he said. She said that things did not change afterwards. She said that Rodney Ledward did not take her seriously whereas other Consultants about whom she had cause to speak, did so. She said that she had spoken to him on a number of occasions about matters that concerned her, but that he was a law unto himself. She had mentioned the matters to Mr Addison and she thought that Mr Addison had spoken to Rodney Ledward about her concerns on one occasion.

18.2.2. She said that one of her concerns had been Rodney Ledward's lack of availability when he was on call. She also recalled that Rodney Ledward had told her that patients do not want a chat they want to be examined and in and out as soon as possible. She said that she had been upset by his attitude.

18.2.3. She told us that when she complained to Rodney Ledward about his being rough in carrying out a vaginal examination on a patient his response was that the patient was a "softie". She said that there were no conversation with a patient before he examined. She said that this made things very difficult for her. She recalled speaking to him about his not mentioning the presence of students to the patient before he saw and/or examined them.

18.2.4. We have mentioned, during the course of the narrative above, the complaints about Rodney Ledward received by the District Health Authority between 1991 and 1993 with which Mrs Darling would have dealt.

Mrs Watts

18.3.1. Mrs Watts was appointed Business Manager of the Obstetric and Gynaecology Directorate for the South East Kent Health Authority in 1991 and retained that position when the Trust was created in April 1994. She was responsible for the budgeting and financing of the division, and dealt with a number of matters including junior staff, bed allocation and surgical waiting lists. Her role was to work closely with whichever Consultant was Clinical Director and also with the Head of Midwifery and Gynaecology Nursing Services. She told us that Mr Davies was Clinical Director when she was first appointed and that Mr Ledward took over that

role on 1st January 1993 until 31st December 1994. Mr Stewart had then become Clinical Director. We have referred to parts of her evidence above.

18.3.2. Mrs Watts also told us that she was aware in 1991 that there was a serious imbalance in the workload of the Consultant Obstetricians and Gynaecologists in the Directorate. She raised the matter with the Consultants and told us that the senior Consultants saw it as a joke and told her that this was what junior consultants were expected to do. She also said that she understood that clinical audit meant the doctors "just looking at interesting cases".

18.3.3. She told us that when she arrived there were a lot of problems with the operating lists and waiting lists. She discovered that Rodney Ledward kept a separate waiting list for sterilisations and that some of the patients had been waiting for 2-3 years. She also said that the nursing staff had told her that Rodney Ledward refused to carry out terminations of pregnancy on the NHS but would offer to do them privately. She asked the nurses to put their allegations in writing but said that they were unwilling to do so. Mrs Watts told us that she raised the matter with Rodney Ledward. He replied that unless doctors were again to be paid an additional payment for sterilisations, patients should not be sterilised on the NHS. We were told that extra NHS payments to consultants for carrying out sterilisations stopped in about 1988 but were started again in about 1991. We understand that these additional payments caused problems for many doctors and Trusts.

18.3.4. Mrs Watts told us that soon after she was appointed she was told that Rodney Ledward's secretary collected cash from private patients and admitted patients at 7.30am for that purpose. She had taken his NHS secretary, Mrs Woodcock, aside and told her that this was illegal and that it must stop. She went so far as to threaten her with disciplinary action. She said that Mrs Woodcock did not deny that she had collected money for Rodney Ledward and said that she had been told to collect it by him. Mrs Watts said that in 1993 she heard a suggestion that Mrs Woodcock was starting to collect cash again. She called Mrs Woodcock to see her and told her there would be no second warning. Mrs Watts then raised the matter with Rodney Ledward. He said that he had asked Mrs Woodcock to do it as a favour and he could

see nothing wrong. Mrs Watts told him that collecting money in cash, in envelopes and not telling the Trust was illegal, because the patients were operated on in an NHS bed and as part of the NHS service but he was getting paid privately by the patient in addition to his NHS salary. Mrs Watts did not raise the issue with Mr Addison as she had thought that it would stop once she had spoken to Rodney Ledward directly. She had understood that the practice ceased. Mr Addison confirmed to us that a new private patient procedure was then drawn up which regulated payments by private patients.

18.3.5. She told us that another of her concerns was that there were occasions when she was not able to contact Rodney Ledward when he was on call. She said that she heard general gossip about patient's suffering from complications after Rodney Ledward had operated on them and that this sort of gossip did not occur in respect of the other consultants. She told us that Rodney Ledward was a quick practitioner but that meant he finished his lists early, not that he saw or operated on more patients. She said that his operating theatre list time was minimal. His operating list at the WHH was on a Wednesday morning but she said that he did much of his administrative work during that session. She told us that he would be in and out of his office all morning although he was due and expected to be in theatre for the whole of the session.

18.3.6. Mrs Watts told us that Rodney Ledward was very intimidating and that like all Consultants he was a god. However she felt that he was more intimidating than the others Consultants.

Mr Lowe

18.4.1. In April 1990 Mr Lowe became manager for support services including out-patients. He held that post until August 1991 when he became business manager in general medicine. He told us that it was during his work with the out-patient department at the WHH that he came across Rodney Ledward. He said he was approachable and jovial with a "hail fellow well met" attitude. He recalled that Rodney Ledward was not a good time keeper at his out patient clinics. He said that he would arrive fairly late and would not be late leaving. We asked Mr Lowe whether

he had ever raised this matter with Rodney Ledward and he accepted that he had not done so. He said that with hindsight this was a fair criticism. Once Mr Lowe's role within the hospital changed in August 1991 he had no other contact with Rodney Ledward and had heard no concerns voiced about Rodney Ledward's practice until he was suspended.

18.4.2. He told us that during the time that he worked for the NHS in Soputh East and East Kent (from 1987 to date) there had been some 5 or 6 reorganisations of the health service. He said: "you are either just getting over one or just getting ready for another one."

Mr Grimoldby

18.5. Mr Grimoldby who was the planning administrator before the Trust was created told us that from the information available to him he was able to calculate, for example, the number of patients being seen by a particular consultant. He had become aware that of the 4 consultant gynaecologists at the WHH the patients of 2 of the Consultants, Mr Ursell and Rodney Ledward, were kept in hospital for a longer period of time after hysterectomy than the patients of Mr Stewart and Mr Davies. Since this meant a variable use of resources this was important for planning purposes and Mr Grimoldby raised the matter with Mr Russell. He understood that Mr Russell spoke about the matter to Mr Ursell and Rodney Ledward. However he emphasised to us that the data available to him was concerned with quantity of work not quality of care to patients or clinical outcome.

Miss Kennett

18.6.1. Miss Kennett, Chief Nursing Officer, spoke about her dealings with Rodney Ledward between 1991 and her retirement in 1994. She said that she had always been very concerned at the way Rodney Ledward handled terminations of pregnancy. She felt that he pushed patients into the private sector whenever he could. She told us that she brought her concerns to the attention of Mrs Watts. She said that she had always tackled problems that arose although she did not feel that she had been given much support. However she said that Mr Addison had supported her. She was not aware that a concern had been raised in 1993 by a number of surgeons about Rodney

Ledward's clinical work. Miss Kennett was a member of the District Management Team until her retirement.

18.6.2. Miss Kennett told us that during the time that she had worked for the Health Authorities (between 1982 and 1994) there has been some 3 or 4 major reorganisations. She said that there were times when she took home "piles of work" because she was trying to do so many jobs. She said that all the staff were stretched. She suggested that this meant that she tended to tackle issues where she could effect a change, not those, such as consultants, where she would not have much say.

Dr Farebrother

18.7.1. Dr Farebrother told us that she had been the Director of Public Health for the South East Kent Health Authority from May 1990 to 1994 and was also a member of the District Management Team. She said that she attended meetings of the Obstetric and Gynaecology Division to which all the Obstetric and Gynaecology Consultants were invited. She said that Rodney Ledward, like the other Consultants, attended most of the time. It was her impression that after Rodney Ledward became Chairman of the Division for 2 years the meetings were held less frequently and not as much work was done at the meetings.

18.7.2. She said it soon became obvious to her that there was a discrepancy in the workload of the Consultants. She also knew of problems which caused a division between the senior and more recently appointed consultants. She was asked to attend their meetings by Mr Stewart in the hope that her presence would make matters easier to discuss. She said that particular issues were dealt with as they arose but that antagonism remained. She said that the District Management Team found it difficult to do anything about this antagonism which she thought must have affected the service being provided by the Division. She also said it was difficult to deal with the question of the variable workload of each Consultant because the problem, as she perceived it, was that patients did not like Rodney Ledward's attitude. She did not pursue that matter with him but she was aware that Mr Russell had spoken to Rodney Ledward. She said that the problem of workload was never resolved.

18.7.3. Dr Farebrother said she thought that Mr Russell worked round other problems concerning Rodney Ledward as they arose: for example the South East Kent Health Authority set up a new clinic for terminations of pregnancy which was developed by Mr Stewart and Mr Davies with Dr Farebrother's support, so that there could be no question in the future of patients being pressurised to go privately. However she said that Rodney Ledward did not participate in the new clinic but put patients who were referred to him for terminations at the end of his normal operating list. She said that as the new Clinic arrangements became more well known GPs stopped referring patients directly to Rodney Ledward. She said that she was aware that he told some patients that terminations were not available within the NHS at their stage of pregnancy. She said this was not discussed with Rodney Ledward as no policy was in place about when terminations would be available on the NHS. She said that the new terminations clinic was established in about 1992. She said that with hindsight something should have been done by the District Management Team to stop Rodney Ledward giving incorrect information to patients and pressurising them to have terminations carried out privately. She said that Rodney Ledward was difficult to talk to and difficult to criticise. She said that consultants were still thought of as all-powerful. She said that she, like the other Consultants, was aware of the problems with Rodney Ledward.

18.7.4. Dr Farebrother told us that consultants in the early 1990s did what they wanted to do and it was only if there was a real problem that they were called to book.

Mr Russell

18.8.1. Mr Russell remained the District General Manager until he retired in March 1994 just before the Trust was created. He told us that he regarded his role as minor in relation to the quality of medical care, particularly as prior to April 1994 Consultants were not accountable to him, but were accountable to the Region. He said that he had always worked on the basis that doctors were regulated by their profession and that it was for the GMC to deal with matters of clinical competence. It was for the GMC to take the first step and once the matter had been dealt with by that body then Management of the Regional Health Authority would take whatever steps

were necessary regarding their employee.

18.8.2. He said that he had never been told by any of the medical or nursing staff nor any of the administrative staff including the Management Team, that they had any misgivings about Rodney Ledward's competence as a clinician. He expressed surprise that he had not been told if there were such concerns. He informed us that his office was in Folkestone which is where he worked.

18.8.3. He told us that Dr Forsythe had told him in about 1991 that Mr Bates had mentioned his and his consultant colleagues concerns about Rodney Ledward's complication rate and that they intended to monitor the position closely. Mr Russell told us that he considered that it was for the consultant surgeons to obtain the specific and concrete information needed so that disciplinary action could be taken. He said that when he retired in March 1994 he had been relieved that nothing had come of the alleged problem while he was District General Manager.

18.8.4. Mr Russell said that he was aware that Rodney Ledward sometimes pressurised patients to become private patients and that he asked for payment in cash. However he said that none of this was capable of proof and therefore the Region could do nothing about it. As we understand it he did not raise this issue with Dr Forsythe, Regional Director of Health, although he did tell him about Rodney Ledward's failure to attend clinics and therefore to comply with his contract.

18.8.5. He told us that complaints against Rodney Ledward were no more numerous nor more serious than against other consultants. He considered that he had a good network for picking up information from the corridors of the hospitals, the "soft" information as he described it to us. He had thought that Rodney Ledward was not concerned with his NHS practice and that he carried out the minimum to comply with his NHS contract. However he said that Rodney Ledward was not the only consultant to follow such a practice.

18.8.6. Mr Russell could not recall how the membership of the three wise men committee was notified to staff.

18.8.7. Mr Russell said that he never felt as easy with the Obstetric and Gynaecology Division as he did with other Divisions, but he had considered that the answer was to employ new and younger Consultants which had been done by the employment of Mr Stewart in 1987 and Mr Davies in 1988.

18.8.8. He told us that although Mr Addison, as Unit General Manager, was answerable to him, nevertheless he had increasingly left matters to Mr Addison as his retirement drew near and particularly as Mr Addison was the acting Chief Executive of the Trust before it was set up.

Mrs Sidwell

18.9.1. Mrs Sidwell, was the Director of Nursing Quality for South Kent Hospitals NHS Trust from April 1994 when the Trust was set up. She was based at Buckland Hospital, Dover. She was responsible for dealing with complaints and also directed nursing within the Trust. She said that she re-organised the management of complaints in the first year after she was appointed. The complaints had not, for example, previously been logged on a database and so she had instituted a new process whereby complaints were dealt with fully and speedily. Having the information on database meant that she could see which ward or which consultant might be having problems and could deal with quality issues that arose from such complaints. She told us that formal legal proceedings were initially logged on the same database but that the Department of Health had required the information to be kept separate. She also told us that she had re-organised the accountability of nursing staff so that after about 1995 they were accountable to a Director of Nursing and no longer to a manager who had no nursing experience.

18.9.2. She told us that she had become aware soon after she had started work in 1994 about the discrepancy in referral rate from GPs to the 4 Consultants for maternity services. She had understood this was because Rodney Ledward was arrogant and also he left the clinics to juniors and the GPs were not happy. She had

changed the system so that midwives were not aligned to Consultants and set up group practices in the community. Otherwise, although she felt she had an open door policy, she told us that no one ever mentioned to her that there was a problem with Rodney Ledward's surgical competence. The only concerns about which she had heard were his arrogance and poor attendance.

18.9.3. Mrs Sidwell told us that after Rodney Ledward was struck off she had set up the Helpline at the Trust for former patients who had any concerns about their treatment under Rodney Ledward.

Mrs Davidson

18.10. Mrs Davidson was the Senior Nurse Patient Liaison officer from 1994 until the of end 1995. She had dealt with patients' complaints from April 1994. She told us that she understood Rodney Ledward had an attitude problem and that he was rough when examining. She told us that this was gossip. She was also aware that private patients brought cash into hospital for Rodney Ledward. She had discussed this with Miss Kennett, Mrs Darling, Mrs Sidwell and Mr Addison. She told us that in 1995 Mr Addison asked her to collect for him any problems she came across concerning Rodney Ledward. She sent complaints about Rodney Ledward to Mr Addison. She said that when she received a complaint about Rodney Ledward she wrote to him for his comments. She had not felt that it was for her to speak to Rodney Ledward about concerns and she left it to her seniors. We have mentioned above the complaints with which Mrs Davidson would have dealt concerning Rodney Ledward from April 1994.

Mr O'Neill

18.11. Mr O'Neill was Business Director of the District Health Authority from 1991 to 1994, Trust Director of Corporate Affairs from 1994 -1996 and Trust Secretary from 1996. He dealt with legal claims and said that he had never been aware of any "patterns of concern" or problems with Rodney Ledward's practice different from that of the other Consultants. He said he had felt that it was a bolt out of the blue when Rodney Ledward was suspended. He told us that he was aware that Rodney Ledward was interested in money and fostering his private practice and had a very commercial mind. We have already referred within the narrative to other evidence

Mr Addison

18.14.1. Mr Addison was appointed the Unit General Manager of the William Harvey Hospital from 1991 and then became Chief Executive of the new Trust from April 1994. He told us that Mr Russell had described Rodney Ledward to him as a likeable rogue. He had also gathered that there was concern about the financial arrangements between Rodney Ledward and Ross University and TSI, and that his financial affairs were not entirely straightforward. He was given to understand that Rodney Ledward was interested in commercial ventures. We have already referred to much of the evidence given to us by Mr Addison during the course of the narrative.

18.14.2. Mr Addison told us that he was aware that the Obstetric and Gynaecology Directorate was always feuding, but that he had not been concerned from the point of view of patient care. He was however aware that the Directorate was dysfunctional. After he became Chief Executive of the Trust he decided that the rotation of the position of Clinical Director was not sensible and he had therefore changed that policy after Rodney Ledward's tenure ended in December 1994, and had drawn up a clear job description of the duties and responsibilities of the Clinical Director. However he said that he was relatively distant from the various Directorates within the Trust and attended the Directorate meetings once a quarter. We were told that Mr Addison was an approachable Chief Executive so that anyone who had concerns could raise them with him.

18.14.3. Mr Addison told us that he was aware of rumour and hearsay about Rodney Ledward but said that did not comprise the body of evidence necessary to take any more formal step. However he said that he dealt with various problems regarding Rodney Ledward as they arose and had felt that this was the best way of ensuring that Rodney Ledward complied with his contract and provided a good service. He stressed that prior to April 1994 the Regional Health Authority was responsible for consultants' contracts in respect of their clinical work. He said that this only changed in April 1994 when the South Kent Hospitals NHS Trust was established, after which consultants were accountable to the Trust.

Mr Blakey

18.15.1. Mr Blakey was Chairman of South Kent NHS Trust from 1st April 1994 when the Trust was set up and had previously been a non-executive director of the South East Kent Health Authority. He gave evidence to us and told us that there was a lot of rumour about Rodney Ledward. He said that he was flamboyant in lots of ways but Rodney Ledward was also very plausible. Mr Blakey said that he had not been told by Mr Addison or anyone else that there were concerns about Rodney Ledward's practice at any time before he was suspended. He said that he was sure that when the Board had considered the question of legal claims against the Trust, it had been noted that there were more involving Rodney Ledward than any other doctor. However he said that the Board were told that this was because of the type of work Rodney Ledward carried out.

18.15.2. Mr Blakey told us that he knew Rodney Ledward because in June 1994 he had invited Mr Blakey to a meeting of TSI and went to subsequent meetings. He did not go again after the meeting in June 1995 when Mr Blakey had not approved of what Rodney Ledward had said about the Trust. We have referred to this matter above.

Mrs Davis

18.16.1. Mrs Davis was a non Executive Director of the Trust from 1st May 1995 to April 1999. She told us that she is a practising Solicitor. She had become aware from the legal cases report supplied to the Board by Mr O'Neill in 1995 that there seemed to be a number of claims from the Obstetric and Gynaecology Department. She was told that it was an area of work which tended to generate legal claims and also that many of the cases were old. However Mrs Davis had not felt comfortable with the number of cases. She therefore asked Mr O'Neill to prepare the report in a different way so that trends could more easily be identified.

18.16.2. She told us that it was quite clear to her after Rodney Ledward had been suspended that no one wanted to work with him again. She said that staff had described him as a bully. She said that they were relieved when he was suspended. She said that after the Disciplinary Inquiry set up by the Trust had reported she was

on the panel which heard submissions on Rodney Ledward's behalf. She told us that Rodney Ledward had attended himself at the hearing and that he had submitted that he simply needed retraining. He did not accept he had done anything wrong and said that the Trust had no grounds to dismiss him. He felt any shortcomings could be remedied by training. She told us that the decision was made to dismiss him summarily from his post.

19. EVIDENCE FROM THE REGIONAL HEALTH AUTHORITY

Dr Forsythe

19.1.1. Dr Forsythe, Director of Public Health, told us that he recalled Mr Bates speaking to him in 1991 about Rodney Ledward's professional competence and that he had asked Mr Bates to collect hard evidence together about Rodney Ledward, to see whether there was a prima facie case which would justify bringing disciplinary proceedings against him. He told us that he had also made the same request of Mr Russell. He said that in the early 1990s a pattern of poor performance was not sufficient to start disciplinary proceedings; it was felt that there had to be one or more cases of serious incompetence. He said that Mr Bates had come to see him about other matters but while talking had raised the question of Rodney Ledward's competence. He asked Mr Bates and Mr Russell to obtain concrete information. He said that he heard nothing more about the matter. Dr Forsythe reminded us that with the introduction of medical audit by the Government in April 1991, additional resources had been made available to carry out audit. As far as he was concerned audit had not picked up any problems with Rodney Ledward's practice. *We comment in passing that Rodney Ledward had been appointed head of medical audit in the Gynaecology and Obstetric division from 1989, and we are aware that audit was not rigorously carried out under his leadership.*

19.1.2. Dr Forsythe did not feel it was his job to go into the division and investigate. He left it to those who worked with Rodney Ledward to establish chapter and verse. He said that it was only from the conversation with Mr Bates in 1991 that he had any knowledge that there was a query over Rodney Ledward's competence. Dr Forsythe

left the Region in 1992. He subsequently became Professorial Fellow in Public Health at the University of Kent at Canterbury.

Dr Forsythe's successor

19.2. Until shortly before our Inquiry was completed we were under the misapprehension that Dr Forsythe had been Director of Public Health until the NHS Trust was created in April 1994. However we realise that in fact he left his post in 1992 and a new Director of Public Health was appointed. We have therefore not heard evidence from the new Director, which we regret, but we did not feel that it was right to delay our Report simply to speak to Dr Forsythe's successor, and in any event we have heard no evidence to suggest that concerns about Rodney Ledward's practice were raised with the new Director of Public Health between 1992 and April 1994, when full responsiblity for consultants' contracts was taken over by the NHS Trust.

20. EVIDENCE OF EAST KENT COMMISSIONING AGENCY

Mr Outhwaite

20.1. Mr Outhwaite told us that in July 1993 he joined the East Kent Commissioning Agency which was a joint body comprising the South East Kent Health Authority and the Canterbury and Thanet Health Authority. He was appointed Chief Executive of the Agency and his role was to start the process of merging the 2 Authorities. He said that the District General Manager for each Authority remained in position so that Mr Russell continued to be the District General Manager in respect of the South East Kent Health Authority. The Agency remained in place until the merger was complete in April 1994. During the nine months he was Chief Executive of the Agency he said that he negotiated the contracts that would be entered into when the Trusts were created and also formulated the relationship that would then exist between each Trust and the new East Kent Health Authority.

21. EVIDENCE FROM EAST KENT HEALTH AUTHORITY

Mr Outhwaite

21.1.1. When the merger was completed in April 1994 and the East Kent Health Authority was created Mr Outhwaite was made Chief Executive of that new body. As we understand it, the East Kent Commissioning Agency was then dissolved.

21.1.2. Mr Outhwaite told us that although he met Rodney Ledward once or twice in 1995 he had no contact with him otherwise. He said that he was aware from gossip about Rodney Ledward, in particular, that he had a large private practice. He also said that as a rsult of a letter written by the Chairman of the South east kent Diistrict GP committee on 21st June 1995 he realised that some GPs were unhappy to refer their obstetric patients to Rodney Ledward. He said that he discussed the matter with Mr Addison, Chief Executive of the Trust, and it was suggested that referrals should not be made by GPs to a named Consultant, so that patients could be allocated by the hospital to Consultants. He said that as consultant's employment and discipline were matters for the Trust, the issue had to be dealt with by the Trust and the Chief Executive, and monitored by the East Kent Health Authority. Mr Outhwaite said that when the Trust found the problems difficult to resolve he and Mr Addison tried to deal with the matters in other ways, for example through the Maternity Services Review. He had not been aware of concerns regarding Rodney Ledward's clinical competence prior to his suspension, although he had heard rumours about his business interests and his approach as a consultant.

21.1.3. He told us that there was not a good system of audit within the Trust so that complication rates were not noted by the Trust or by the Health Authority. He thought that without a robust system of audit concerns about a consultant's practice could not be picked up. He said that he became aware that in comparison with the rest of the country the Gynaecologists in East Kent carried out a high number of D&Cs, and hysterectomies, and that their intervention rate for patients aged between 25 and 45 was much higher than the national average. He said that some Consultants had higher rates than others, but that it was a practice which ran right across the Gynaecology Consultant body. He said that Rodney Ledward did not stand out from

his colleagues in respect of those procedures. He said these matters were tackled by the East Kent Health Authority working closely with GPs, consultants and the Trust because it was clear that a change in clinical practice was required.

21.1.4. Mr Outhwaite said that he considered that prior to the introduction of clinical governance there was no clear indication from the Department of Health as to who had responsibility for quality of patient care.

21.1.5. He told us that when disciplinary proceedings were started against Rodney Ledward he had been surprised by the clinical problems that were raised as he had not previously been told of concerns about Rodney Ledward's clinical practice. He told us that disciplinary procedures were a matter for the Trust to carry out, although the Trust had kept the East Kent Health Authority fully informed.

21.1.6. Mr Outhwaite told us that the new East Kent Health Authority was responsible for assessing the health needs of the local population and for planning the appropriate services with Trusts and GPs who will provide the services locally.

22. EVIDENCE FROM PRIVATE HOSPITALS WHERE RODNEY LEDWARD WORKED

The Chaucer Hospital - Mr Gough

22.1.1. Mr Gough told us that he was appointed Executive Director of the Chaucer Hospital in October 1990. He told us that Rodney Ledward had admitting rights at the hospital. Mr Gough had not noticed that any patient was the subject of repeated operations. He said that the number of patients upon whom Rodney Ledward operated at the Chaucer Hospital decreased over the years. He said that he had been told about concerns soon after he arrived in 1990 and that by about 1993 he and the Medical Advisory Committee of the Hospital had decided to monitor matters more closely. He told us that the anaesthetists were very unhappy anaesthetising for Rodney Ledward. As it happened, one of the anaesthetists who worked at the Chaucer Hospital became ill and the other anaesthetists said they had no time

available to work with Rodney Ledward. He said that Rodney Ledward then tried to introduce his own anaesthetist but Mr Gough told him in a letter that any anaesthetist had to have admitting rights to the hospital and that he could not therefore operate with the anaesthetist suggested.

22.1.2. Mr Gough said that he and the Medical Advisory Committee had felt that there was nothing concrete about which they could challenge Rodney Ledward. However he told us that there remained unease and he therefore did not encourage Rodney Ledward's practice at the Chaucer Hospital. Mr Gough reduced the theatre time that he was allocated. He said he was able to do this because Rodney Ledward did not have the volume of work to justify regular theatre time.

22.1.3. He told us that the hospital did not receive any complaints from patients about Rodney Ledward so that his concerns were rather nebulous. He also told us that most of Rodney Ledward's patients thought he was charming. Mr Gough said that when Rodney Ledward was suspended by the Trust it had not come as a great surprise to him.

St Saviour's Hospital - Mr Tempest

22.2.1. Mr Tempest continued to work as the general manager of St Saviour's Hospital throughout this period until June 1995. Mrs Biddle who had been Matron from 1993 took on the role as acting manager until a new manager was appointed in January 1996. Mr Tempest said that he had introduced a system at St Saviour's whereby all fees were collected by the hospital which then had responsibility for paying the surgeon, the anaesthetist and others. This meant that the patient only had to sign one cheque.

22.2.2. Mr Tempest told us that he was not concerned about Rodney Ledward's practice until he was approached by 3 consultant surgeons separately in December 1993. They were Mr Bates, Mr Derry and Mr Stewart. The gist of what they told him was that there was concern about Rodney Ledward's practice and in particular complications after surgery requiring re-operation. It was said that he might be

contacted by Mr Addison, acting Chief Executive of the shadow South Kent Hospitals NHS Trust, to discuss the actions the Trust were taking, and that in any event he might wish to look at Rodney Ledward's practice at St Saviour's. As a result of these conversations Mr Tempest told us that he arranged for an audit of re-operation rates over the previous 18 months for all gynaecologists who had admitting rights at the hospital. He asked Mrs Biddle to carry out the audit. From what we were told and from documents we have seen it seems that the results were as follows:

Consultant	**Total operations 1993**	**re-operations 1993**
Rodney Ledward	85	3
Consultant A	80	0
Consultant B	154	1
Consultant C	108	0

22.2.3. Mr Tempest had considered the results with his senior colleague but they had felt that the sample was too small to draw any definite conclusions. He told us that he informed Mr Derry of the results and asked to be kept informed about any developments within the NHS. He heard nothing from the South East Kent Health Authority nor anyone else. He said that apart from the 3 Consultants coming to see him in December 1993 no one from the Authority had ever approached him about the matter.

22.2.4. He told us that it was decided that the situation would continue to be monitored at St Saviour's and from 1994 onwards all data about complications was collected by St Saviour's Hospital in respect of all Consultant Surgeons who had admitting rights there. This was reviewed every quarter and he said that over the next 2 years Rodney Ledward only had 2 patients who needed re-operations. He had not therefore picked up that there was any continuing problem with Rodney Ledward. He was aware that some of Rodney Ledward's patients stayed in hospital longer than the patients of other gynaecologists but he felt that this probably reflected a difference

in approach. He told us that during the 1990s nursing staff did not question consultants about treatment of patients but that this culture changed once Mrs Biddle was appointed Matron in 1993. He said that she advocated a teamwork approach.

22.2.5. He told us that since patients were treated privately by Consultants any legal claims brought against a particular surgeon would not usually be notified to St Saviour's but would be dealt with by the consultants own defence union. He was therefore not aware of all claims made against Rodney Ledward in respect of private patients treated at St Saviour's. He said that the number of patients' complaints about Consultants was below 0.5% but he recognised that their complaints procedure may not have been widely known. He had not been aware of patients complaining about Rodney Ledward's care.

22.2.6. Mr Tempest said that Rodney Ledward could be a flamboyant character who played the part of a consultant with a carnation in his button hole. He told us that some people may have felt intimidated by him.

Mrs Biddle

22.3.1. Mrs Biddle was appointed the Matron at St.Saviour's from October 1993. She told us that she got on well with Rodney Ledward and had no problems with him at all. When she had first arrived at St saviour's she said that she had found the culture very different to that to which she was accustomed. She said that the nursing staff did exactly what the Consultant asked them to do and did not question treatment or make suggestions. Mrs Biddle said she wanted to change this and she encouraged the nursing staff to question and contribute to procedures that were within their province. She had a great deal of clinical experience herself and she therefore was able to suggest changes. She said that slowly the culture changed. She told us that she went to see the Sister in charge normally every morning and at lunch time and also before she went home every evening to discuss each patient who was on the ward, whether there were any problems and generally to keep an eye on the care of patients. She told us that when she was not present at the hospital she was available on the telephone in case problems arose.

22.3.2. She told us that in 1993 she had been asked by Mr Tempest to review the re-operation rates of the Consultant Gynaecologists who had admitting rights at St Saviour's. She said that she went through the theatre register first of all to see what re-operations had occurred and the clinical indications for such procedures. The register did not state which surgeon had been operating so that she said that she then looked at the theatre records for each re-operation she had found. This did not provide her with details of any unplanned re-admissions to hospital but she had only been asked to obtain the details of unplanned re-operations. She presented the data she collected to Mr Tempest. Once he had obtained advice about the information obtained he told her that there seemed to be evidence that Rodney Ledward had a higher re-operation rate than his colleagues but it was decided to take no further action on the data collected but to monitor the position in the future. She had subsequently collected the information but had decided that it would be more useful if the data collected allowed the consultant concerned to be identified and covered re-admissions, re-operations, transfers to another hospital and infections. She was not aware of any particular problem with Rodney Ledward's practice between 1994 and his suspension in 1996 as a result of this exercise. She recalled that he had 2 re-operations during the 2 year period. She said that the nursing staff did not inform her of any problems with him and she had held monthly meetings with her senior nurses as well as meeting them on a daily basis. She was involved with the major problem that arose at the end of January 1996 when one of the St Saviour patients had to be transferred to the WHH. She had been on call and had dealt with the problem as it emerged.

Mr Martin

22.4.1. Mr Martin was appointed the General Manager of St Saviour's Hospital in January 1996. He said that he had hardly met Rodney Ledward by the time he was suspended by the Trust in early February 1996.

22.4.2. He said that Rodney Ledward's admitting rights to St Saviour's were withdrawn on the day he was suspended by the Trust, because admitting rights are dependent on a Consultant being able to transfer his patients to the NHS for further treatment if circumstances demand. That rule applies whenever a Consultant is suspended by a Trust because of a matter relating to his clinical work.

23. EVIDENCE BY AND ON BEHALF OF RODNEY LEDWARD

Rodney Ledward

23.1.1. Rodney Ledward wrote to us to tell us that when he had been Clinical Director in 1993 and 1994 he had asked management for extra help and for a 5th Consultant to be appointed because the Directorate was overworked. However he was told by Mr Addison and Dr Padley that there was no money available for a 5th Consultant. He was asked to add extra patients to his operating lists. He said that in order to contribute to the Directorate's workload he had set up an outreach clinic at a GP's surgery which he attended to see local patients once a month between midday and 1pm. He told us that Mr Stewart and Mr Davies then began to attend outreach clinics regularly, attending about 10 a month between them. He said that this was the reason for the discrepancy in referrals to the consultants and that other factors (such as the fact that all patients who were referred to the new termination of pregnancy clinic were admitted under the name of Mr Davies and all colposcopy patients were admitted under Mr Stewart's name) distorted the figures. Rodney Ledward said he had been asked about the differences in referrals between himself and his colleagues and for the reasons set out above had said that in his view someone was being mischievous in raising this matter.

23.1.2. Rodney Ledward told us that he felt it was important for the Directorate to work together as a team in order to provide the best care for patients. He had not felt that Mr Stewart was a team player and he had considered it necessary to report him to Mr Addison over his management of a high risk patient in the Buckland Hospital which was designated a low risk hospital for obstetric care. He accepted that Mr Addison had investigated the matter and found no fault on Mr Stewart's part. However he understood that Mr Stewart had been prompted by this episode to make allegations against Rodney Ledward himself. He said that he recalled an occasion when Mr Stewart and Mr Davies had been critical of one of their consultant colleagues and Rodney Ledward had been able to defuse the situation. He had felt that Mr Addison was biased in favour of Mr Stewart and Mr Davies.

23.1.3. He told us that Mr Stewart had been authoritarian in his approach when he

had become Clinical Director in 1995. He had not discussed matters with his colleagues but simply made decisions over the heads of the other consultants. He said that there was a lack of communication and teamwork. Rodney Ledward said that he always worked very hard and although it was not in his nature to complain he had been unhappy that his request for a fifth consultant had fallen on deaf ears and reminded us that, since he was dismissed, a fifth consultant has now been appointed.

23.1.4. He told us that the question of the teaching fund which he had established had been raised with him by the Chief Executive, Mr Addison. He told us that the account was set up to accommodate funds from accepting medical students from Ross University. He said that other Directorates had similar funds and after he had closed the account, as requested so to do, he had suggested that all such funds should be reviewed by the Trust.

23.1.5. Rodney Ledward said that the TSI evening lectures continued to flourish and that many lecturers had spoken to staff from the WHH and the Buckland Hospital. He said the lectures were open to nurses, GPs, Dentists and others and that they were always well attended. The evening tended to end with a dinner or supper and although other centres which lecturers attended paid for the costs of the lecturer, in Kent Rodney Ledward had paid for those costs himself.

23.1.6. Rodney Ledward stated that he was never warned or criticised for poor timekeeping nor was he ever criticised for rudeness to patients. He was only accused by Mr Addison of being too cheerful and smiling too much.

23.1.7. He told us that he had always worked hard during his time as a Consultant, that he had honoured his NHS contract, had a busy private practice, was the Royal College of Obstetricians and Gynaecologists' Tutor in Kent for many years, acted as in house tutor to students and junior doctors, was Clinical Director when requested, published a series of books and co-ordinated the continuing medical education programme for doctors in the Directorate. He said that from his appointment in 1980 he had always run the weekly teaching programme for junior staff. However he felt that his style was incompatible with his fellow consultants in the later years.

23.1.8. Rodney Ledward told us that in his view (and as a result of what he was told by other Consultant Gynaecologists from outside the Kent area) he was made a scapegoat and that a vendetta had been pursued against him. He felt that criticisms of his work were made in isolation and were not properly compared with the work of consultant colleagues. He did not accept that his complication rate was higher than others and indeed he had been led to believe by at least one eminent Consultant who had looked at the cases considered by the GMC that in some years his complication rate was below average. He felt that he had been badly treated after his many years of service to the hospital. He was concerned that no Consultant Gynaecologist was a member of the GMC panel which judged his work and he was also concerned that the Chairman was a pathologist, in the same specialisation as Dr Padley who had been instrumental in putting forward the cases to be considered. Rodney Ledward clearly felt that a number of colleagues at the WHH had wanted to have him removed from the Trust by whatever means.

23.1.9. He told us that he had been surprised, upset and hurt by some of the allegations made by nursing staff about him and by some of his Consultant colleagues. He felt that at least some of them had been coached. He also commented on the media criticism to which he has been subjected which he considered upsetting and untrue. He felt that many patients had come forward to the Helpline established by the Trust because of the possibility that they might receive compensation. He also felt that some of his colleagues who were asked to review patients who contacted the Trust helpline had shown a lack of objectivity and balance and fuelled criticisms from patients. He also said that he was concerned at the appalling use of public funds which were spent on pursuing him and not being spent on patient care. Finally he told us that "no person ever expressed any concern about my practice at any time in terms of complications...".

Mrs Woodcock

23.2.1. Mrs Woodcock, Rodney Ledward's NHS secretary, told us that after TSI was asked to leave the WHH she reduced her NHS hours and on Mondays worked at the new TSI offices. She said that Rodney Ledward's timetable was then as follows:

	Morning	Afternoon
Monday	Harley Street	Royal London Hospital
Tuesday	Royal Victoria Gynaecology Outpatients WHH antenatal clinic Ward rounds	Lunchtime meeting Colposcopy clinic at WHH Administration
Wednesday	Operating at WHH and overseeing registrar's list	Administration and labour ward
Thursday	Antenatal ward rounds at Dover and Deal	Outreach clinic until 1400
Friday	Operating list at Buckland	Antenatal clinic, Folkestone WHH Administration

23.2.2. She told us about the lunchtime meetings on Tuesdays when Rodney Ledward would give a teaching session and a drug company representative would pay for sandwiches and coffee. She said that the money was paid into a teaching fund and that Rodney Ledward bought books for the library from the fund. She told us that when he was at the WHH carrying out an operating list he would return to his office during the session to carry out administrative work. She said that on Friday afternoons he would drop into the WHH to pick up his post.

23.2.3. Mrs Woodcock told us that she had not been accountable to the Business Manager, Mrs Watts. She told us that she felt accountable to her Consultant in the first instance. She said it had been uncomfortable and that Mrs Watts had not made life easy for her.

23.2.4. She told us that she had collected cash from a number of patients when they did not want any letters sent to their homes; for example if they were to undergo terminations of pregnancy. She said that she attended the hospital at 08.30 and the patients brought the cash to her office. She said she always offered to obtain a receipt and that sometimes Rodney Ledward wrote or signed a receipt. She told us that she then handed the cash to him and he dealt with it. She told us that she had never heard any concerns about Rodney Ledward. She was completely shocked when he was

suspended. Mrs Woodcock told us that she was amazed that so many women had come forward after he had been struck off. She said that whenever a patient had a problem about which they telephoned her she would raise the matter with Rodney Ledward and he would ask her to arrange an appointment for him to see the patient. She said that in her view there was a vendetta against him. She was also of the view that many of his former patients had been prompted to complain in order to obtain compensation.

23.2.5. Mrs Woodcock told us that Rodney Ledward was a flamboyant character. She also told us that she was aware that the Obstetric and Gynaecology Directorate was divided between the 2 senior Consultants and the 2 more recently appointed Consultants. She said that Rodney Ledward was very helpful to the junior staff particularly at the Tuesday lunchtime meetings when particular cases were discussed. She said that neither Mr Stewart nor Mr Davies attended the meetings.

Miss Harris

23.3. Miss Harris, was Rodney Ledward's private secretary throughout this period and continued to administer his private practice and do his accounts. She was wholly supportive of him and his work, she felt he had always dealt with his patients in a good and proper manner and she told us that she was appalled by the vendetta which she perceived was waged against him. She has remained throughout a loyal and firm supporter of her employer.

24. Department of Health Circulars

The Patients' Charter

24.1.1. In 1991 the Patients' charter was published by the Department of Health . It described the NHS as "a service that always puts the patient first, providing services that meet clearly defined national and local standards...."

24.1.2. It set out 7 existing rights for every patient in respect of their care within the NHS including:

> "No 4: the right to be referred to a consultant acceptable to you when your GP thinks it is necessary;
>
> No 5: the right to be given a clear explanation of any treatment proposed, including any risks and any alternatives, before you decide whether you will agree to the treatment;
>
> No 7: the right to choose whether or not you wish to take part in .... medical student training."

24.1.3. The Charter also envisaged that from 1st April 1992 patients would have further rights in respect of information about local resources, quality standards, maximum waiting list times, guaranteed admission to hospital within 2 years of being placed on a waiting list, and complaints being investigated and responded to promptly by the chief executive or general manager. Further rights were to be given as "circumstances and resources allow".

The Health of the Nation

24.2. In June 1991 the Department of Health published a discussion paper entitled The Health Of the Nation. It set out the Government's proposals for the development of a health strategy. Its aims were to identify key areas of health care where it was thought that improvements could be made; to set targets in those areas at national and local levels which would then be monitored; and to bring further areas into the system as knowledge improved. A number of key areas were suggested and comments were invited.

Guidance for Staff on relations with Public and Media - EL(93)13

24.3.1. In June 1993 the Department of Health published guidance for staff encouraging openness and dialogue within the NHS. It was stated that the NHS exists to meet the needs of patients and went on to say that all NHS staff have a duty to draw to the attention of managers any matter they consider to be damaging to the interest of a patient. A duty was also placed on every NHS manager to ensure that staff were easily able to express their concerns through all levels of management to the Trust, and that managers were also bound to ensure that all concerns were dealt with thoroughly and fairly. It was also emphasised as follows:

> **"Under no circumstances are employees who express their views about health service issues in accordance with this guidance to be penalised in any way for doing so."**

24.3.2. All NHS employers were to establish procedures after full consultation for handling staff concerns about health care issues. It was stated that Managers should always:

> take concerns seriously;
> consider them fully and sympathetically;
> recognise that raising a concern can be difficult for staff;
> seek advice from health care professionals where appropriate.

24.3.3. *This Guidance in our view contained most appropriate advice for the Department to give NHS staff and managers. However we express concern that the document's title suggesting that it offered guidance on staff relations with the public and media may have meant that the message for staff and managers was not acted upon in the way envisaged.*

Reporting Adverse Incidents - HSG(93)15

24.4. Also in June 1993 the Department of Health published guidance to ensure the prompt reporting of adverse incidents in particular in relation to medicines and defective equipment.

Clinical Audit - EL(93)59

24.5.1. In July 1993 the Department of Health published a document entitled Clinical Audit. The pamphlet stated: "Clinical audit involves systematically looking at the procedures used for diagnosis, care and treatment, examining how associated resources are used and investigating the effect care has on outcome and quality of life for the patient." The purpose of the circular was to review the process started in 1989 pursuant to the document entitled "Working for Patients". It set out the Department's policy for development of multi-professional clinical audit. It set out the fundamental principles of clinical audit which should:

be professionally led;
be seen as an educational process;
be based on the setting of standards;
generate results to improve outcome of quality care;
involve management;
be confidential;
be informed by views of patients.

24.5.2. It also stated that chief executives should have overall responsibility for the quality of care provided for patients and must therefore have confidence in local audit. The Chief Executive was to be actively involved in clinical audit.

Codes of Conduct and Accountability for NHS Boards

24.6. In April 1994 the Department of Health set out Codes with which Members of Trust Boards were required to comply so as to ensure effective running and management of NHS Authorities and Trusts. It emphasised that patients must come first and stressed that since the NHS is publicly funded, it must be accountable to parliament for the services it provides and for the effective and economical use of taxpayers' money.

Disciplinary Procedures for Hospital Staff - HSG(94)49

24.7. In October 1994 Guidance was published by the Department of Health as to suspension of staff and stated that immediate suspension might be appropriate to protect patients. It was recommended that the procedures should be incorporated into

local disciplinary procedures. It set out the steps to be followed when suspension was carried out and advised that suspension should be on full pay. Guidance as to time limits for the various procedural steps were set out, although it was accepted that there might be circumstances where adherence to the time limits was not possible.

Code of Practice on Openness in the NHS

24.8. In April 1995 the Department of Health published a Code on the provision of information to the public. It was stated that Trusts and Authorities must provide information about how to contact the Community Health Council and Health Ombudsman and how to gain access to personal medical records.

Guidance on Implementation of the Code on Openness

24.9. Guidance on the Code mentioned above, was published in May 1995.

25. Professional Conduct and Discipline Pamphlets published by the General Medical Council (GMC) known as "The Blue Books"

Pamphlet published in February 1991

25.1.1. This Blue Book made several changes to the existing duties of a doctor. We mention the following changes which in our view are relevant to our Inquiry.

25.1.2. Where it was considered, after preliminary investigation by the GMC, that an allegation of serious professional misconduct should not be pursued, for example because the matter did not raise a question of serious professional misconduct, the decision not to proceed could only be made after consultation between the President of the GMC and a "lay screener".

25.1.3. Under the heading **Delegation of medical duties to professional colleagues** it was stated:

"... consultants in hospital practice, and doctors engaged in private practice... should seek to ensure that proper arrangements are put in hand to cover their own duties... during any period of absence..... Consultants and other senior hospital staff should delegate to junior colleagues only those duties which are within their capabilities."

25.1.4. Under a new heading **Comments about professional colleagues**, the pamphlet recognised certain situations where doctors might properly comment on another's practice. It stated:

> "Doctors are frequently called upon to express a view about a colleague's professional practice. This may, for example, happen in the course of a medical audit or peer review procedure, or when a doctor is asked to give a reference about a colleague.... Honest comment is entirely acceptable in such circumstances, provided that it is carefully considered and can be justified, that it is offered in good

faith and that it is intended to promote the best interests of patients.

Further it is any doctor's duty, where the circumstances so warrant, to inform an appropriate person or body about a colleague whose professional conduct or fitness to practise may be called in question or whose professional performance appears to be in some way deficient. Arrangements exist to deal with such problems, and they must be used in order to ensure that high standards of medical practice are maintained.

However, gratuitous and unsustainable comment which...sets out to undermine trust in a professional colleague's knowledge or skills is unethical."

25.1.5. *We have emphasised this part of the 1991 Blue Book in particular, because it meant that after February 1991 any doctor who was concerned about another doctor's conduct, fitness or competence, had a positive duty to report that doctor. However there was no clear guidance as to who was an "appropriate person or body" to whom the matter should be reported, nor was there clear guidance as to what arrangements existed to deal with such problems.*

Pamphlet published in May 1992

25.2. In our view this Blue Book made no major changes relevant to our Inquiry.

Pamphlet published in January 1993

25.3. Again it is our view there is nothing new in this pamphlet which is relevant to our Inquiry.

Pamphlet published in December 1993

25.4. Again this pamphlet made no major changes which in our view are relevant to our Inquiry.

A New Booklet " Good Medical Practice" was published in October 1995

25.5.1. In October 1995 the Council issued a completely new booklet entitled **Good Medical Practice**. It is our understanding that it replaced the earlier Blue Books. At the beginning of the booklet it stated:

> "Patients are entitled to good standards of practice and care from their doctors. Essential elements of this are professional competence, good relationships with patients and colleagues and observance of professional ethical obligations."

25.5.2. The duties of a doctor were set out under a number of headings including the following:

Good clinical care
Keeping up to date
Teaching
Maintaining trust
Confidentiality
Abuse of your professional position
Your duty to protect all patients
Working with colleagues
Working in teams
Delegating care to non-medical staff and students
Arranging cover
Decisions about access to medical care
Probity in professional practice
Financial and commercial dealings
Conflicts of interest
Research

25.5.3. We mention some of the duties which were set out in more detail under the various headings that we have referred to above:

> "In providing care you must: be competent when making diagnoses and when giving...treatment; keep clear, accurate and contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or treatment prescribed.
>
> You must work with colleagues to monitor and improve the quality of health care. In particular, you should take part in regular and systematic clinical audit.
>
> To establish and maintain trust [with patients] you must:
>
> * listen to patients and respect their views;
> * treat every patient politely and considerately;
> * respect patients' dignity and privacy;
> * give patients the information they ask for or need about their condition, its treatment and prognosis
> * give information to patients in a way they can understand;
> * respect the rights of patients to be fully involved in decisions about their care;
> * respect the rights of patients to refuse treatment or take part in teaching or research;
> * be accessible to patients when you are on duty;
> * respond to criticisms and complaints promptly and constructively.
>
> You must not allow your views about a patient's lifestyle...social status or perceived economic worth to prejudice the treatment you give or arrange.

You must not abuse your patients' trust. You must not for example: put pressure on your patients to give money ... to you; recommend or subject patients to investigation or treatment which you know is not in their best interests.

You must protect patients when you believe that a colleague's conduct, performance or health is a threat to them. Before taking action, you should do your best to find out the facts. Then, if necessary, you must tell someone from the employing authority or from a regulatory body. Your comments about colleagues must be honest. If you are not sure what to do, ask an experienced colleague. The safety of patients must come first at all times.

You must not make any patient doubt a colleague's knowledge or skills by making unnecessary or unsustainable comments about them.
Health care is increasingly provided by multi-disciplinary teams. You are expected to work constructively within such teams and respect the skills and contributions of colleagues.

If you are leading a team, you must do your best to make sure that the whole team understands the need to provide a polite and effective service ....

You must be satisfied that, when you are off duty, suitable arrangements are made for your patients' medical care. These arrangements should include effective handover procedures and clear communications between doctors.

You must be honest and trustworthy."

25.6. *Commentary on the GMC Pamphlets*

25.6.1. *In 1991 there was a major change in the duties of a doctor namely to report on a colleague when there were concerns about his conduct, performance or fitness to practise. Otherwise the format of the Blue Books remained the same. However the booklet* ***Good Medical Practice****, published in October 1995, demonstrated a new and refreshing approach. No longer was the first section of the Code taken up with Disciplinary Procedures. For the first time the booklet started and ended with setting out in clear language the duties of a doctor in relation to his professional practice. We comment that Good Medical Practice was much easier to read and digest than its predecessors and we commend the GMC for carrying out this wholesale change. In our view, the advice given in the pamphlet was, for the first time, set out in a clear and logical way. We consider that there is a need for clarity and simplicity of expression if doctors are to read, understand and, most importantly, to follow the duties set down by their professional body. In our view this radical change in content and style should have alerted doctors to the need to read and follow the new code. However from the evidence we have heard, we are not convinced that every doctor appreciates the importance of being familiar with the code embodied in Good Medical Practice.*

26. Code of Professional Conduct for Nurses, Midwives and Health Visitors published by the United Kingdom Central Council for Nursing (UKCC)

Code of June 1992

26.1.1. In June 1992 the third edition of the UKCC Code of Professional Conduct was published. The first duty of a nurse was set out, namely:

"to safeguard and promote the interests of individual patients and clients"

26.1.2. The Code also stated that a registered nurse is personally accountable for his/her practice and:

"...must act always in such a manner as to promote and safeguard the interests and well-being of patients....".

26.1.3. Nurses were also enjoined:

(i) to ensure that no action or omission on his/her part or within his/her sphere of responsibility is detrimental to the interests, condition or safety of patients;

(ii) to work in an open and co-operative manner with patients; and

(iii) to report to an appropriate person...any circumstances in which safe and appropriate care for patients cannot be provided.

27. *Our Commentary on Rodney Ledward's practice during the period 1st January 1991 and 31st January 1996*

27.1. *It is our impression from all we have read and heard, that during this 5 year period concerns about Rodney Ledward and his practice were known by many doctors, nurses and administrative staff. They all seem to have felt that he was a difficult man to confront: that when matters were raised with him he did not accept that he had done anything wrong, and that little change in his practice was ever discernible. Apart from post operative complications, there were serious concerns about his attitude and behaviour, his pressurising of patients to become private patients, his financial interests, his seeming lack of interest in the NHS, and his poor attendance at clinics or when on call. At the same time he remained a good teacher of junior staff, he encouraged lecturers to attend the Kent area under the auspices of TSI and he continued to foster the arrangement with Ross University to train overseas doctors.*

27.2. *He clearly had a good relationship with Mr Ursell but did not consider that Mr Stewart should have been Clinical Director, resented his management and brought a formal complaint against his colleague's clinical competence. In a Directorate that was already divided this can only have meant that it became even more dysfunctional.*

27.3. *We are once again forced to the conclusion that the only person who had complete knowledge of the problems with his practice was Rodney Ledward himself. Despite the number of patients who suffered damage during his surgery or suffered complications afterwards, it never seems to have crossed his mind that there was anything amiss with his technique. Despite complaints from patients, challenges from some of the nursing staff to his practice, management investigations, a disciplinary hearing and a formal warning nothing seems to have made him stop and think that possibly he was at fault. He appears to have been supremely confident in his abilities and actions. Nothing apparently gave him pause for thought.*

27.4. *During this period of time we are satisfied that change was being promulgated within the NHS by the Department of Health. Patients' rights had been set down in*

the Patients' Charter in 1991; staff had been encouraged to raise concerns and had been promised that their concerns would be dealt with thoroughly and fairly in the Department's Circular dated 1993; clinical audit was to be part of the whole NHS delivery of service from 1993; NHS Trust Boards were made accountable for the service provided to patients from 1994; and in 1995 a policy of openness with the public about the provision of information was to be pursued within the NHS as a whole. The reforms in the Health Service meant that Consultants were no longer autonomous, they were to be held to account via audit and by their colleagues. Of course reforms take time to work through a large and complicated organisation, but we do not consider that the reforms were adopted fully and properly in South East Kent. The reforms had to be driven from the top, but our impression is that for much of the period management time was being spent converting to Trust status and then establishing the Trust, so that these new initiatives were not followed as rigorously as they should have been. It is our view that these changes within the NHS had little impact on Rodney Ledward or on the rest of the staff at the South Kent Hospitals NHS Trust.

27.5. *We were told by Mr Russell that patients' formal complaints about Rodney Ledward were no more numerous nor more serious than against other consultants. We have not inquired into complaints made against other consultants who worked in hospitals run by the South East Kent Health Authority and the South Kent Hospitals NHS Trust, as that was beyond our remit. In our view, from the documentation we have seen and described above, the complaints by patients about Rodney Ledward should have alerted management and administrative staff to the fact that there was a serious problem with his practice. If complaints were indeed as numerous and as serious against other consultants, then that only strengthens our view that management needed to look at the quality of care being provided in the hospitals for which they were responsible.*

27.6. *As we have already said it seems that many of the medical, nursing and administrative staff knew there was a major concern about Rodney Ledward and his practice during the 5 years ending in January 1996; they just did not know how to cope with it. We have heard that management decided to deal with each problem*

separately as it arose. This was a start but it seems to us that no one looked at the whole problem; no one stood back and considered the effect of the concerns about Rodney Ledward on patients, on staff within the hospitals where he worked, and on the whole service being provided first by the Health Authority and then by the Trust. We accept that we have had the advantage of hearing about concerns over a condensed period of time and in respect of both Rodney Ledward's NHS and private practices. However, our information has been obtained at considerable remove from the events both in time and in place, and investigation at the time of incidents and as they occurred would probably have provided a more detailed and more accurate picture.

27.7. *We fully accept that when major re-organisation was going on, it may have been easier to concentrate on that, rather than on the service actually being provided to patients in hospitals. But, as had been stated by the Department of Health for many years, patients must always come first. Whatever organisational or administrative difficulties were being dealt with should never have meant that patients's needs were not met as a first priority.*

27.8. *We also accept that people with a powerful personality, such as Rodney Ledward, are not easy to constrain. We can all think of well known figures who have shown a similar personality trait and, particularly, lack of any insight. We found the analogy with Mr Toad very graphic. We also understand that the longer problems had continued to run without hindrance, the more difficult it became to tackle them.*

27.9. *However we consider that each problem required proper investigation as it came to light and then needed to be considered together with all the the other problems. To deal with each in isolation meant that no one ever appreciated the full extent of the concerns about Rodney Ledward.*

28. *Rodney Ledward's Competence*

28.1. *From the cases we have considered during the period from 1991 to the end of Janauary 1996, both in the NHS and in the private sector, it seems to us there was sufficient and strong evidence of a lack of competence by Rodney Ledward as a Consultant Gynaecologist, to raise serious concerns within the South East Kent Health Authority and later, within the NHS Trust. The speed with which he carried out the waiting list initiative in January 1993 and the problems that ensued from that list in our view typify the problems with his practice.*

29. *Rodney Ledward's Conduct*

29.1. *We have heard evidence that during this 5 year period Rodney Ledward continued to pressurise patients to become his private patients and we have been most concerned that he seems to have fostered his private practice by encouraging NHS patients to use the funds of the St Saviour's Charitable Trust. We point out that he started an outreach clinic in a surgery which was situated in the area where patients were able to apply to the Charity for financial help. The Trust did not arrange this clinic and took no steps to ensure that it was properly set up and organised.*

29.2. *We have heard from a few patients that Rodney Ledward examined them internally without a chaperone being present. We have not been able to investigate these allegations properly and we note that such allegations were not made at the time. We therefore do not feel able to say any more about this. However it seems from what we have been told by patients and nursing staff, that sometimes Rodney Ledward carried out vaginal examinations on patients without wearing gloves. Such a practice is wholly improper.*

29.3. *Rodney Ledward appears to have ignored the limitations on the number of operations he carried out for the waiting list initiative in January 1993; he attended a private patient when he had told the Trust he was ill and had been signed off from work; he sometimes did not attend clinics as required and when he did attend he did*

not stay for the full session; he appears to have accepted money from drug companies without properly accounting to the Trust; it seems that on one occasion he may have been drunk while in the hospital.

30. ***Rodney Ledward's Attitude and Manner***

30.1. *We have heard a great deal of evidence from patients that they found Rodney Ledward intimidating in his attitude and manner towards them and felt belittled by his comments. It is our impression that he frequently showed little interest in patients, their concerns and worries, particularly if they were NHS patients. He presented himself as arrogant and overbearing; we have heard that he did not take time to examine patients properly or gently, nor did he take time to explain matters; everything seems to have been done in a rush, with the interests of patients being placed firmly second to his own.*

30.2. *We have also heard that during this 5 year period there were occasions when Rodney Ledward shouted at professional colleagues and intimidated them. We accept that in any organisation even the most placid of people can occasionally lose their temper. But from what we have heard, Rodney Ledward's outbursts were sustained and intemperate and it is clear that no sincere apology ever followed.*

31. ***Should Rodney Ledward's failings have been noted and acted upon by the South East Kent Health Authority or the Regional Health Authority, or after 1994, by the South Kent Hospitals NHS Trust?***

Before creation of the Trust in April 1994

31.1. *We are of the view that both the Regional Health Authority and the South East Kent Health Authority had a responsibility to ensure that proper care was being provided to patients. Region had a duty in law. The South East Kent Health*

Authority also had a responsibility to ensure that NHS staff working in its hospitals, whether directly employed by the Authority or not, were working competently. We are satisfied that in 1991 concerns about Rodney Ledward's practice had been raised with the Regional Director of Public Health, Dr Forsythe, and that the District General Manager of the South East Kent Health Authority, Mr Russell, and the Unit General Manager of the WHH, Mr Addison, had been informed of the general surgeons' concerns about Rodney Ledward's competence. We are satisfied that Dr Forsythe had asked Mr Russell to provide him with concrete examples of Rodney Ledward's incompetence and that it was reasonable for him to rely on Mr Russell to investigate the matter.

31.2. *It is therefore our view that during this period there was a need by the senior management of the South East Kent Health Authority to deal with the various concerns that had been raised about Rodney Ledward and his practice. The whole matter needed to be looked into by, for example, asking nursing and theatre staff, and Rodney Ledward's Obstetric and Gynaecology Consultant colleagues and also the General Surgeons whether there were concerns about Rodney Ledward's practice. Simply to rely on monitoring by the surgeons themselves was to abdicate responsibility for what was a problem for management. Only those who managed the hospitals where Rodney Ledward worked had the ability and authority to investigate the concerns properly. We consider that it was unrealistic to expect a Consultant General Surgeon to have the time and authority to investigate poor performance of a colleague in a different specialty. We accept that investigation would have been demanding of time and energy by management. It would have been a difficult and unpleasant task. However in our view managers are appointed to manage and if they shrink from that responsibility, the NHS is poorly served.*

31.3. *We comment that in the culture that existed at the time it was most unusual for consultants to report on a colleague to senior management of the Health Authority and the Region. In our view the fact that one did so in 1991 should have prompted further inquiry at the time.*

31.4. *We accept that the quality of evidence needed to satisfy the disciplinary procedure set out in the 1990 Department of Health Circular (HC(90)9) was very high but that should not in our view affect the investigation that needs to be carried out. The quality of the evidence can only be judged once an investigation has been carried out and the facts have been ascertained.*

31.5. *Then in January 1993 there was clear evidence of Rodney Ledward's breach of the agreement in relation to the waiting list initiative, and problems with 3 of the 7 patients upon whom he had carried out major surgery. This should have been brought to the attention of senior management who should have investigated his practice fully.*

31.6. *In December 1993 a General Surgeon and 2 Gynaecologists expressed their serious worries about Rodney Ledward to Mr Addison who was then acting Chief Executive for the shadow Trust. An audit was decided upon but no audit was carried out. In our view such an audit was well overdue in the Gynaecology Unit.*

31.7. *We are unsure whether theatre staff recorded and monitored all surgical activity, as had been recommended in the Bevan Report in 1989, but had management ensured that this was done then data would have been readily available in the operating theatre registers. It would only have been necessary for a theatre sister or a consultant to go through the registers and pick out in respect of each consultant, for example, the number of intra-operative complications and details of patients' being taken back to theatre for re-operation. That data might well have shown that there was a serious problem with Rodney Ledward's practice.*

31.8. *We accept that much time and energy was being expended on the creation of the Trust and on another Directorate within the WHH which we were told had serious problems. However by the end of 1993 a number of respected surgeons had brought to the attention of Mr Addison, acting Chief Executive, problems in respect of Rodney Ledward's competence. These in addition to a number of other concerns that were known about by him at the time should have meant that this was not a matter that was left and forgotten. We consider that it should have received proper attention and as a*

matter of urgency. In our view the concerns of the surgeons demanded to be taken seriously. It appears that none of these concerns was brought to the attention of the Regional Health Authority.

After creation of the Trust in April 1994

31.9. *From April 1994 consultant contracts were held by the Trust and no longer by the Region. Therefore any matter concerning a consultant after that time, both in law and practice, fell to be dealt with by the Trust. Region might help, but the primary responsibility lay thereafter with the Chief Executive of the Trust.*

31.10. *In February 1995 Rodney Ledward complained about a Consultant colleague to Mr Addison, Chief Executive, and to Mr Blakey, Chairman of the Trust. The matter was fully investigated and Rodney Ledward eventually apologised for his assertions. His own practice was called into question during this investigation. It seems odd that this did not remind Mr Addison of the complaints of the general surgeons and gynaecologists some 15 months previously.*

31.11. *In the summer of 1995 the Trust management was aware (as they had probably known for some time) that there was an imbalance in the work of the 4 Consultant Gynaecologists. The matter was taken up with the local South East Kent GP Committee. The GPs discussed their concerns about Rodney Ledward and a letter was sent by the Chairman of the Committee to Mr Addison, Chief Executive of the Trust. At the subsequent meeting between the Chairman of the GP Committee, Mr Addison and Dr Padley (Medical Director), the GP informed them of the concerns about Rodney Ledward although he may not have made it clear that there were also concerns about Rodney Ledward's clinical competence. However the fact that the Chairman of the GP committee had written in strong terms, and sent copies to the Chairman of the Trust, and the Chairman and Chief Executive of the East Kent Health Authority, should in our view have alerted Mr Addison and Dr Padley to the measure of concern felt by the GPs, and to the fact that there might be a major problem with Rodney Ledward's practice. After the discussion with the GP, Mr Addison asked him to speak to Rodney Ledward himself about the GPs' concerns. We consider that this was again to abidcate responsibility for a serious management*

problem. In our view it was quite wrong to leave it to the GP to meet Rodney Ledward to resolve matters, it failed to do justice to the serious matters that were being raised with management and failed to give the lead that was necessary. We consider that Mr Addison should have set up a formal meeting for the three of them to discuss the problems which had been raised.

31.12. *We consider that a full investigation into the GPs' concerns by asking doctors, nurses and administrative staff about the matters which had been raised, should have been put in hand, and proper audit of the Gynaecologists should have been carried out. No one took active responsibilty to collect and collate all the information that was available. In our view senior management failed to carry out its duties and responsibilties in the way that the NHS and the public is entitled to expect.*

31.13. *The disciplinary action taken in August 1995 as a result of Rodney Ledward treating a private patient when he was signed off sick from the WHH, was a proper step, but it was dealt with in isolation and did not trigger a full investigation of all the matters which were causing concern. For example Rodney Ledward's attendance at his gynaecology clinic in Folkestone for only one hour, when the session was scheduled to last for three hours, never seems to have been investigated or monitored.*

31.14. *We accept that when matters did finally come to a head at the end of January 1996 Dr Padley, Mr Addison and the Trust Board acted appropriately in suspending Rodney Ledward and instituting disciplinary proceedings. They obtained advice and followed it and Dr Padley spent a great deal of time and energy, supported by Mr Addison and the Board, in investigating matters sufficiently to come before the Disciplinary Inquiry panel that was set up.*

31.15. *But it had taken 16 years to reach that point. For the previous 10 years or so we consider that management were or should have been alerted to serious concerns about Rodney Ledward and his practice. Such concerns increased as the years went by. It is a sad and sorry tale that it took until the end of January 1996 for the matter to be taken in hand in the way it should have been many years previously. There had been opportunities: there had been matters raised by staff and patients which should*

have been investigated. It did not serve Rodney Ledward's patients, the staff he worked with or Rodney Ledward himself to permit him to carry on practice in the way he did for so many years. Had senior management acted earlier, as in our view they should have done, many of the problems with which we have been confronted, would have been avoided.

32. *Should Rodney Ledward's failings have been noted and acted upon by the private hospitals where he habitually worked?*

32.1. *It seems that there were concerns about Rodney Ledward's practice at the Chaucer Hospital. Although Mr Gough, General Manager at that hospital, had no concrete evidence about Rodney Ledward's practice, he was sufficiently concerned by what he had been told and his own observations, to take steps to reduce the time allowed to Rodney Ledward to treat private patients at the hospital.*

32.2. *In December 1993 a number of Consultant Surgeons from the WHH, who had admitting rights at St Saviour's Hospital informed Mr Tempest, the General Manager at that hospital, that they had concerns about Rodney Ledward's surgical complication rate. The matter was taken seriously by St Saviour's and was investigated. We commend the prompt action taken at St Saviour's. However no contact was made by the management of the shadow NHS Trust with St Saviour's management, as had been envisaged.*

32.3. *Although the result of the investigations carried out at St Saviour's showed that Rodney Ledward had a higher complication rate than his gynaecological colleagues, nevertheless it was felt that since the sample was relatively small it was not a matter that should be taken further, other than that audit should continue for the future and indeed would be widened.*

32.4. *Therefore in the absence of any contact from Mr Addison to Mr Tempest, no one looked at the whole issue of Rodney Ledward's complication rate for both his NHS and private practice. Perhaps one could suggest that St Saviour's should have itself been in touch with Mr Addison, but in the real world we can see that there is not always an easy dialogue between the NHS and the private sector and, in any event Mr Tempest had been told that the shadow Trust would be in touch with him. The fact that Mr Addison never contacted him may well have lulled him into a false sense of security that there was indeed no problem with Rodney Ledward's clinical practice.*

PART VI - RODNEY LEDWARD'S PRACTICE AFTER HE WAS SUSPENDED ON 6TH FEBRUARY 1996

PART VI

RODNEY LEDWARD'S PRACTICE AFTER HE WAS SUSPENDED ON 6TH FEBRUARY 1996

1. PRIVATE PRACTICE IN KENT

1.1. Rodney Ledward was suspended by the South East Kent Hospitals NHS Trust on 6th February 1996 and disciplinary proceedings were brought against him. While those proceedings were pending he carried on private practice under an arrangement with a GP at a local surgery for a short while.

1.2. In December 1996, after the disciplinary proceedings had been concluded, he was dismissed from his post as a Consultant Gynaecologist and Obstetrician and he was reported to the GMC. He appealed against his dismissal and his appeal was dismissed in May 1997. However in accordance with disciplinary procedures he continued to be paid by the Trust until his appeal was dismissed.

2. EMPLOYMENT BY THE MINISTRY OF DEFENCE AT THE PRINCESS MARY'S HOSPITAL, AKROTIRI, CYPRUS

2.1. In the meantime, on 16th February 1997 Rodney Ledward commenced employment as a Consultant Gynaecologist and Obstetrician for the Ministry of Defence at the Princess Mary's Hospital at Akrotiri, Cyprus. He remained employed there until 28th May 1997. A number of his former patients expressed their concern to us that Rodney Ledward was able to continue to practise after he was dismissed by the Trust for incompetence and misconduct, and we felt that it was necessary for the purposes of our Inquiry to investigate this matter. We also express our concern that he may have been paid by two public bodies at the same time between February and May 1997, although we accept that neither was aware of this fact at the time.

2.2. Mr Brian Johnson wrote to tell us that he took early retirement from the position of Consultant Gynaecologist and Obstetrician at the Princess Mary's Hospital in Cyprus in 1997. He had known Rodney Ledward as a friend from 1966, and it appears that he suggested that Rodney Ledward apply for the locum consultancy that Mr Johnson's early retirement created. We were told by the Ministry of Defence that Mr Johnson also strongly recommended Rodney Ledward to the other Consultant Obstetrician and Gynaecologist at the Princess Mary's Hospital, Mr Awad. Rodney Ledward applied for the post and provided a copy of his curriculum vitae and 2 references. The references were both from eminent Consultant Obstetricians and Gynaecologists and we have seen copies of those references.

2.3. One referee wrote that he knew Rodney Ledward as a colleague and as a teacher of medical students but that he had no personal knowledge of his surgical abilities. He mentioned that patients referred by Rodney Ledward to him had been properly assessed and prepared by Rodney Ledward and that such patients had spoken very highly of him. He also stated that he had found Rodney Ledward to be an honest man of high integrity whom he considered would serve the Hospital well.

2.4. The other referee said that he knew Rodney Ledward through programmes of continuing medical education. He said that he could not comment on Rodney Ledward's practice in obstetrics and gynaecology but said that he was a man of integrity and honesty "who is extremely trustworthy and who has the highest ethical and moral standards." He also commented on his dedication and contribution to medical teaching. He gave Rodney Ledward "my highest personal recommendation and endorsement."

2.5. The Ministry of Defence told us that since this was a short-term casual post Rodney Ledward was not interviewed and his last employer was not contacted. He was appointed locum consultant on the strength of the personal recommendation of Mr Johnson and the 2 written references referred to above.

2.6. Mr Johnson wrote to us to say that he had been aware that Rodney Ledward had been dismissed from his consultant post in Kent when he recommended him for the

locum consultancy in Cyprus. He told us that he made Mr Awad aware of the circumstances in which Rodney Ledward was applying for the position. By contrast we were told by the Ministry of Defence that it was not known that Rodney Ledward had been dismissed or that he had been referred to the GMC until just before he left Cyprus in May 1997. The Ministry of Defence also said that they only learned about the problem when the Commanding Officer of the Princess Mary's Hospital in Cyprus received an anonymous telephone call about Rodney Ledward's dismissal from the Trust and his referral to the GMC. When asked about the matter Rodney Ledward had apparently told the Commanding Officer that he left his position because of a disagreement and that his appearance before the GMC was a matter of routine. The Ministry of Defence told us that during his locum contract only one patient complained "about a minor procedural problem concerning Rodney Ledward" and that this was resolved satisfactorily after Mr Awad intervened.

2.7. We were told that Rodney Ledward applied for a fixed term position at the Princess Mary's Hospital when it was recommended that an up to date reference should be obtained from his last employer, should he be the preferred candidate. In the event he was not offered the appointment.

2.8. Mr Johnson remains of the view that Rodney Ledward was unfairly dismissed and unfairly struck off the Medical Register. He wrote to us in strong terms criticising the behaviour of the Trust and the GMC's Professional Conduct Committee. It therefore seems likely that he did strongly recommend Rodney Ledward for the position of locum consultant.

2.9. *We comment that it seems to us wrong that a doctor, who has been dismissed for incompetence and misconduct by a NHS Trust, should be able to obtain employment by another Government Department. It is our view that the immediate past employer should always be contacted for a reference whether the position applied for is temporary or permanent.*

3. SUBSEQUENT EMPLOYMENT AS CONSULTANT

3.1. It appears that Rodney Ledward then applied for a post as Consultant Obstetrician and Gynaecologist at a hospital in Kuwait. We were told by Dr Padley, Medical Director, that the Kuwait Hospital had telephoned the WHH because they were seriously considering employing Rodney Ledward. He had not given the NHS Trust as a reference but the Kuwaiti authorities were simply checking up as a matter of routine. They were told that Rodney Ledward had been dismissed from his employment and that he was currently under investigation by the GMC. We have not been able to discover whether or not Rodney Ledward ever was employed in Kuwait after his dismissal by the Trust. A further enquiry of Dr Padley was made by a hospital in Muscat in February 1998 and he replied in similar terms. Again we have no knowledge as to whether Rodney Ledward was ever employed there after he had been dismissed by the Trust.

PART VII

RECOMMENDATIONS

CONTENTS

GENERAL PRINCIPLES WHICH UNDERLIE THE QUALITY OF CARE

A number of general principles have emerged from our consideration of Rodney Ledward's work as a doctor.

1. The NHS and private health care exist to provide good health care to patients. That is the overriding objective and every other consideration must be secondary to it.

2. A culture of openness with patients and between colleagues is a vital component of good health care.

3. The sooner concerns about a doctor's practice are noted and acted upon, the greater the chance that patient care will be safeguarded, and the greater the chance that deficiencies in the doctor's practice will be remedied before his or her career is damaged.

4. It is in the interests of all those who provide or assist in the provision of care, all NHS managers and the NHS as a whole, that concerns are raised and dealt with promptly.

5. The calibre and personality of key managerial staff are crucial to the provision of good health care.

CLINICAL GOVERNANCE IN THE NHS

INTRODUCTION

1. As we have already said, the NHS exists to provide good health care to patients. That is the overriding objective, and everything else must be secondary to that principle. This is now enacted by statute in S.18 of the Health Act 1999 which states:

> "It is the duty of each Health Authority, Primary Care Trust and NHS Trust to put and keep in place arrangements for the purpose of monitoring and improving the quality of health care which it provides to individuals."

2. **The vast majority of doctors, and other health care professionals provide good care to patients and work together as a team to give a good service of which the NHS should be proud.**

3. Unfortunately there is a very small minority who do not provide good care and we have heard about a number of horrific incidents within the NHS. It is this small minority with which we have been concerned.

4. The terms of our Inquiry required us to make recommendations arising from the Rodney Ledward case, particularly in respect of the development of Clinical Governance within the NHS locally and nationally. Many NHS employees to whom we have spoken seemed only to have a hazy understanding of what the expression Clinical Governance means. We understand Clinical Governance to be:

> A comprehensive framework which ensures that high quality care is provided to patients, ensures that standards continuously improve, encourages clinical excellence and provides clear accountability.

5. The concept of Clinical Governance was first described by the Department of Health in a document entitled A First Class Service, published in September 1998, and was introduced into all NHS Trusts and Health Authorities in April 1999. The system provides for NHS Trust Chief Executives to bear the ultimate responsibility for Clinical Governance in their Trusts. Every Trust must also have a Clinical Governance Committee to monitor Clinical Governance throughout the Trust. The members of the Committee must work together closely to ensure that Clinical Governance is effective. The Trust's Medical Director will be a member of that committee and is particularly concerned with all aspects of Clinical Governance relating to doctors, and for medical care provided to patients.

6. There are many different component parts of Clinical Governance. We do not make recommendations on all aspects of Clinical Governance; we confine ourselves to those where we feel that our Inquiry has given us some insight into how NHS Trust systems could be improved in order to provide good quality care for patients throughout the NHS, and to ensure the effectiveness of Clinical Governance.

7. It is our strong view that, in order for Clinical Governance to be effective, doctors and other healthcare professionals must be given time to permit them to participate fully in all the various aspects of Clinical Governance.

8. It is also our strong view that however good systems are, they will fail unless they are managed by people with the right personality, with drive and ability and who can command respect. The appointment of such people in key management positions is vital to the efficient running of the NHS.

9. We deal in particular with the following aspects of Clinical Governance:

Incident Reporting
Audit
Complaints and Claims
Appraisal
Use of Data

Liaison between NHS Trusts and GPs

Whistleblowing

10. We then go on to deal with other areas of concern which have been highlighted during the course of our Inquiry, where we feel that we can make useful recommendations to improve the quality of care.

11. In the recommendations which follow we have tried to simplify and build on existing NHS procedures and practice adopting, in particular, the pockets of good practice currently followed in some NHS Trusts about which we have heard. We are well aware that the NHS has undergone frequent change over the last 20 years, but in our view, repeated and radical change does not always promote good quality care for patients.

12. We have been told that the South Kent Hospitals NHS Trust introduced many changes at their hospitals, including the introduction of Clinical Governance, in the period after the disciplinary proceedings were instituted against Rodney Ledward. We do not deal with those changes specifically, preferring instead to make recommendations which we consider are sensible for adoption throughout the NHS.

INCIDENT REPORTING

1. A Clinical Incident Reporting system aims to ensure that untoward events, which occur in hospital, are identified and investigated and that lessons are learned. A Clinical or Critical Incident Report form should be completed when anything untoward occurs. That includes any variation from the norm: for example, a patient who develops a haematoma after surgery; any unusual event: for example no chaperone being present when a doctor carries out a vaginal examination; and anything untoward: for example a porter who fails to take a specimen to a laboratory. Forms are to be filled in by anyone who is aware of the incident. We heard evidence that generally nurses are very good at filling in such forms; by contrast doctors rarely fill in a form.

2. We were told that there was no system of clinical incident reporting in place before Rodney Ledward was suspended, although there was a procedure for reporting accidents which occurred to patients and staff.

3. We have heard from a number of witnesses about the clinical incident reporting systems now followed in the NHS Trusts in which they work. Some told us it was part of their everyday life; some told us that they had never filled in a form. Our strong impression is that there is a large divergence in practice throughout the NHS.

4. A culture of openness, which we consider is vital to the provision of good quality care to patients, should mean that filling out clinical incident forms is second nature. Obviously the need to complete forms requires common sense and a balanced approach. We are not advocating that every minor event should trigger completion of a form.

5. It is our view that a good clinical incident reporting system, which is properly organised and managed by an effective Clinical Risk Manager, would have picked up concerns about Rodney Ledward's practice. Such a Manager would soon be able to decide whether incidents which were being reported were too trivial, or on the other

hand, whether incidents which required discussion and possible remedial action were not being reported. The system of incident reporting is dependent on there being an efficient and respected person in charge.

6. It appears that many Trusts have devised their own incident reporting systems and have established a number of events which trigger an employee to complete a clinical incident report. We have heard that some Trusts do not require the person filling in the form to identify themselves; other Trusts require identification of the person filling in the form.

7. Many witnesses told us that, although they filled in forms, they did not receive any feedback as to what steps, if any, had been taken to deal with the incident, or to prevent recurrence of the incident. Others told us that regular meetings are held in the hospitals in which they work when incident reports are discussed, any changes are decided upon and feedback is given.

8. We are aware that in 1999 the Royal College of Obstetricians and Gynaecologists approved a list of events in gynaecology (which had been drawn up at the John Radcliffe Hospital, Oxford) for which an incident report should be completed, for example for post-operative complications such as major infection, serious haemorrhage or damage to the urinary tract.

9. In our view a good system of incident reporting is essential for patients and staff alike, and the merits will become obvious to the sceptical, the more the system is seen to work. It should mean that concerns are picked up promptly and remedial action taken before patients and colleagues are put at risk. It will also permit NHS Trust employees, including doctors, to be given an early opportunity to change their practices where something untoward has occurred. In particular an efficient system of incident reporting should identify multiple untoward incidents which involve an individual doctor where each episode is not, on its own, sufficiently serious to draw attention to poor performance.

RECOMMENDATIONS

(i) *The present clinical or critical incident forms should be renamed Incident Reports because they should cover all aspects of care in hospital.* Thus matters of conduct as well as clinical matters should all be covered by the same system in order that problem areas may be identified and practice altered. One of the secondary advantages of the reporting system is that a written and contemporaneous record of the incident is made so that there is no need to rely, if necessary at a later stage, on imperfect recollection or hearsay.

(ii) *Each Royal College should identify a minimum list of untoward **clinical** events which should trigger the completion of an incident report. Basic decision making which is outside the norm should also be covered by the system.* Thus the decision to carry out hysterectomy on a patient under 30 years of age could, and probably should, be part of the trigger list identified by the Royal College of Obstetricians and Gynaecologists. The list should be added to locally by each Clinical Directorate as the system is being operated. Therefore Trusts will learn from experience. It is also important that there should be a blank section on the incident report form so that untoward events not covered in the list can be recorded.

(iii) *Each Trust should develop a list of untoward **non-clinical** events which should trigger the filling in of an incident report.* This would cover issues of conduct in the widest sense. Thus if a hospital porter is late to take a patient to theatre or a doctor is rude to a patient or a nurse, those should be events which would trigger a report being completed. The list of events on the incident report form should be added to and amended with experience. Once again one section of the form should be left blank to allow for an untoward event to be reported which is not within one of those listed.

(iv) *The person completing the form should generally identify themselves.* We consider that the provision of a name on the bottom of the form encourages the culture of openness which should underlie the NHS.

(v) *Any NHS employee should be required to complete an incident report form if he or she is aware of an untoward event.* For example health care support workers would complete a form when a piece of equipment is broken. Porters would fill in a form if they found the operating theatre locked when it should not have been. A surgeon would fill in a form when he or she caused accidental damage to a patient while operating. These are but examples of the system as it should work. We give them to show that the system depends on the participation of all employees in the Trust. *Diligent and conscientious completion of forms is essential to the effectiveness of the system.*

(vi) *The person in overall charge of incident reporting, the Clinical Risk Manager, must ensure that forms are completed whenever an identified trigger event has occurred or whenever an incident has occurred which is outside the normal or expected. This requires that the person in charge of incident reporting is pro-active, exercises initiative, and goes out into the hospital to ensure that the system is working in practice in every Directorate. The calibre of the person and the status he or she has within the NHS Trust is vital to the effectiveness of the system. The Clinical Risk Manager should be directly answerable to the Chief Executive of the NHS Trust and should be a member of the Clinical Governance Committee of the NHS Trust.*

(vii) *Completed forms must be collected, considered and acted upon by a named individual within each Directorate. That person must be a clinician who commands the respect of other members of the Directorate so that problems can be picked up and acted upon urgently if necessary. The person must be allotted time within his or her contract to carry out this task.* All members of the Directorate should know who has the responsibility within the Directorate for fulfilling this role. That individual should discuss with the Clinical Director areas of concern that arise from the reports, and should be answerable to the Clinical Risk Manager. Sometimes incident reports will identify an aspect of care which requires audit; sometimes a detailed investigation will need to be carried out.

(viii) *Discussion should take place regularly at Directorate meetings as to the various untoward events that have been recorded; as to any subsequent investigation or audit; and as to how practice should be altered. It is vital that the person in charge of incident reporting within the Directorate ensures that any change in practice decided upon is fully implemented within the Directorate. It is also vital that staff who have completed forms are informed of what steps have been taken as a result.*

(ix) *The Clinical Risk Manager must liaise closely with the person in charge of complaints and claims to ensure that problems are identified early, and any necessary change in practice is introduced and then properly monitored.*

AUDIT

1. Audit is perhaps the most important component of Clinical Governance. Clinical audit is crucial to improving quality of care and audit should also be used to demonstrate whether other components of Clinical Governance, for example incident reporting, are effective.

2. Good doctors have always practised some sort of informal audit of their own practices. In 1989, in a document entitled Working for Patients, the Department of Health advised on the need for systematic medical audit by doctors. By 1993, in the document entitled Clinical Audit (EL(93)59) it was recognised that care of patients was often multi-disciplinary in that it was provided by a whole range of doctors and other healthcare professionals. Audit therefore expanded to cover that multi-disciplinary care and became known as clinical audit.

3. In essence audit requires doctors and others who provide care to see whether they have achieved set standards and, if not, to identify in what respects they have not done so. Audit then requires them to decide on and introduce change to ensure that the standards are reached. Finally audit requires that any such change is monitored to ensure that the perceived deficiencies have been rectified and the set standards achieved.

4. Topics to be chosen for audit in hospitals need to include those where there are concerns about a practice which may have been identified by the system of incident reporting, or where a practice may be different from that followed elsewhere. Audit requires collaboration between those who provide care and those who manage the service.

5. The National Confidential Enquiries into Peri-operative Deaths, into Stillbirths and Deaths in Infancy, into Maternal Deaths, and into Suicides and Homicides, carry out well established audit on a national basis. We are also aware that audit has moved on considerably since it was first formally introduced in 1989. The Royal Colleges

have established a number of clinical standards. Clinical guidelines have been developed nationally and locally to set out best practice in certain fields of medicine. The Department of Health has in recent years selected certain topics for national and local audit, for example, the managements of cataracts. The National Centre for Clinical Audit supports this process. The Cochrane Collaboration provides information about best practice as a result of evaluation of research. In addition we understand that the new National Institute for Clinical Excellence will provide considerable direction for audit nationally, and will promote good clinical standards.

6. During the course of our Inquiry we have heard that after 1989 audit was spasmodic in the Directorate of Obstetrics and Gynaecology at the William Harvey Hospital and tended to focus on particular cases which appealed to an individual doctor or which might be good examples for teaching purposes. There seems to have been no systematic audit covering the work of all the Consultant Gynaecologists at the WHH, apart from that carried out in the early 1980s. From the evidence we have heard it does not appear that every NHS Trust has operated a rigorous and effective system of audit. We consider that had a good system of audit been in place in the Obstetric and Gynaecology Directorate at the WHH, the problems with Rodney Ledward's practice, to which we have referred at length above, would have been recognised long before he was suspended.

7. We were told by patients and GPs that sometimes a patient who has undergone surgery contacts his or her GP after discharge from hospital because of a problem that has arisen. In some instances the GP may be able to deal with the matter without contacting the consultant concerned so that the consultant is unaware that a problem has developed. This means that the consultant, and indeed the Directorate in which he or she works, may have an incomplete picture for example, of complication rates, or the outcome of surgery.

8. In our view good quality care for patients is made up of both care in hospitals and care in the community, but to date there seems to have been little collaboration between the two component parts in respect of audit. Patients are affected by the quality of care provided and they have a considerable interest in wanting to ensure

that effective audit is carried out. In our view audit of the overall provision of care in hospital and in the community, which should include both outcome and patient satisfaction, is the ideal.

9. We also consider that clinical audit, when properly carried out, encourages a culture of openness.

RECOMMENDATIONS

We would hope that much of what follows is already in place in every NHS Trust, but we set out recommendations to underline the importance of audit in ensuring that good quality care is provided to patients.

(i) *All doctors, including consultants, must participate in clinical audit and must cooperate with the demands of audit in the Directorate in which they work.*

(ii) *Audit requires thought and deliberation, and time for audit should be allowed for within every doctor's contract.* It should not be seen as something to fit in between patients or when a doctor suddenly finds that he or she has a spare 5 minutes.

(iii) *The consultant who is the lead clinician for audit in each Directorate should ensure that appropriate topics are chosen for audit, data is collected conscientiously and is valid, the results are discussed, deficiencies are identified, changes in practice are formulated promptly and properly disseminated, and a date is set for re-audit to ensure that any deficiencies previously identified have been rectified. The consultant who leads audit in each Directorate is a key figure in the provision of quality care to patients, and needs adequate time as part of his or her contract to carry out these tasks.*

(iv) *Each NHS Trust must have appointed a clinician to be the Head of Audit who should chair the audit committee, comprising the lead consultants in audit of each Directorate. The Head of Audit should co-ordinate and organise effective audit*

throughout the Trust, should be answerable directly to the Chief Executive and be a member of the Clinical Governance Committee of the NHS Trust. He or she must have the drive and enthusiasm to want to ensure that clinical audit is effective and is seen to be effective throughout the Trust. It is essential that the Head of Audit is given an identified period of time within the working week to carry out audit responsibilities properly.

(v) *We are of the view that the Department of Health should consider ways to audit the longterm outcome of patients after hospital inpatient care. Collaboration between NHS Trusts and Primary Care Groups would be essential, and lay people should be involved in such audit particularly when considering patients' expectations against outcome.*

COMPLAINTS AND CLAIMS

COMPLAINTS

1. We have heard about a number of formal complaints made against Rodney Ledward and a number of claims brought against the Health Authority or NHS Trust as a result of his practice, some of which we have described in the earlier parts of this Report.

2. We have considered the various Department of Health Circulars on complaints and how the procedures were followed before February 1996 within the South East Kent Health Authority and the South Kent Hospitals NHS Trust. It will have been clear that we do not consider that complaints about Rodney Ledward's practice were always handled well. Complaints are currently made by patients to a Trust under a procedure introduced by the Department of Health in 1996.

3. Complaints' Guidance for the NHS was published in March 1996 under the title:

COMPLAINTS Listening ... Acting ... Improving

Guidance on implementation of the NHS Complaints Procedure

4. The Guidance is 65 pages long and has 7 appendices. It requires each NHS Trust and Health Authority to appoint a complaints manager and at least one convener, (one of whom must be a non-executive director of the Board). If a complainant indicates at any stage in the procedure that he or she intends to take legal action the complaints procedure must cease.

5. In summary the procedures require oral complaints to be dealt with at the time they are made. Written complaints are to be referred to the complaints manager. After investigation a written reply is to be sent to the complainant by the Chief Executive. The procedure envisages that written complaints will be answered within 20 days and the complainant then has 28 days in which to request a convener to set up an Independent Review Panel. The complainant has no right to demand the setting up

of such a panel; the decision rests with the convener.

6. The convener normally decides whether to convene an Independent Review Panel within 20 days of the complainant's request. Where the complaint includes an issue of clinical competence the convener must take appropriate clinical advice before making the decision. If the convener decides that no panel should be set up, the complainant then has the right to go to the Health Service Commissioner, the Ombudsman. If the convener decides to set up a Panel, then 3 members of the Panel are appointed within 20 days, with an independent lay chairman and often the convener as one member of the Panel. If complaint is made about an issue of clinical competence then the panel must be advised by at least two independent clinical assessors who prepare reports for the Panel. The assessors are taken from a list established by the Regional Office, on behalf of the Secretary of State for Health. The final report of the Panel is normally delivered within 60 days, but the Panel has no executive power to ensure that its advice is followed. On receipt of the report the Chief Executive of the Trust or Health Authority must inform the complainant within 20 days of any action to be taken and advise that if the patient remains dissatisfied then he or she can go to the Ombudsman. The Trust or Health Authority concerned then decides upon and carries out any action as a result of the complaint. Of the 89,000 complaints made last year to NHS Trusts we were told that approximately 600 proceeded to an Independent Review Panel.

7. We heard evidence that there was considerable dissatisfaction in the way complaints are dealt with both at local and national level. We consider that the existing complaints procedures are lengthy, cumbersome and time consuming. In effect where a complaint is made and the complainant remains dissatisfied, then (after the initial NHS Trust investigation) it may take 5 months or more to reach the end of the procedures. We cannot believe that this in anyone's best interests. It has been said for years that the complaints procedure should be simple, speedy and fair. We do not consider that the present procedures meet these aims. In our view, the establishment of a simple and straightforward procedure for dealing with complaints would work to the benefit of patients and Trust employees (including doctors) alike.

8. We have also been very concerned to learn that some patients are reluctant to complain when they are in hospital, because they fear that their care and treatment may be adversely affected if they do complain at the time.

9. We have heard that some NHS Trusts currently tackle the whole issue of complaints in a sensible, positive and efficient way. We were told that where there is an efficient system, only very rarely (about once a year) does a patient wish to take a complaint further to the Independent Review Panel. We consider that this good practice needs to be followed throughout the NHS. If a good system is in place at local level then we see no need for the additional stage of referral to an Independent Review Panel before the complainant should be permitted to go to the Health Ombudsman, who since April 1996 has had power to deal with clinical matters. In our view referral to an Independent Review Panel is expensive, time consuming and disruptive.

CLAIMS

10. Members of the public may bring legal claims for compensation against NHS Trusts in respect of negligent care by the employees of the Trust. In the recent past a protocol has been devised for dealing with potential claims before proceedings are started. The protocol has been endorsed by the new Court Civil Procedure Rules which came into force on 26th April 1999.

> "The protocol -
> * encourages a climate of openness when something has "gone wrong" with a patient's treatment or the patient is dissatisfied with that treatment and/or the outcome. This reflects the new and developing requirements for clinical governance within healthcare".

11. The Clinical Disputes Forum, which drew up the Protocol, stated:

> "A climate of mistrust and lack of openness can seriously damage the

patient/clinician relationship, unnecessarily prolong disputes (especially litigation) and reduce the resources available for treating patients".

12. In essence the potential claimant must now set out in a letter, before the claim is made, a summary of the facts, state exactly what is the grievance and why the patient considers the Trust and its employees failed to provide proper care. The Trust has 3 months in which to provide an admission that care was inadequate or to give a detailed and reasoned answer.

13. It has been beyond our remit to investigate whether current or past claims against Rodney Ledward have been properly dealt with. However we consider that the new spirit of openness which underlies the Court Rules should encourage a proper response from all parties to litigation.

OPENNESS IN THE NHS

14. We cannot emphasise too strongly the need for the culture of openness throughout the NHS. If concerns and anxieties are ignored or brushed under the carpet, patients will mistrust their doctors and the whole service being provided by the NHS. It is in everyone's interests to be open and frank. There is much anecdotal evidence that such an approach often defuses a potentially serious and expensive claim; that patients feel able to place confidence and trust in those caring for them; and that the burden of guilt on doctors and other carers is lessened.

15. This principle is recognised by the GMC in the 1998 edition of Good Medical Practice. The relevant parts read:

> "Patients who complain about the care or treatment they have received have a right to expect a prompt and appropriate response. As a doctor you have a professional responsibility to deal with complaints constructively and honestly. You should co-operate with any complaints procedure which applies to your work. You must not allow a patient's complaint to prejudice the care or treatment you provide or arrange for that patient.

If a patient under your care has suffered serious harm, through misadventure or for any other reason, you should act immediately to put matters right, if that is possible. You should explain fully to the patient what has happened and the likely long and short term effects. When appropriate you should offer an apology...."

We agree that saying sorry can, in appropriate circumstances, defuse a difficult and sometimes costly legal investigation. However from the evidence we have heard we are concerned that not every doctor feels able to be open and frank with his or her patient.

16. To expect a doctor to admit that he or she has made a mistake is dependent on the NHS operating a culture in which it is accepted that the very best of doctors will on occasions make mistakes. It also requires other doctors and managers to provide support, to talk about the matter openly and to help doctors avoid any repetition. Without such a culture, doctors may try to hide mistakes and act defensively, even attempting to blame others, rather than look into why the error occurred in the first place and learn how to prevent it happening again.

RECOMMENDATIONS

(i) *All complaints and claims should be managed by the same department within a NHS Trust. One person, the Complaints and Claims Manager, should be in charge of the Complaints and Claims Department, being answerable to the Chief Executive and being a member of the Clinical Governance Committee of the NHS Trust.* The purpose of having one person in charge of complaints and claims is so that information can be compared, patterns and trends can be noted and the provision of care to patients may be amended as a result of understanding any shortcomings in current practice. Uniformity and consistency of approach are essential in a Trust and one person in overall charge of complaints and claims should aid that process.

(ii) *The role of the Complaints and Claims Manager is pivotal. The person needs to be a good listener, receptive, responsive and able to go quickly to the heart of the concern. Such a person needs to be able to command the respect of all Trust employees, including doctors, and to be able to deal sensitively with patient's concerns. The role should be given to someone who is keen to do the job. It requires interest, initiative and a pro-active approach.*

(iii) *A flexible and responsive approach to complaints is vital and it is essential that the main cause of complaint is responded to head on.* We have seen in our consideration of the complaints about Rodney Ledward that too often the patient's main cause for concern remained unanswered while only the peripheral matters were dealt with. When a complaint is made, the essential question to be considered is: what is the patient really complaining about? Sometimes people are not good at expressing themselves and an astute and sympathetic Complaints and Claims Manager may well find that the first step is to telephone the patient, if possible, to find out exactly what is troubling them. The complaint needs to be answered so that relevant personnel involved with the patient's care should be spoken to and, if necessary, arrangements made for the doctor and patient to meet in the presence of the Complaints and Claims Manager. There will be a whole range of responses which will need to be tailored to meet the individual case.

(iv) An incident which gives rise to a complaint or claim should in most cases have triggered the completion of an incident report at the time it occurred. This will therefore provide contemporaneous information which will be of use when replying to the complaint or claim. *Absence of an incident report in respect of a complaint or claim should prompt investigation to ensure that the incident reporting system is working effectively.* This is but an example of why it is necessary for the Clinical Risk Manager and the Complaints and Claims Manager to work closely together.

(v) We approve the recommendation of the national legal charity, the Public Law Project, which in September 1999 recommended in a document entitled Cause for Complaint?, that: *all employees in a NHS Trust should on appointment be trained in dealing with on-the-spot complaints and responding to other complaints. We also*

consider that further training should be given to all employees from time to time, which would serve to re-inforce the culture of openness.

(vi) *Patients who have concerns about their care must be able to raise the matter while they are in the hospital and be given a full and proper response at the time.* Staff, including doctors, need to listen and answer questions. We recognise that this may be time consuming. A system should be devised in every NHS Trust whereby concerns are dealt with promptly at the time they are made, and recorded in the patients notes. If the patient remains dissatisfied then a further discussion should take place in the presence of the patient's relative or friend, if desired, which should also be noted in the patient's records.

(vii) *If a doctor or other person providing care to a patient realises that something has "gone wrong", or the outcome is not as intended, a full explanation needs to be given by a person who is able to speak authoritatively about the problem.* For example, if a patient has to be taken back to theatre because of haemmorrhage, it is important that a doctor of sufficient seniority, preferably the consultant, sees the patient to explain in detail what has happened. The explanation should be recorded in the patient's notes.

(viii) *Whenever the Complaints and Claims Manager is alerted to the fact that someone has not responded properly to a complaint at the time or when a subsequent complaint is made, he or she must raise the matter with the Chief Executive.*

(ix) *If a patient still has a concern after the complaint has been responded to with sensitivity and fairness and after proper investigation, then the patient should be advised that he or she may take the complaint to the Health Service Ombudsman.* The fact that the next stage is directly to the Ombudsman will in our view encourage complaints to be dealt with fully and properly by the Complaints and Claims Manager within the NHS Trust. If an excessive number of complaints against a particular NHS Trust are made to the Ombudsman, this will quickly be apparent from the data collected by the Ombudsman's department.

(x) *The current system of referral to an Independent Review Panel should be abolished.*

(xi) *Legal Claims will be referred to the Trust's legal advisors but the Complaints and Claims Manager should have input into the initial investigations and should remain involved in the management of the claim.*

(xii) *The Complaints and Claims Manager of a NHS Trust must work closely with the Clinical Risk Manager to ensure that problems are identified early, and any necessary change in practice is introduced and then properly monitored.*

(xiii) We approve the suggestion by the Department of Health in the document entitled A First Class Service, that the new Commission for Health Improvement might examine complaints and claims handling nationally. The Health Ombudsman could well refer concerns about a particular NHS Trust's dealing with complaints direct to the Commission. The Commission could also be a source of help and advice where a difficult and intractable problem was identified by the Ombudsman or a Complaints and Claims Manager. It should also encourage a uniform and consistent approach to complaints throughout the NHS.

APPRAISAL

1. We have heard no evidence to suggest that there was any system of appraisal of consultants at the South East Kent Health Authority or the South Kent Hospitals NHS Trust before Rodney Ledward's suspension by the Trust.

2. The appraisal and assessment of junior doctors was introduced to the NHS in the 1990s with the implementation of Calman training. We were told that there was considerable antipathy to the process but that over the years it has become increasingly accepted. A number of witnesses have spoken to us about appraisal in practice and we have read a number of documents, including those from the Royal College of Obstetricians and Gynaecologists, which refer to appraisal.

3. Appraisal of junior doctors should be carried out regularly by their Clinical or Educational Supervisor. Junior doctors should also maintain a Personal Development File, which forms a record of their working career. We have heard evidence that there were some concerns about Rodney Ledward when he was a junior doctor and we consider that an efficient system of appraisal may well have picked up any such concerns at that time.

4. We consider that there is a need for appraisal of all doctors, including consultants. Appraisal should cover both clinical and non-clinical aspects of care. Appraisal should be a positive and supportive process and should include an assessment of performance based on data collected, for example, as a result of audit. In most cases such appraisal will allow the achievements of the consultant to be recognised. However assessment of performance will also allow concerns to be raised at an early stage so that these can be discussed and a plan of action decided upon to try to resolve the problem or concern. Incident reporting, clinical audit and complaints and claims involving the consultant's work should therefore all form part of the appraisal. It seems to us that concerns about Rodney Ledward, for example, lack of insight or improper delegation to junior staff, as well as poor clinical

performance, would have been picked up under a proper system of appraisal.

5. From the evidence we have heard there is no uniformity of approach to appraisal of consultants within the NHS. Some NHS Trusts carry out such appraisal; others do not. As a result of the recommendation in the Department of Health document, A First Class Service, which was published in 1998, all health professionals including consultants, are expected to create and maintain training and development plans from 1st April 2000. We refer to these as Personal Development Plans.

6. It has long been recognised that all doctors need to keep their skills and knowledge up to date. Continuing Professional Development describes the process of lifelong learning which does not end when a doctor qualifies or becomes a consultant. As envisaged by the document entitled Continuing Professional Development published by the Department of Health in July 1999, the assessment of a doctor's Continuing Professional Development and Personal Development Plan should form part of every doctor's annual appraisal.

7. We were told that Rodney Ledward attended a number of Obstetric and Gynaecology conferences and lectures in England and abroad, and that on occasions he attended Professor Grudzinskas' operating sessions at The Royal London Hospital.

8. It was pointed out to us in evidence that there is an assumption that doctors who attend medical conferences are somehow keeping up to date. Attendance on its own at such meetings is not enough to ensure improvement in quality of care; appraisal, assessment and evaluation of new skills is also required. It should therefore be the responsibility of the Medical Director of every NHS Trust to ensure that its clinicians keep their skills up to date both in theory and in practice.

9. We consider that the role of appraisal will only be welcomed by all consultants if the system is fair, constructive and handled with sensitivity. The whole process should be geared to ensuring that the doctor being appraised is professionally fulfilled, and that the care provided to patients continuously improves. In our view a good appraisal system will also encourage openness between consultants.

10. The data collected as a result of incident reporting, audit and complaints and claims, should all be used when appraising a doctor's performance.

RECOMMENDATIONS

(i) *There should be an annual appraisal of all consultants, which should cover Continuing Professional Development and assessment of performance. Incident reporting, clinical audit and complaints and claims involving the consultant's work should all form part of the appraisal.* This would indicate any areas which might require attention, or suggest new areas of learning, and the doctor being appraised would be able to raise any concerns and discuss new areas into which he or she would like his or her practice to extend.

(ii) *Appraisal of consultants should normally be carried out by a consultant of the same specialty, who will generally be the Clinical Director, so that the process is undertaken by someone who understands the work of the consultant.*

(iii) *The Clinical Director of each Directorate should also be appraised annually and this should be carried out by the Medical Director of the Trust in conjunction with a consultant from the same specialty as the Clinical Director.*

(iv) *Consultants need training in what is required of them when they act as appraisers, and in what is required of them when they are being appraised, and they need to be allowed time within their working commitments to carry out such appraisal or to be appraised themselves.*

(v) *It should be the responsibility of a NHS Trust's Medical Director, who is answerable to the Chief Executive, and a member of the Clinical Governance Committee, to ensure that an effective system of appraisal is in place so that he or she is alerted to any problem about a doctor's clinical performance, and can ensure that*

doctors employed by the Trust are keeping their knowledge and skills up to date. If there is an effective and robust system of appraisal and assessment, the quality of care provided to patients will improve.

USE OF DATA

1. NHS Trusts routinely collect data, for example in respect of administrative matters such as the admission and discharge of patients, and also in respect of clinical matters such as diagnosis and surgical procedures carried out. This data has historically been collected for costing purposes. Some NHS Trusts now employ business consultants to analyse this data to look for variations in outcome and practice so that both issues of quality and quantity can be analysed from the same data.

2. With the advent of Clinical Governance, which includes the need for all health care staff (a) to complete incident report forms, (b) to participate in audit, and (c) to assist in answering complaints and claims, a great deal of data now has to be collected by every NHS Trust. We consider that such data should be used by Trusts and the NHS as a whole to identify both local problems and national trends, and to help establish national benchmarks for the provision of care. We are also of the view that this data should be used in the appraisal of doctors so that any areas of concern can be identified early. Any national benchmarks that have been established should be used to ensure that a doctor is performing at least to the level of national standards.

3. We were told that there is no benchmark, for example, for the number of surgical cases carried out by a gynaecologist where ureteric damage is caused, or where the patient has to be taken back to theatre because of haemorrhage, or where the patient develops a post surgical infection. The absence of any benchmarks was relied on by Rodney Ledward in the NHS Trust's Disciplinary Proceedings and in the GMC Professional Conduct Proceedings. It was argued that every gynaecologist is likely to have carried out a case where, for example, he or she has damaged a ureter or where the patient has suffered from post operative haemorrhage or infection. Therefore no one can say how many such untoward events are within acceptable bounds, especially when the surgeon might be operating on particularly difficult cases.

4. In our view if data were collected throughout the country about these incidents, then national standards or benchmarks would be identified and doctors would be able to assess how they individually, and collectively as a unit, measured up.

5. We have heard that a comprehensive patient-orientated database has been collected nationally by the Society of Cardiothoracic Surgeons in respect of cardiothoracic surgery. Data is submitted voluntarily by over 70% of cardiothoracic units every year. Benchmarks or standards have been established as a result, which enable surgeons to see how their figures compare nationally. Over the years the system has become more refined, and different case mixes are now factored into the data. This means that cases of particular difficulty are not given the same weighting as more straightforward surgery. We were told that this use of data has proved most beneficial for the provision of cardiothoracic care throughout the NHS.

6. We understand that surgeons in other specialties consider that the collection and use of similar data is too difficult to achieve because theirs is not a small specialty, as is cardiothoracic surgery. In our view the use of current technology might well be able to collate and use such data to provide benchmarks in every specialist area of medicine.

RECOMMENDATIONS

(i) *We recommend that the Department of Health should consider whether a national system of data collection could be devised so that benchmarks can be identified for a whole range of medical and surgical specialties.* Use of such data would also identify trends and different practices, and would pick up areas of poor performance.

(ii) *The collection and analysis of data both by NHS Trusts and nationally is of importance in the whole question of provision of good quality care. In our view it is vital that each Directorate and NHS Trust ensures that full and accurate data is collected.*

(iii) *Every Directorate in a NHS Trust should identify someone who is interested in the task, who understands the importance of the accuracy of data and understands the problems associated with that particular area of medicine.* Their role should be seen as an important and demanding one. The person responsible must be fastidious in ensuring that accurate and valid data is collected, and in chasing those who show reluctance to participate in data collection. This takes time, effort and application and time should be allowed within the person's contract to permit proper data collection.

(iv) *The data collected by each Directorate should be reviewed by the Clinical Director so that any areas of concern may be identified and problems rectified.*

(v) *Every NHS Trust should have a head of Information Technology whose job is to ensure that full and accurate data is collected across the Trust and to work with clinicians and management to identify areas of concern and improve the quality of care provided to patients. The head of Information Technology will also be responsible for ensuring that all relevant data is provided for national consideration so that, for example, benchmarks can be established in which doctors will have confidence.*

(vi) *The Clinical Governance Committee of the NHS Trust should review the data collected across the Trust, to ensure that all Directorates are performing well.*

LIAISON BETWEEN NHS TRUSTS AND GPs

1. A number of GPs told us of their concerns about Rodney Ledward's practice. For example some felt that he pressurised patients to become his private patients; some felt that his patients suffered too many complications after his surgery; some felt that he failed to give full and proper information to them about their patients. The GPs said that they had no idea how or with whom to raise the matter, and they had felt that their only remedy was to refer their patients to consultants other than Rodney Ledward.

2. There have been Local Medical Committees in existence since the NHS was established to consider terms and conditions of service, and local Committees of GPs were also set up. However it seems that neither of these provided GPs with the ability to communicate formally with hospital consultants. We were told that Cog Wheel Committees in Kent used to be a reasonable means of communication between GPs and consultants but that from sometime in the 1990s they were abolished. In any event GPs did not feel able to raise their concerns about Rodney Ledward through such committees.

3. Although there were meetings with hospital doctors on a social or informal level, a number of GPs said that they were not appropriate venues at which to raise concerns about Rodney Ledward. We were told that there remained no formal means of communication with the South Kent Hospitals NHS Trusts until a new Clinical Liaison Group was recently established. This Group encourages GPs with concerns to voice them at an early stage.

4. As we have said, a number of GPs told us that the only step which they felt able to take when they were concerned about Rodney Ledward's practice, was to refer their patients to other consultants. However we consider that this sidesteps any problem and means that a concern about a doctor's practice may go unrecognised by the employer if changes in referral practice are ignored.

5. We were also told by a number of patients that sometimes they had asked their GP to refer them to another consultant after they had expressed unhappiness with their care under Rodney Ledward. Some GPs expressed unwillingness to refer elsewhere, as they seemed to feel that it might be unethical. Sometimes patients wanted a second opinion and were told by their GPs that Rodney Ledward was a top consultant and that they should continue to be advised by him. We felt that there seemed to be some reluctance in a number of GPs to refer patients for a second opinion, possibly because of the inference that the GP might have been thought to be criticising Rodney Ledward.

6. We have the impression from the evidence we have heard that some GPs establish a good relationship with hospital doctors and contact them informally on the telephone whenever they feel this is necessary. It is clear to us however that some GPs are reluctant to take such steps.

7. By section 26 of the Health Act 1999 a duty is now imposed on Health Authorities, NHS Trusts and Primary Care Trusts to co-operate with one another.

RECOMMENDATIONS

(i) *A climate of openness in the NHS must be fostered by GPs and other healthcare professionals as well as by doctors and others working in hospitals.*

(ii) *Every NHS Trust, at both Trust and Directorate level, should monitor GP referrals so that patterns or change in patterns of referral can be identified, and any GP concerns dealt with.*

(iii) *There is a need for Clinical Liaison Groups to be established in every area, whose members should include consultants employed by the local NHS Trust and GPs working in the locality. The Group should meet regularly and should formulate a*

procedure for bringing concerns of the Committee or of individuals to the attention of the Medical Director or, in an appropriate case, to the Chief Executive of the Trust.

(iv) *GPs and others working to provide patient care in the community should be told how they can contact the Medical Director of a NHS Trust when they have concerns about a doctor employed by the Trust.*

(v) Every patient has the right under the Patients' Charter:

> " To be referred to a consultant acceptable to you when your GP thinks it necessary, and to be referred for a second opinion if you and your GP agree this is desirable."

GPs should be reminded of their duties to patients under the Patients' Charter.

(vi) We have already recommended that the Department of Health should consider ways to audit the care of patients by GPs and other healthcare professionals after their discharge from hospital particularly with regard to outcome and patients' expectations. Collaboration between NHS Trusts and Primary Care Groups would be essential. In our view lay people should be involved in such audit especially when considering patients' expectations against outcome. We consider that this exercise would also help liaison between NHS Trusts and GPs.

WHISTLEBLOWING

1. We apologise for using the term "whistleblowing". We do so because it is succinct and it is readily understood. We are mindful of the need for the use of clear language in the NHS so that new concepts are easily and properly understood by all who work within the NHS.

2. During our Inquiry we have heard that people did not speak out regarding their concerns about Rodney Ledward for a range of different reasons. For example a number of his colleagues were concerned that he pressurised patients to become private patients, but they felt inhibited from doing anything about it. The culture of not telling tales is powerful and superficially attractive. However, if patient care is to be at the heart of the practice of medicine, then anything which has the potential to place patients at risk must be brought out into the open, and raised with appropriate clinical or managerial staff.

3. As set out in the 1998 GMC booklet Good Medical Practice, a doctor is required to:

> "protect patients when you believe that a doctor's or other colleague's health, conduct or performance is a threat to them.
>
> Before taking action, you should do your best to find out the facts. Then, if necessary, you must follow your employer's procedures or tell an appropriate person from the employing authority.... Your comments about colleagues must be honest.....The safety of patients must come first at all times."

4. We consider that a proper and efficient system of clinical governance, particularly in relation to incident reporting and audit, should mean there is little need to whistleblow. However that cannot be the complete answer in our view, and it is clearly necessary to have a system running in parallel which enables employees (whether a porter or a fellow doctor) who have concerns about a doctor's practice, to

raise their concerns without fear. For example those who were concerned that Rodney Ledward might be pressurising patients to become private patients needed some means of communicating this fact to a person with the authority to investigate and deal with the matter.

5. We are aware that there is anxiety that some people may be prompted by malice to whistleblow. In our view it is important that where such malice is demonstrated, the person who whistleblows should be made the subject of strict disciplinary procedures.

6. In August 1999 the Department of Health issued useful Guidance to NHS Trusts and Health Authorities (HSC 1999/98) regarding whistleblowing and the Public Interest Disclosure Act 1998 and in general we endorse that Guidance.

RECOMMENDATIONS

(i) *There should be a confidential Hotline in every NHS Trust, which can be used to notify concerns about an employee to an appropriate person. A record should be kept of all such telephone calls.*

(ii) *The person who receives the calls on the Hotline, who need not necessarily be part of the management team, must be sympathetic, responsive and command respect within the NHS Trust. In our view it is essential that the person who receives the calls has all those qualities, as the role is vital to the proper and efficient running of a Trust, and to the protection of patients.* Of course the Hotline does not need to be available 24 hours a day, but staff should know when and how they can make use of the Hotline and must also know that, at the very least, their initial contact will be kept confidential.

(iii) *The person who responds to Hotline calls should be answerable to a non-executive Director of the NHS Trust who will be responsible for ensuring that concerns raised via the Hotline are properly followed up.*

(iv) *The NHS Trust should provide support for the person who has the courage to whistleblow.* Support may need to encompass counselling, legal advice and financial support to respond to proceedings in defamation. This list is not intended to be exhaustive - it merely illustrates the range of support that may need to be provided to an employee, as the individual circumstances require.

(v) *Both the GMC and the UKCC should be made prescribed bodies under S.43 of the Employment Rights Act 1996 as amended by the Public Interest Disclosure Act 1998, to whom an employee may disclose information without incurring disciplinary measures by the employing Trust.*

(vi) *Where malice is demonstrated by a person who whistleblows, then he or she should be made the subject of strict disciplinary procedures.*

CLINICAL GOVERNANCE IN THE PRIVATE SECTOR

1. We have heard a considerable amount of evidence about the provision of care to patients in the private sector. We have been particularly concerned that private hospitals are self regulating, and that doctors who work in them work largely in isolation and are autonomous. Although Rodney Ledward worked in a number of private hospitals in Kent and in London, the South East Kent Health Authority and later, the South Kent Hospitals NHS Trust, knew little about his work in the private sector, save that he had a flourishing private practice.

2. We were told that on occasions Rodney Ledward's private patients, who developed complications after his surgery, were transferred to the William Harvey Hospital within the NHS. The NHS continues to provide a back-up service for the care of private patients when, for example, a post surgical complication occurs with which the consultant cannot deal at the private hospital. We are also aware that sometimes NHS Trusts pay for NHS patients to be treated within the private sector. There is clearly a degree of overlap in patient care between the NHS and private sectors. In our view it is in the interests of both sectors to ensure that the quality of care being provided is as good as each other.

3. Generally only NHS consultants have admitting rights to private hospitals although we have heard that other doctors may be permitted to work in some private hospitals, particularly in London. We have not been able to explore that matter in any depth since it was beyond our remit. We have therefore concentrated on the quality of care provided by NHS consultants who also work at private hospitals.

4. NHS consultants are permitted to pursue private practices outside their NHS commitment. We understand that consultants who have retired from the NHS may continue to work exclusively in the private sector.

5. We have heard of a number of concerns about Rodney Ledward's practice in the private sector, for example:

(a) sometimes he did not attend his private patients when asked to do so, or did not arrange proper cover for his private patients when he was elsewhere; sometimes he did not answer his mobile telephone or respond to messages left for him asking him to attend one of his private patients;

(b) Rodney Ledward carried out his private practice in a number of private hospitals in central London as well as in Kent;

(c) a number of his patients needed to be transferred to a NHS hospital when complications developed;

(d) Rodney Ledward's in-patient notes in respect of private patients were brief;

(e) on one occasion about which we have heard, Rodney Ledward operated on a patient at a private hospital in London and then returned to Kent leaving the patient to the care solely of the resident medical officer at that hospital.

6. A number of witnesses have also told us about some more general concerns about private care, for example:

(a) in the past, private hospitals did not concern themselves with the quality of care provided to their patients, as this was considered to be a matter between the patient and his or her consultant;

(b) NHS Trusts and private hospitals know little, if anything, about the work of a consultant when he or she is working in the other sector;

(c) in some private hospitals there is no clear and satisfactory procedure for patients to make a complaint about clinical matters relating to the care given to

them by their consultant;

(d) private hospitals are often unaware when a former patient brings legal proceedings against a doctor in respect of care provided to the patient while at the private hospital;

(e) sometimes consultants carry out surgical procedures in private hospitals which they do not carry out within the NHS;

(f) sometimes doctors who have been suspended by a NHS Trust because of concerns about their clinical performance, have been able to continue to work within the private sector.

7. In our view the provision of good quality care to patients must be the primary aim of all health providers, whether in the private or NHS sectors. We were told that this is now accepted by those who run private hospitals and we were also pleased to hear that Clinical Governance is already being introduced within the private sector. In our view Clinical Governance should apply to private hospitals just as it does to NHS hospitals, so that patients receive good quality care whether they are being treated in a private hospital, or in a NHS hospital, or whether they use the services of both.

8. We consider that it is essential not only to ensure that there is proper Clinical Governance of private work but also that similar Clinical Governance systems cover a consultant's work both in the NHS and in the private sector. In our view a similar system of Clinical Governance followed in both the private and public sectors will ensure that patient care is always put first.

RECOMMENDATIONS

(i) *As NHS consultants are permitted to carry out private work, it is vital that their private work should not in any way prejudice (i) patient care in either sector or (ii) the proper fulfilment of their contractual obligations to their employing NHS Trust.*

(ii) *The Chief Executive or General Manager of each private hospital should be responsible for the quality of care provided in that hospital, and should ensure that all components of Clinical Governance are followed in the private sector just as in the NHS.* He or she will no doubt be aided in this task by the Chairman of the Medical Advisory Committee of the hospital. If Clinical Governance in its widest sense is carried out in every private hospital, then a consultant who has admitting rights there will be subject, for example, to systems of incident reporting and audit, and will be required to assist in the complaints and claims procedure.

(iii) *It should be a condition of admitting rights being granted by a private hospital to a NHS consultant or former NHS consultant that he or she should agree to whatever Clinical Governance procedures the hospital establishes from time to time.*

(iv) *It should be a condition of a consultant's admitting rights at a private hospital that he or she should be readily available to advise and/or attend his or her patients, or should have arranged cover from a consultant of the same specialty who also has admitting rights at the hospital.*

(v) *A similar complaints and claims procedure should be adopted by the private sector to that which we have recommended for the NHS.* This would enable private patients to apply to the Health Service Ombudsman where they were not satisfied that their complaints had been dealt with satisfactorily by the private hospital.

(vi) *There should be only one Ombudsman for all Health matters.* We disagree with the Fifth Report of the Health Committee published in July 1999, that a new Ombudsman should be appointed purely to cover the private sector.

(vii) *If there is concern in a private hospital about the clinical performance of a consultant who has admitting rights at the hospital, then the private hospital should be entitled to require the consultant concerned to supply relevant information for example audit information, about his or her practice in the NHS and in other private hospitals where he or she works.*

(viii) *If there is concern in a NHS hospital about the clinical performance of a consultant who has admitting rights at one or more private hospitals, then the NHS Trust should be entitled to require the doctor concerned to supply relevant information, for example audit information, about his or her practice in those private hospitals.*

DISCIPLINARY PROCEDURES

1. We consider that the disciplinary procedures enshrined in the Department of Health circular HC(90)9, which we have described above in Part IV para 18.5 of our Report, may well have acted to deter the South East Kent Health Authority and the South Kent Hospitals NHS Trust from bringing disciplinary proceedings against Rodney Ledward. When the Trust finally instituted such proceedings at the beginning of February 1996, much work had to be done to ensure that the procedures were complied with. The NHS Trust management found themselves without any guidance as to how to implement HC(90)9 but took steps to obtain advice on how to proceed. As a result the NHS Trust management obtained a great deal of documentary evidence in the form of medical records, oral evidence from a variety of witnesses, and independent expert advice from consultant gynaecologists on a number of selected cases. A full disciplinary hearing was then held under the chairmanship of a Queen's Counsel. It took 10 months to comply with the disciplinary procedures laid down in HC(90)9 and adopted in the Trust's disciplinary Code. We express the view that within the confines of HC(90)9 Dr Padley, the Trust's Medical Director, supported by Mr Addison, Chief Executive, took on the major responsibility for ensuring that the disciplinary process was carried out properly. We do not under-estimate the task before them at that stage. We are aware that some members of the medical profession were very critical of the NHS Trust for the steps they took, even suggesting that management were engaged in a witch hunt.

2. We understand that the cost to the Trust of the disciplinary proceedings against Rodney Ledward was in the region of £500,000. A number of witnesses told us that it would be a brave Chief Executive and Medical Director who began such a procedure without being very sure of the outcome. They felt that had such expenditure been incurred and the disciplinary panel not found the cases against Rodney Ledward proved, the Chief Executive and the Medical Director would have had to resign. We mention this not because it is our view that such a consequence should have followed, but to show how the procedure militates at a number of different levels against steps being taken to discipline a consultant. It reinforces our

view that the earlier remedial action can be taken where there are concerns about a doctor's practice, the better for all concerned.

3. Rodney Ledward was summarily dismissed on 17th December 1996 and he appealed to the Secretary of State on the following day. On 31st January 1997 his advisors were informed that the Secretary of State did not have jurisdiction to hear his appeal. That was confirmed in writing on 18th February 1997.

4. He had in the meantime also appealed under the Trust's own disciplinary procedures which were based on HC(90)9. The hearing of his appeal took place on 1st May 1997 and the appeal was dismissed. Rodney Ledward was notified of the decision on 13th May 1997. From the day he was suspended on 6th February 1996 until his appeal was dismissed in May 1997 Rodney Ledward was paid by the NHS Trust in accordance with the procedures set out in HC(90)9. Despite receiving full pay, we have heard that he began to work as a consultant in Cyprus for the Ministry of Defence in February 1997. In the absence of hearing from Rodney Ledward himself about this matter, we are concerned that he may have been paid both by the NHS and by the Ministry of Defence between February and May 1997 and we have already expressed our disquiet at this expenditure of public money if this were the case.

5. In May 1997 Rodney Ledward applied to an Employment Tribunal claiming that he had been unfairly dismissed. The hearing was due to take place on 23rd July 1997 but he abandoned his claim on 18th July 1997.

6. We have heard evidence from a variety of Trusts and lawyers about the disciplinary procedure set out in HC(90)9. In our view it is outmoded, cumbersome and costly. The principles upon which HC(90)9 was based were first introduced in 1961 when the NHS was a different organisation and employment law was very different. It seems to serve neither employer nor employee, but above all it does not serve patients. We consider that one part of the procedure, namely Annex E, has merit. We have heard from a number of witnesses that it is a procedure which has been used on many occasions and that it works. Annex E provides for independent

professional assessors to investigate and advise on (a) a doctor's professional conduct or competence or (b) disagreements within departments. However the procedures and steps to be taken under Annex E are numerous and detailed and contain a fatal flaw: Annex E only applies in cases where dismissal is not envisaged, and a decision has to be made at the outset as to whether the procedure is appropriate, although at that stage much of the relevant evidence will not available.

7. We have also read with interest the recent consultative paper Supporting Doctors, Protecting Patients which sets out proposals from the Department of Health about disciplinary procedures for doctors in the future. In that document it is suggested that a number of Assessment and Support Centres should be set up round the country to co-ordinate and manage referrals from NHS Trusts in respect of doctors about whom there are concerns as to their practice. We approve of this idea.

8. However we consider that one central, national and independent Centre would best carry out these functions. We have some misgivings as to whether the name of the Assessment and Support Centre proposed in the consultative paper is apt, since it could imply that a doctor would be expected to attend the Centre, whereas we see the Centre as a body, headed by a physician or surgeon, with a small complement of staff who would orchestrate and monitor referrals made to it nationwide. We see great advantage in just one national Centre which can pick up recurrent problems and themes early, can consider best practice and can generally co-ordinate the whole approach to problem doctors. The Centre would ensure consistency, and speed referrals to the GMC, where necessary. It would provide a great source of support to NHS Trust management and, in time to doctors, if the scheme is seen to work, and to work efficiently. We consider that the Royal Colleges should be used by the Centre to nominate expert assessors to carry out investigation of a doctor's performance, and that this will give doctors a degree of confidence in the system.

9. By contrast where there are concerns about a doctor's conduct, whether personal, for example bullying, or professional, for example not wearing gloves to carry out vaginal examinations on patients or failing to attend clinics, we consider that this should be dealt with in exactly the same way as conduct issues in respect of all other

NHS employees including secretaries, porters, nurses and other health professionals. The procedure should be the same in whichever part of the country the person works, and if an employee (including a doctor) is dismissed on grounds of conduct any grievance he has should be taken up by him within the existing law, to an Employment Tribunal or the civil courts. A NHS Trust might, in certain circumstances, consider it necessary to refer the doctor to the GMC at the same time as it is pursuing its own disciplinary process.

RECOMMENDATIONS

(i) *The present disciplinary process governed by HC(90)9 should be abolished.*

(ii) *There needs to be uniformity of approach about disciplinary matters nationally throughout the NHS.* We see no merit in each Trust devising its own system. Procedures should be developed centrally and adopted by every Trust to deal with matters of discipline.

(iii) ***A DOCTOR'S CONDUCT***

All issues relating to a doctor's conduct should be determined by a NHS Trust's own internal employment procedures.

(iv) ***A DOCTOR'S CLINICAL PERFORMANCE***

(a) *There should be one central, national and independent Assessment and Support Centre to which NHS Trusts would normally refer doctors about whose clinical performance they have concerns. The national Centre would co-ordinate and manage such referrals.* Whenever a Trust is concerned about the professional competence of a doctor it should refer the doctor to the Assessment and Support Centre. An employing Trust will often not have the knowledge and expertise itself to judge the competence of a doctor, and will need advice and

help which must be independent. It will only rarely be the case that a NHS Trust will refer straight to the GMC.

(b) *Referral of a doctor to the centre by a NHS Trust should be made as soon as there are real concerns about the doctor's performance. We cannot emphasise too strongly the need for early referral so that any potential problems are corrected to the benefit of patients, the NHS Trust and the doctor. We would envisage that referral should be made long before patients are put at risk and that therefore there will be no need to suspend the doctor. However if patients are considered to be at risk then the Centre would advise the NHS Trust to suspend the doctor pending the Centre's assessment.*

(c) *Where a doctor is suspended pending investigation of his clinical performance, he or she should not be permitted to work elsewhere within the NHS or within the private sector.*

(d) *Referral to the Centre should also be made if two or more doctors working in the same NHS Trust are involved in a serious functional dispute which jeopardises the service being provided to patients.*

(e) *If a doctor is unwilling to cooperate in the referral and/or subsequent investigation, that should be a disciplinary matter which would be dealt with under the normal "conduct" terms of his or her employment. The Trust should be entitled to suspend and/or dismiss a doctor for refusal to cooperate.*

(f) *On referral, the Centre should then contact the appropriate Royal College and ask for the names of relevant experts who would provide the rapid response necessary to investigate the doctor's performance about which the Trust has expressed concern.* It would be essential for the Colleges to maintain up to date lists of such experts in all specialties. However we are mindful of the fact that practising clinicians would have to drop their normal clinical work at short notice and that this is very disruptive of the service being provided to patients in the NHS. We therefore suggest that the panel should include former consultants who

have recently retired. As skills and experience soon become dated we suggest that former consultants should remain on the panel for no more than 5 years post retirement. Such people could be readily called upon at short notice without affecting patient care.

(g) *The investigating team should include a lay member, and perhaps a GP, and all members of the team need to be trained by the Centre to ensure uniformity of approach and consistency.* It should provide a rapid response to the referral. Where a doctor's performance is under question a lay person must have input to ensure that patients' interests are properly represented, although we consider that technical performance of a doctor must be evaluated by a doctor's professional peers.

(h) *After investigating the concerns, the Team would draw up a written report including its recommendations and would supply them to the doctor, the NHS Trust and the Centre simultaneously.* The Centre should be unfettered in the range of recommendations it can make, so that for example it could declare that there was no problem with the doctor's performance, or that the doctor needed retraining, or refer back to the Trust recommending that the problem was serious and intractable, or refer the doctor to the GMC. The doctor would be entitled to make representations to the Centre and the Centre would decide what steps, if any, needed to be taken by the Trust. *It would be for the Trust and the doctor to implement any recommendation, but the Centre would need to ensure that its recommendation had been carried out and to ensure that the doctor's performance was monitored thereafter.*

(i) *if the Centre's report and recommendation is that the doctor's performance is serious and intractable, then the Trust should be able to rely on that evidence to dismiss the doctor.*

(v) *Once a doctor is dismissed by a Trust, his or her pay should terminate as applies to all other NHS employees.*

ALERT LETTERS

1. An "alert letter" is written when a doctor is dismissed, suspended or has given grounds for considering that he or she could be a danger to patients, other staff or themselves, and there is reason to believe that he or she may seek work elsewhere. An alert letter notifies a recipient who is considering employing the doctor to contact the doctor's previous employer. The practice of writing alert letters has been in existence for a number of years.

2. In February 1996, when Rodney Ledward was suspended, the South Kent Hospitals NHS Trust notified local private hospitals and local GPs. However it does not appear that any general alert letter was issued. We understand that this was because the Trust was given legal advice that such action might prejudice the disciplinary proceedings. The Ministry of Defence had not seen any alert letter when it was considering employing Rodney Ledward in February 1997 and did not contact the South Kent Hospitals NHS Trust before they employed Rodney Ledward, but relied on the word of the consultant whom they had previously employed in the post as to Rodney Ledward's current abilities, and two references from eminent gynaecologists both of whom stated that they had no direct knowledge of his surgical abilities.

3. In August 1997 Guidance in HSG(97)36 was given by the NHS Executive as to when alert letters should be issued. It set out the circumstances in which Health Authorities and NHS Trusts should notify the Regional Director of Public Health, so that the Regional Director might decide in conjunction with the NHS Executive, whether an alert letter should be written. The circular stated that if the GMC had already suspended or made a doctor's registration conditional then there was no need for an alert letter.

4. In the executive summary of the circular it states: "In particular references should be taken up with previous employers and account should be taken of any gaps

in employment." It then goes on to say under the heading Background: "Although employing Health Authorities and NHS Trusts should call for references from previous employers they cannot be assured that they will be told about previous employment in which the doctor...gave unsatisfactory service or was suspended or dismissed." We are most concerned about this advice.

5. We consider that it should be imperative (a) for any Health Authority or NHS Trust to contact the most recent former employer of any doctor whom they are considering employing, particularly one about whom an alert letter has been issued; and (b) that any information given by a previous employer must be completely accurate. We consider that not to mention that the doctor gave unsatisfactory service, was dismissed or suspended would be improper.

RECOMMENDATIONS

(i) *Alert letters need to be issued whenever a doctor is suspended or dismissed from his employment and there is a concern about safety to patients, other staff or the doctor himself.* The decision whether an alert letter should be written would often be made by the new Assessment and Support Centre to which, as we have already said, concerns about a doctor's performance should be conveyed.

(ii) *Although in a later section we recommend that every Health Authority or NHS Trust which is considering employing a doctor should seek information about the doctor from the Trust by which he or she was most recently employed, it is even more vital where an alert letter is issued.*

(iii) *Any information provided by a previous employer must be full, accurate and in writing.*

THE GENERAL MEDICAL COUNCIL

We deal with 4 aspects of the General Medical Council namely: (1) Professional Conduct Proceedings, (2) Restoration to the Medical Register; (3) Performance Procedures and (4) Revalidation.

1. PROFESSIONAL CONDUCT PROCEEDINGS

1.1. Rodney Ledward was dismissed by the South Kent Hospitals NHS Trust in December 1996 and the GMC was first notified on 12th December 1996. The Report of the Trust's internal disciplinary Inquiry (which was chaired by Roger Henderson QC) was sent to the GMC on 17th December 1996. On 17th January 1997 the papers were passed to a GMC screener, who was Chairman of the Preliminary Proceedings Committee. On 22nd January 1997 the GMC asked the Trust to supply details of the names of the patients whose cases had been investigated by the Disciplinary Inquiry and details of the evidence given before the Inquiry. The Trust obtained the consent of each patient to her medical records being sent to the GMC. The evidence requested was sent to the GMC by the solicitors to the Trust on 17th February 1997 who also informed the GMC that Rodney Ledward was appealing against his dismissal.

1.2. Rodney Ledward's appeal under the Trust's own disciplinary procedures was dismissed in May 1997 and the Trust informed the GMC of that fact. At the end of May 1997, the GMC screener decided to refer the matter to a meeting of the Preliminary Proceedings Committee to be held on 10th July 1997. An independent expert report on the cases was sought from a Professor in Obstetrics and Gynaecology notwithstanding that two independent expert Consultant Gynaecologists had given evidence to the Henderson Inquiry on behalf of the Trust, and another two on behalf of Rodney Ledward. The new expert's report was available within a week and on

11th June 1997 the GMC wrote for the first time to Rodney Ledward to say that the GMC was considering his professional conduct.

1.3. The GMC's letter to Rodney Ledward was returned as he was no longer living at the address to which it was sent, but on 28th June 1997 Rodney Ledward contacted the GMC to say that his solicitors had instructions to act on his behalf. The solicitors wrote to the GMC on 3rd July asking for the meeting of the Preliminary Proceedings Committee to be deferred as they had only recently been instructed by Rodney Ledward. This request was accepted and the meeting was deferred until 10th October 1997 which was the next date when the Committee was to meet.

1.4. At that meeting, held on 10th October 1997, the Preliminary Proceedings Committee decided to refer Rodney Ledward to the Professional Conduct Committee of the GMC and imposed an interim suspension on him to stop him from practising as a doctor in the meantime.

1.5. The hearing of the Professional Conduct Committee did not begin until almost a year later, on 14th September 1998. It was completed on 30th September 1998. Rodney Ledward's name was erased from the Medical Register from that date. By the terms of the Medical Act 1983 he could not apply for his name to be restored to the Register until 10 months had elapsed from the date of erasure. A number of Rodney Ledward's former patients were shocked that he could make such an application after such a short space of time.

1.6. We heard a great deal of evidence from a number of Rodney Ledward's former patients as well as from a number of his former colleagues that the whole process, from the time he was first referred to the GMC in December 1996, until the time his name was struck off the Register in September 1998, was too long. We agree. We also heard evidence that the GMC hearing was challenging, stressful and emotionally draining for those who gave evidence. Criticism was made of the procedure in that it was like a criminal trial, and that allegations were made against witnesses which made them feel that they were the people who had been at fault. A number of consultants told us that had they known what it would be like they would not have

given evidence and would never subject themselves to a similar experience again. It is clear to us that some found the experience unforgettable and psychologically damaging. We expect, although we have heard no evidence to this effect, that Rodney Ledward suffered a similar experience. We heard some criticism of the fact that there was no Gynaecologist, not even a surgeon, on the panel which determined the matter.

1.7. We were told that the GMC considered all but one of the cases which had been considered by the Henderson Inquiry. Many witnesses gave evidence before the Henderson Inquiry and then again, about 2 years later, before the GMC. Different solicitors were used by the Trust in bringing the Disciplinary Proceedings before the Henderson Inquiry, from those used by the GMC in the proceedings before the Professional Conduct Committee. The same Queen's Counsel was however used by the Trust and the GMC for the 2 hearings. Rodney Ledward used the same solicitors in the 2 sets of proceedings but used a different Queen's Counsel.

1.8. We consider that there was unnecessary duplication of effort in the 2 sets of proceedings and we do not consider that it is fair for witnesses to have to go through the same or similar proceedings twice. Of course it is a very serious matter to erase a doctor's name from the Medical Register, but we have seen and heard nothing to suggest that the Inquiry chaired by Roger Henderson QC was anything but fair. It seems from what we have read and heard that proper rules on the admissibility of evidence were adopted, that the rules of natural justice were followed, and that a high standard of civil proof was used to determine the issues. We consider that the sort of procedure adopted by the Trust is apt for determining the question of whether a doctor's name should be removed from the Register.

1.9. We heard from some witnesses that they believed that Rodney Ledward had friends in high places, some of whom were members of the GMC. That increased their reluctance to report him or to give evidence.

1.10. We also mention that some eminent doctors who knew Rodney Ledward socially or from academic meetings wrote in strident terms in his support although

they had little or no first hand knowledge of his skills as a Gynaecologist. Loyalty to one's colleagues is right and proper, but loyalty can be misplaced if facts are not ascertained, or conclusions are drawn before facts are ascertained. We have been told that some Consultants who worked alongside Rodney Ledward in the Trust and who gave evidence against him in the Disciplinary proceedings or before the GMC, or both, were left in no doubt by some of their eminent colleagues that if the case against Rodney Ledward did not succeed they would find themselves ostracised. They also told us that they knew they would not, in those circumstances, be able to continue to be employed in their present positions and indeed might find it difficult to find an alternative post. We are very concerned that a climate of fear and retribution was engendered consciously or unconsciously by senior members of the profession.

1.11. We heard evidence from the GMC that over the last two years the numbers of interim suspensions imposed on doctors has considerably increased, that the Preliminary Proceedings Committee now meets more frequently, and that the Professional Conduct Committee has increased the number of its hearing days. We were told that it is now possible for the GMC to act more quickly when concerns about a doctor are referred to it and that two cases relating to a doctor's conduct have been fast tracked, and have taken about two months in total. However we remain of the view that in many cases, particularly regarding clinical performance, there is too much delay before proceedings are complete.

1.12. We have already referred in the earlier section on Disciplinary Procedures to the new Assessment and Support Centre which we would like to see set up and to which doctors would be referred by their employers when there are concerns about their professional practice. We have also suggested that the existing NHS Trust disciplinary procedures set out in HC (90)9 should be abolished. We consider that if those recommendations are followed, the duplication of effort about which we have heard in the NHS Trust Disciplinary Proceedings and in the GMC Professional Conduct Committee should be avoided.

1.13. We consider that the length of time before which a doctor can apply for his name to be restored to the Medical Register should be determined by the Professional

Conduct Committee at the time it orders such erasure. In our view that Committee will be in the best position to judge the length of time that is appropriate having taken into account the case against the doctor and any mitigation.

RECOMMENDATIONS

(i) *A hearing before the Professional Conduct Committee of the GMC should be determined on the civil standard of proof, on the strong balance of probabilities. It should not be seen or conducted as a criminal trial.*

(ii) *In order to ensure that the proceedings are carried out fairly and independently, a Circuit Judge or experienced Recorder of the Crown Court should sit as the Chairman. One of the panel members should be a person who practises in the same speciality as the doctor before the Committee. The panel should continue to have lay members and training of all members is essential.*

(iii) *Committee members must declare any interest they have in the proceedings, for example that they know the doctor concerned or they know one of the witnesses.*

(iv) *Witnesses should be given adequate support before, during and after the hearing.*

(v) *It is vital that timetables are set by the GMC and adhered to.*

(vi) *Whenever a doctor is referred by a NHS Trust to the GMC for any reason, the doctor should be notified at once by the GMC of its involvement and why the doctor has been referred.* Natural justice requires no less.

(vii) *The Medical Act should be amended to allow the Professional Conduct Committee, when it erases a doctor's name from the Medical Register, to determine at that time the minimum period of erasure which it is felt to be appropriate.*

2. RESTORATION TO THE MEDICAL REGISTER

2.1. Rodney Ledward has not, so far as we are aware, applied to be restored to the Medical Register. However we have read and heard evidence about one doctor who has recently successfully applied for restoration to the Medical Register although we had concerns that robust and tested evidence may not have been put before the Professional Conduct Committee by the applicant. Where the removal of a doctor's name is undertaken with such attention to detail, it seems only right that restoration to the Register should merit similar care.

2.2. One difficulty that results from erasure is that, since a doctor is not allowed to practise while his or her name is erased, it will be impossible to show that his or her skills and performance have improved or been corrected in the meantime. Therefore once a doctor has applied for restoration and, if the Committee considered that the circumstances warrant it, the doctor should in our view be given conditional registration which would allow re-training under direct supervision.

RECOMMENDATIONS

(i) *Where a person whose name has been erased from the Medical Register applies to be restored to the Register the same standard of proof should apply as to the original proceedings and the burden of proof should be on the applicant.*

(ii) *The Committee should be able to make a provisional declaration as to whether the applicant might be restored to the Register at some time in the future and, if it makes such a declaration, it should then grant conditional registration in order to allow re-training and assessment of the doctor under direct supervision.* If the new Assessment and Support Centre we have already referred to is established, then this might be the appropriate body to organise such re-assessment and retraining.

3. PERFORMANCE PROCEDURES

3.1. The Medical (Professional Performance) Act 1995 amended the Medical Act 1983 to permit the GMC to deal with incompetent doctors who might present a risk to patients. We were told that the new procedures came into force on 1st July 1997 and permit the GMC to act when the professional performance of a doctor is "seriously deficient". The Department of Health published Guidance in December 1997. Under the procedure a NHS Trust can refer a doctor to the GMC when it has serious concerns about a doctor's practice, and the GMC will investigate the matter.

3.2. The doctor's performance is first screened by a GMC preliminary screener; if it is decided that the case should proceed after such screening then the doctor's performance is assessed by an independent panel of assessors appointed by the Assessment Referral Committee. If the doctor's performance is found to be deficient, remedial action, for example counselling or retraining, will be arranged by the NHS Trust. This is then followed by reassessment. If the doctor's performance is found to be seriously deficient then he or she must either be suspended from the Medical Register or registration must be made conditional. Suspension can be made indefinite, but conditional registration can only be imposed for a maximum of 3 years at a time.

3.3. We were told that only a few cases have so far been assessed under the new professional performance procedures since they came into force in July 1997. Some have taken some 6 months or more even to reach the stage where remedial action is advised.

3.4. In our view these procedures, which are only triggered when a doctor's performance is thought to be **seriously** deficient, are complicated and bound, save in the most straightforward cases, to take a considerable amount of time to carry out. If there is to be a national Assessment and Support Centre, which we have recommended above, then we consider that there will be no need for the GMC also to assess the performance of doctors. It can all be done by the new Centre; we would

hope at an earlier stage before a doctor's performance is seriously deficient and in a more timely fashion.

3.5. We consider that a national Assessment and Support Centre would have a number of advantages over the procedures currently adopted by the GMC. First, the Centre will be seen to be independent and objective, secondly duplication of effort will be avoided, and above all the procedure can be instituted at a much earlier time. The GMC test of "seriously deficient performance" would be inappropriate. In our view a NHS Trust should refer doctors as soon as any shortcomings appear so that they can be retrained or guided into a different and proper practice. Although referral to the Assessment and Support Centre is bound, to begin with at least, to carry some stigma, in our view that is nothing compared to the stigma that currently occurs when a doctor is referred to the GMC. Overall we believe that that the new Assessment and Support Centre is likely to assess a doctor's performance quickly and independently, when the first signs of problems arise. The procedures seem to us far preferable to those of the GMC carried out under the 1995 Act.

3.6. There may be occasions, for example if a patient or GP refers a doctor directly to the GMC, that the GMC would itself refer a doctor for assessment of his or her performance to the Assessment and Support Centre. We consider that would be a sensible course of action and might mean that a doctor is referred to the Centre when a Trust has not itself recognised any problem and the doctor is unaware of any problems with his or her practice.

3.7. In our view the GMC's role is properly concerned with whether doctors are fit to practise and therefore entitled to be included on the Medical Register. Monitoring the performance of a doctor whenever concerns arise, seems to us to be more properly carried out by a body different from the GMC.

RECOMMENDATIONS

(i) *The GMC Professional Performance Procedures will be unnecessary, if and when the proposed new national Assessment and Support Centre is set up, and should thereafter be abolished.*

4. REVALIDATION

4.1. It has been proposed by the GMC that revalidation of doctors should be introduced within the next year or so, which will require every doctor to demonstrate that his or her name should properly remain on the Medical Register.

4.2. In our view if clinical governance is fully implemented and properly monitored, then there should be no difficulty for any doctor in satisfying the revalidation requirements. The information required for revalidation will be the information which should already have been obtained on an ongoing basis as part of clinical governance.

4.3. We welcome the process of revalidation, but purely as a long stop measure to ensure that no doctor, about whom there should be concerns, has slipped through the net.

REFERENCES

1. The references written for Rodney Ledward on his appointment to the post of consultant were not available for us to see. However, as stated above, we have seen the written references he produced when he applied for a position with Princess Mary's Hospital, Akrotiri in Cyprus where the referees stated that they had no direct knowledge of his clinical and surgical skills. During the course of our Inquiry we have heard about a number of concerns regarding references which are provided for junior doctors and consultants.

2. Problem areas about which we have heard include the following:

(a) that concerns about a doctor's practice may be omitted from a reference;

(b) that assumptions may be made about a doctor's clinical competence as a result of his academic record or the fact that he is socially charming;

(c) that references may be provided although the referee has no knowledge of the doctor's clinical skills;

(d) that a person who provides a reference may only have an historical knowledge of the doctor's skills;

(e) that a reference is not always provided by the doctor's immediate past employing body;

(f) that a referee runs the risk that an action in defamation may be brought in respect of what he or she has said.

3. We have seen an example of a structured reference form used in one NHS Trust which aims to ensure that all relevant areas are properly covered and helps the referee to provide appropriate information.

4. In the 1998 edition of Good Medical Practice, the GMC describes a doctor's duties in relation to references as follows:

> "You must be honest and objective when assessing the performance of those you have supervised or trained. Patients may be put at risk if you confirm the competence of someone who has not reached or maintained a satisfactory standard of practice.
>
> When providing references for colleagues your comments must be honest and justifiable; you must include all relevant information which has a bearing on the colleague's competence, performance, reliability and conduct."

5. In our view it is important that reliance should be placed on clinical skills as well as on a doctor's academic record, the writing of articles, and speaking or attendance at academic meetings. Our impression is that in the past academic expertise may have been considered more important than practical, clinical skills. In our view both are important; both need to be considered when a doctor is applying for a new post.

6. We consider that it should be imperative for any Health Authority or NHS Trust to contact the most recent former employing body of any doctor whom they are considering employing.

7. It has been suggested to us that in this technologically advanced age a doctor's employment history could be recorded centrally so that any prospective employer can find out exactly where the doctor has previously been employed and for how long. This would also disclose any gaps in employment. We consider that this is a sensible suggestion.

RECOMMENDATIONS

(i) ***Consideration should be given to setting up a central system whereby every doctors' employment history is recorded as to the name of the employer and the length of employment.***

(ii) *Every Health Authority or NHS Trust must seek a reference about a doctor whom they are considering employing, from the employing body who most recently employed the doctor. The reference should cover the doctor's work record for his previous employer and any gaps in service should be fully investigated by the prospective employer.*

(iii) *Every Health Authority or NHS Trust must also seek a reference about a doctor whom they are considering employing, from a professional colleague of the doctor, who has first hand and up-to-date knowledge of the doctor's clinical skills and professional performance.*

(iv) *When a doctor supplies a reference for a colleague it is essential that the obligations imposed by the GMC in Good Medical Practice are adhered to.* Failure to comply with such obligations should amount to serious professional misconduct. It is also important that doctors should realise that they are accountable for what they have written in a reference.

(v) *Any reference must be full, accurate and in writing.*

(vi) *The Department of Health should devise separate structured reference forms to be used as models by the employing body and professional referees, which could then be modified as circumstances dictate.*

(vii) *Doctors who seek a new position should be prepared to make available to their prospective employer their Professional Development Plans.*

CHAPERONES

1. We have heard from some of Rodney Ledward's former patients that no chaperone was present when they were undergoing a vaginal examination. In September 1997 the Royal College of Obstetricians and Gynaecologists published a report on Intimate Examinations which recommended that a chaperone should be offered to all patients undergoing gynaecological or obstetric examination.

2. In our view the presence of a chaperone will provide reassurance to an anxious patient and protects the patient from real or perceived forms of abuse. The presence of a chaperone helps to safe-guard the patient from a doctor causing unnecessary pain, either physically or emotionally, during such an examination.

3. The presence of a chaperone also protects a doctor from false allegations of sexual or other impropriety.

RECOMMENDATIONS

(i) *All obstetric and gynaecological units should adopt the guidelines proposed by the Royal College of Obstetricians and Gynaecologists in 1997, which include:*

(a) a full explanation of the reasons for an intimate examination should be given to patients and their verbal consent obtained before such an examination is carried out;

(b) all patients should be asked if they would like a chaperone present while undergoing an intimate examination.

CONSENT FORMS

1. We have heard a considerable amount of evidence concerning consent forms relating to Rodney Ledward's practice. Some of his former patients told us that he did not explain what was written on the consent form, or that he asked them to sign a consent form after they had been given premedication, or that he carried out a surgical procedure for which they had given no consent at all. A number of patients told us that Rodney Ledward gave them little or no verbal explanation about the surgery he advised and failed to give them any warning about any risks associated with such surgery, for example the risk of incontinence. However we were told that he wrote a number of pamphlets about certain gynaecological procedures which he gave to patients.

2. The Patient's Charter published in 1991 recognised that every patient had the right to be given a clear explanation of any treatment proposed, including any risks and any alternatives, before the patient decided whether to agree to the treatment.

3. We are aware there is a growing practice in respect of elective surgery (that is surgery which is not done as an emergency), that only a doctor who will carry out the operation, or is capable of carrying out the operation, will obtain the patient's consent, and only after the doctor has given sufficient oral and written information to the patient, in a way he or she can understand, so that the patient is able to make an informed decision as to whether to undergo the proposed surgery. We approve of this practice.

4. It has been suggested to us that consent forms have had their day and that what is needed is a full discussion with the patient in the presence of a friend or relative, with a clear note being made at the time of the risks and benefits and what the patient has been told. A carbon copy of the note would be given to the patient to take away. In our view such a practice would underline the open approach which we consider is vital to ensure that good quality care is provided to patients. However we consider that the whole topic needs to be the subject of proper research.

5. Patient satisfaction surveys would help identify best practice on the issue of consent.

RECOMMENDATIONS

(i) *We recommend that the Department of Health should consider, with other interested bodies, the whole question of consent to surgery.*

OCCUPATIONAL HEALTH AND THE THREE WISE MEN COMMITTEES

1. An Occupational Health Department in a hospital provides care for all the employees of that hospital in respect of health problems which impinge on or relate to their work.

2. We have heard anecdotal evidence that many, if not most doctors, make reluctant patients and do not seek advice or help from the occupational health department. Some of course go to see their own GPs but too often it appears that doctors feel they should just "soldier on". We were told that many consult their consultant colleagues almost in passing in the corridor.

3. That practice may have been one of the reasons that the Three Wise Men Committees were introduced into hospitals in 1982 by the DoH circular HC(82)13. A committee was to be set up in each Health Authority which would meet to investigate any concern about the risk of harm to patients as a result of the physical or mental illness (including addiction) of a doctor. Any member of staff could refer a doctor to the committee but, in reality, only fellow doctors ever did so. Even then referrals were few and far between. We heard evidence that the three wise men committee set up by the South East Kent Health Authority (which was in existence between 1982 and 1994) hardly ever met, its membership was not well known and Rodney Ledward was never brought to its attention. Nothing changed after the South Kent Hospitals NHS Trust was established in April 1994.

4. Although, as we have said, we heard no evidence to suggest that Rodney Ledward suffered ill-health, it was known that his attitude to patients and staff left much to be desired and that he had little or no insight into any concerns about him or his practice. Personality problems may be a symptom of illness, but in the culture that existed formerly within the NHS it is perhaps not surprising that no one referred

Rodney Ledward to the three wise men committee.

5. We have heard from a number of doctors who either practise in occupational health or have views about the role of occupational health. We have also heard that the three wise men committee has in some hospitals been re-named the Professional Standards Advisory Group or Committee. We were told about one such group which is very active and deals promptly and appropriately with all concerns about a doctor's health, conduct or competence.

6. We have read and endorse the recommendations of the Independent Inquiry into Amanda Jenkinson, the Bullock Report which was published in May 1997, on the role and practice of occupational health medicine.

7. We understand that every Trust has an Occupational Health Department but obviously the resources of such a department depend on the size of the Trust. Where the department is small some Trusts have established a system of referral to a large department locally, so that it can readily refer its employees to such a centre for help and advice.

8. Where a doctor is referred to an Occupational Health Department or refers him or herself to the Department, the normal doctor/patient relationship will arise and therefore any consultation or treatment must remain confidential. Under the terms of the 1995 GMC booklet on Confidentiality, the principles of confidentiality by which a doctor must abide in treating his patient are set out. They include:

> "Patients have a right to expect that you will not disclose any personal information which you learn during the course of your professional duties, unless they give permission....;
>
> You must respect requests by patients that information should not be disclosed to third parties, save in exceptional circumstances **(for example, where the health or safety of others would otherwise be at serious risk)**..."

RECOMMENDATIONS

(i) *The role of occupational health for doctors is important for the proper provision of care to patients and should be encouraged.* Far too often it has been seen as a department that is relevant to others employed in the NHS but that somehow doctors themselves are exempt or beyond its ministrations. This culture must change if patients are not to be placed at risk of harm. Doctors who are ill or who have health problems (just like the rest of us) cannot do their jobs properly without help.

(ii) *If a doctor is not performing his or her job well, consideration should always be given as to whether referral to an occupational health physician might discover an underlying health problem.* The essential question is whether the doctor is fit to practise. Personality problems (for example bullying), eccentricity (for example not talking to junior staff), or inability to communicate with patients and staff, are all examples of problems where the occupational health physician may well be able to help the doctor before damage is caused to patients, staff or the doctor.

(iii) *Formal arrangements should be established between local Trusts to ensure that the full range of occupational health care is available to all employees, including doctors.*

(iv) *Three wise men committees should be abolished.*

(v) *Consideration should be given by each Trust that has a Professional Standards Advisory Group or Committee as to whether, if the Occupational Health Department is used properly, there is any need for such groups or committees.* In our view the more arrangements that are in place the more likely it is that the concerns about a doctor will not be properly referred, that in effect he or she will "fall through the net". We consider that simple, straightforward lines of communication and referral are essential to the effective running of Trusts and the NHS as a whole. Diversity of procedures tends to encourage people to think that someone else has the problem in

hand.

(vi) *A direct contact line needs to be established to the Medical Director of each Trust so that* ***anyone*** *who has concerns about a doctor's health and well being, in the widest sense, should inform the Medical Director.* Just as other employees can be referred by his or her manager to the Occupational Health Department, so should the Medical Director be able to refer a doctor when there are concerns about the doctor's health and well being.

(vii) *Every student who qualifies as a doctor should be screened by the Occupational Health Department and such screening should also take place whenever a doctor changes employer.*

(viii) *We endorse the recommendation of the Bullock Report that a system should be devised whereby occupational health records follow healthcare professionals (which would include doctors) from one employment to another.*

MEDICAL STUDENTS

1. Although we heard nothing adverse about Rodney Ledward as a medical student, it is clear from the evidence we have heard, that there were some concerns about him from his earliest days as a doctor. We have already stated that in our view it is essential that any concerns about a doctor should be picked up as early as possible so that they can be remedied and we consider that the selection and training of medical students is a vital component of this process.

2. By S.5 of the Medical Act 1983, the Education Committee of the GMC is charged with the general function of promoting high standards of medical education and co-ordinating all stages of medical education. Its recommendations, which are set out in a document entitled Tomorrow's Doctors, which was published in 1993, are directed to medical schools throughout the country.

3. We have been told that some medical schools make an offer to a prospective student to study medicine conditional on a health screen. We approve this practice as it should go some way to ensure that only those who are physically and mentally able to cope with a career in medicine, are accepted by a medical school. The continuing interest of an Occupational Health Department with medical students seems to us to be beneficial to the training of doctors and should simply form part of the occupational health care of a doctor, throughout his or her working life.

4. We also approve of those medical schools which teach ethics as part of the medical course, from the very outset of the course. Ethics, and particularly the duties of a doctor as set out in the GMC booklets such as Good Medical Practice, should be central to training. In our view the duties should be part of the introduction to medicine and should be re-emphasised throughout the student's training. However we have heard from a number of doctors that they have never read Good Medical Practice.

RECOMMENDATIONS

(i) *An offer from a Medical School to study medicine should always be conditional on the student passing an occupational health screen.*

(ii) *Ethics and the duties of a doctor should be taught throughout a medical student's training so that they are second nature to a student when he or she qualifies. We recommend that the Council of Heads of Medical Schools and the GMC should together decide how best to emphasise the importance of ethics and the duties of a doctor, so that every student is fully aware of their responsibilities as a doctor before they qualify.*

DEALING WITH A MAJOR CLINICAL INCIDENT

1. A number of former patients of Rodney Ledward formed themselves into a support group during the period between his dismissal by the South Kent Hospitals NHS Trust in December 1996 and the Professional Conduct Proceedings before the GMC in September 1998. After he was struck off the Medical Register in September 1998 the GMC contacted the local Community Health Council (the CHC) in Ashford, Kent to urge them to help the former patients of Rodney Ledward. We were told by the CHC that it was asked by the GMC to set up and co-ordinate a support group for such patients. With the help of the CHC, an official Group was established with the lady who had previously organised the informal support group, being chosen to chair the new formal group. The CHC, the South Kent Hospitals NHS Trust and the Kent Area Health Authority together called a public meeting in November 1998. It was attended by over 200 people and the media. Many former patients of Rodney Ledward who had been treated by him within the private sector also attended the meeting.

2. At that meeting in November 1998 Dr Padley, the Medical Director of the NHS Trust, attended and spoke. He announced that the Trust was setting up a Helpline for former patients of Rodney Ledward so that medical help could be provided if it were needed; to consider whether any patients had a legal claim against the Trust and to assist such patients in obtaining legal advice; to inform former patients that the Trust would not take any point that a claim was statute barred because of the delay in bringing any claim; and to try to provide patients with help in claiming compensation.

3. A Helpline office was established at the William Harvey Hospital to deal with all calls from former patients of Rodney Ledward. Initially the office was inundated with calls. Patients' notes were retrieved, and reviewed by 2 of the NHS Trust's consultant gynaecologists. Many callers were seen by the consultants and time was taken to go through their notes and provide explanations and advice. As the numbers grew the other consultants in the NHS Trust Directorate also became involved.

Former patients who asked to be seen by a woman consultant were accommodated. Sometimes further investigation and treatment was advised and offered. A letter was sent after each consultation either to the patient or to her GP setting out the results of the review, the clinical findings and any advice given. The patients were seen as quickly as possible to limit their distress and concern. A counselling service was offered which a number of patients accepted. Others did not want help. From all we have heard it seems that the South Kent Hospitals NHS Trust did all it could to minimise further anxiety to the former patients of Rodney Ledward.

4. We have heard that to date 511 women have contacted the Helpline, of whom 154 had been Rodney Ledward's private patients. 377 were offered a consultation with a consultant gynaecologist, 309 were seen by one of the consultants and 121 of those needed further assessment. 117 were reassured that they had not been operated on by Rodney Ledward.

5. The NHS Trust offered a similar service to former patients of Rodney Ledward who had been treated by him as private patients, but the Trust could not deal with any legal claims which such patients brought against Rodney Ledward as the Trust was not his employer when he was working in the private sector. We were told that there have been a number of such claims and that the statutory defence of limitation has been raised in many, if not all. This has caused a great deal of distress to women, particularly those who were persuaded by Rodney Ledward to become his private patients, or whose private care was paid for by the St Saviour's Charitable Trust.

6. The CHC told us that it was concerned to ensure that the Support Group was seen to be independent of the NHS Trust. Solicitors who act for a number of Rodney Ledward's former patients told us that many of their clients were concerned that they were to be seen by a consultant employed by the South Kent Hospitals NHS Trust. The clients did not feel that the assessment would be wholly independent and were concerned that the Trust was simply embarking on a damage limitation exercise.

7. We consider that when a major clinical incident occurs which concerns the welfare of a number of patients, an open approach is necessary, whether in the public

or the private sector. After Rodney Ledward's name was erased from the Medical Register, the Consultants in Obstetrics and Gynaecology from the South Kent Hospitals NHS Trust who saw his former patients, took on a heavy burden when they were also trying to run their own practices. This highlights one of the problems. All those employed in the Directorate of Obstetrics and Gynaecology had been placed under considerable stress as a result of the Rodney Ledward case. The fact that the Consultant body was subsequently engaged in attending many of Rodney Ledward's former patients not only took them away from their normal work in the Directorate, but also added to that burden.

8. The Helpline was clearly a good idea so that there was a direct contact point for patients who had concerns. However in our view it would have been preferable if, once medical records had been retrieved, a wholly independent body of consultant gynaecologists had been asked to see the former patients who wished to talk through their problems and concerns. This would have helped to restore confidence in local doctors, local hospitals and the NHS. We consider that it is vital to ensure that any help is not only independent, but is seen to be independent. This would not have been as easy or probably as quick to achieve, but many patients told us of their lingering doubts which we consider might have been more easily allayed if they had been seen by a consultant not connected with the William Harvey Hospital. This would seem to us to be an area which the Department of Health should properly investigate since there have been a number of incidents in the NHS where a large number of patients have been affected. Practical guidance as to how to cope with such an incident would, in our view, be welcomed by NHS Trusts.

RECOMMENDATIONS

(i) ***Whenever a major clinical incident has occurred as a result of failures by those who work within a NHS Trust, and where a number of patients are involved, such patients should be offered a consultation by a consultant of the appropriate specialty who is independent of the NHS Trust concerned.***

(ii) ***The Department of Health should consider providing guidance to NHS Trusts as to how to deal with a major clinical incident.***

ORGANISATION IN THE NHS

1. CHANGE IN THE NHS

1.1 We have been told by a number of witnesses that the amount of organisational change introduced in the NHS over the last 20 years has been very difficult to accommodate. We have been concerned in particular that the changes from the South East Kent District, to the South East Kent Health Authority, to the South Kent Hospitals NHS Trust, to the very recently established East Kent Hospitals NHS Trust, all of which have occurred within the last 20 years, may well have diverted managers and doctors from ensuring that good quality care was provided for patients.

1.2. We consider that change in the NHS always needs to be properly evaluated, whether in relation to organisational change, or to the contractual obligations of staff, or to procedures and policies laid down for provision of care for patients. We are very conscious that we too in our recommendations are advocating more change. However our aim has been to simplify and build on existing procedures and practice, not to introduce radical change which would cause even more disruption to an already hard pressed service.

2. DOCUMENTS IN THE NHS

2.1. We have seen and read many documents produced by the NHS Executive and the Department of Health and we believe that we have identified those which have been most relevant to our Inquiry. However we cannot be sure. We have been very concerned at the multiplicity of documentation that emanates from within the NHS and we should point out that many documents have been very difficult for us to obtain. That difficulty is compounded by the fact that not all such documents are dated and not all are easily cross referable. It is our impression from the large number of witnesses to whom we have spoken, that documents are received by managers and doctors and then left unread. The fact that many are long, detailed and

full of jargon which is difficult to understand, may well contribute to the fact that such documents are set aside.

2.2. We have been pleased to note that in some recent NHS documents, dates and references of other relevant publications are listed together. We refer by way of example to the document entitled Clinical Audit in the NHS published by the NHS Executive in October 1996 where Appendices 7 and 8 list relevant documents. We point out however that the document Clinical Audit does not itself bear a number.

2.3. We believe that the Department of Health is already trying to reduce the number of documents circularised and we applaud that aim. However we consider that further work needs to be done to rationalise, simplify and reduce the amount of paperwork sent from the NHS (in all its manifestations) to NHS Trusts and Health Authorities.

2.4. As in many organisations, the NHS has developed its own language and use of acronyms. However in our view simple, straightforward language that leaves no one in doubt as to its meaning, should be used in all NHS documents.

A FINAL WORD

1. VULNERABILITY OF WOMEN WITH GYNAECOLOGICAL PROBLEMS

1.1 We have realised during the course of our Inquiry that many women do not find it easy to talk about problems of a gynaecological nature with their husbands, partners, family or friends. Because of this lack of openness about gynaecological problems generally in society, many women feel vulnerable and unable to express their concerns and anxieties, for example about incontinence, even to their doctors. In our view it is essential that gynaecologists are constantly aware of this vulnerability and respond sensitively. A responsive and understanding manner will do much to allow women to voice their concerns, and a good example provided by a consultant will be emulated by junior doctors and greatly appreciated by patients and nursing staff.

2. THE EFFECT ON PATIENTS OF RODNEY LEDWARD'S DISMISSAL

2.1 Finally we should say that we have been very troubled that many women have been damaged by the aftermath of Rodney Ledward's dismissal. They have been plagued by doubts and worry which has been fed by media attention and press reporting. A number have high hopes of our Inquiry; we fear they may be disappointed because we cannot wave a magic wand and make all well. All we can do is put forward recommendations which we consider would go some way to ensure that a similar problem does not recur within the NHS without being noted and dealt with at an early stage, so that patients are protected from unnecessary harm.

APPENDIX 1

PROCEDURE TO BE ADOPTED BY THE INQUIRY PANEL

FORMER PATIENTS OF RODNEY LEDWARD

We shall ask each patient who contacts us whether they consent to their medical records being disclosed to and for the purposes of the Inquiry; we shall also ask them whether they would wish their identities to be kept confidential within the body of the report and will respect their wishes.

We shall invite former patients of Rodney Ledward to write to us setting out what they wish to tell us including any information as to whether they told anyone employed by the hospital, or their GP, or anyone else about their concerns. We shall also ask them whether they would want to give oral evidence to the panel or are happy simply to put their evidence in writing.

Oral Evidence

For those patients who wish to give oral evidence to us we shall probably in the first instance ask them to expand on their evidence in writing. We must point out that we cannot guarantee that we will be able to allocate sufficient time to hear oral evidence from all such witnesses. We hope they will understand that it will be difficult to hear from all patients, particularly those who may have given oral evidence to others before.

For those witnesses from whom we wish to hear oral evidence we shall write to them in advance informing them:

(a) of the areas and matters of concern about which we wish to hear from them;

(b) that they may bring a friend, relative, solicitor or anyone else they wish to accompany them but that it is their evidence we wish to hear and that it is they who will be expected to answer our questions;

(c) that we shall invite them to say what they want to us and raise any matter which they feel might be important to our Inquiry, and that then individual panel members will ask them questions;

(d) that what they tell us will remain confidential save to the extent that we need to rely on their evidence to support the findings in our report; and that their identities will be kept confidential within the body of our report whenever they have asked for their identity not to be disclosed;

(e) that what they say will be recorded in writing so that we have an accurate record of what they tell us;

(f) that we will arrange a convenient date for them to come and give evidence to us, will give them directions as to where to come, and will offer to pay their reasonable expenses.

STAFF AT N.H.S.AND PRIVATE HOSPITALS WHERE RODNEY LEDWARD WORKED OR TO WHICH HE REFERRED PATIENTS; AND GENERAL PRACTITIONERS AND OTHERS WHO HAD CONTACT WITH RODNEY LEDWARD OR HIS PATIENTS

We shall ask medical, nursing, managerial and administrative staff at hospitals run by the South Kent Hospitals NHS Trust and any other hospitals, whether private or NHS, where Rodney Ledward practised or to which he referred patients, to write to us setting out what information they can provide to help the Inquiry. We shall also ask General Practitioners who referred patients to Rodney Ledward, and others who had contact with him or his patients, to write to us setting out what information they can provide to help the Inquiry. We will say that the matters about which we

wish to hear evidence include:

(i) any concerns they had about the practice or activities of Rodney Ledward;

(ii) whether they did anything about their concerns;

(iii) if so, what steps or other actions they took, including notifying anyone else, and what was the response thereto, if any;

(iv) if they took no such step, the reasons why they did not;

(v) how systems in respect of quality of performance have changed over the years;

(vi) what systems are now in place to ensure good quality and practice.

Oral Evidence

For those witnesses from whom we wish to hear oral evidence we may in the first instance ask them to expand on their written evidence again in writing. Before they come to give evidence we shall write to them informing them:

(a) of the areas and matters of concern about which we wish to hear from them;

(b) that they may bring a friend, relative, colleague, member of a trade union, solicitor or anyone else they wish to accompany them but that it is their evidence we wish to hear and that it is they who will be expected to answer our questions. However we will not permit anyone to accompany a witness who may have a conflict of interest with that witness, eg a member of staff senior to the witness or a member of management.

(c) that we shall invite them to say what they want to us and raise any matter which they feel might be important to our Inquiry, and that then individual panel members will ask them questions;

(d) that what they tell us will remain confidential save to the extent that we need to carry out our Inquiry properly and to the extent that we need to rely on their evidence to support the findings in our report;

(e) that what they say will be recorded in writing so that we have an accurate record of what they tell us;

(f) that if we consider that there are areas of potential criticism these will be put to witnesses, either when they first give evidence or later, and they will be given an opportunity to respond;

(g) that if we find that we have criticisms of any witness, then we shall give written notice thereof to the witness so that he/she may comment on our criticisms and bring to our attention any matter which he/she considers is relevant. Such further comments will be expected to be received by us within 14 days of the notice and will be taken into account before we finalise our report;

(h) that we will arrange a convenient date for them to come and give evidence to us, will give them directions as to where to come and will offer to pay their reasonable expenses; we will endeavour to ensure thay they are kept away from their working commitments for as short a time as possible.

VIEWS OF PROFESSIONAL AND OTHER WITNESSES AS TO RECOMMENDATIONS FOR THE FUTURE IN RESPECT OF QUALITY AND PRACTICE WITHIN THE N.H.S.

We shall invite written representations from professional bodies and other interested parties as to present arrangements for clinical governance in the NHS and as to any recommendations they may have for the future.

We may ask those professional bodies or interested parties to give oral evidence to us about their views and recommendations and will pay their reasonable expenses.

Generally

1. We invite anyone who feels that they may have something useful to contribute to our Inquiry to make written submissions to us for our consideration.

2. We shall make our findings of fact on the basis of evidence received, both oral and in writing, and shall apply the civil standard of proof, namely the balance of probabilities.

3. All our sittings will be conducted in private.

4. The findings of the Inquiry and its recommendations will be made public but not the evidence that has been submitted to us, whether oral or in writing, save as is disclosed within the body of our Report.

April 1999

APPENDIX 2

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APPENDIX 3

LIST OF NON FACTUAL EXPERT WITNESSES

AND OTHER INTERESTED PARTIES

Mr A Alaily	Consultant Obstetrician and Gynaecologist	Conquest Hospital Sussex
Mr R Arkell	Head of Guidance Support Unit for Doctors and Dentists	Trent Region
Dr W Armstrong	The Physicians Health Plan	London
Professor M J P Arthur	Head of the School of Medicine	University of Southampton
Mr J Badenoch QC		London
Dr A Bailey	Chief Medical Advisor	Prime Health

Dr C Bowie	Clinical Governance Lead	Public Health Directorate NHS Executive London
Professor L Cardozo	Professor of Urogynaecology	Kings College Hospital London
Mr J Chawner	Former Chairman of the Central Consultants and Specialists Committee	British Medical Association London
Mr R Clements	Consultant Obstetrician and Gynaecologist	London
Mr E Cooper	Solicitor	Russell, Jones and Walker London
Professor P Dawson	Professor of Medical Imaging	University of London
Mr M Dent	Solicitor	Doyle Clayton London
Professor L Donaldson	Chief Medical Officer	Department of Health

Professor J Drife	Vice President	Royal College of Obstetricians and Gynaecologists
Miss K Erskine	Consultant Obstetrician and Gynaecologist	Homerton Hospital London
Mr J Evans	Solicitor	Bevan Ashford Exeter
Professor L Fitzgerald	Professor of Human Resource Development	De Montfort University Leicester
Dr I Frisken	Senior House Officer	St Mary's Hospital London
Ms R Gray	Head of Clinical Services	BUPA
Dr R Hangartner	Senior Medical Executive	PPP Healthcare Group
Mr G Harries	Chief Executive	CHKS Warwickshire

Professor D J Hatch	Professor of Paediatric Anaesthesia	Institute of Child Health and Great Ormond Street Hospital, London
Dr P Hawker	Chairman of the Central Consultants and Specialists Committee	British Medical Association London
Dr B Hicks	Dean Director South Thames Department of Postgraduate Medical and Dental Education	University of London
Dr P Homa	Director	Commission for Health Improvement
Sir Donald Irvine	President	General Medical Council
Miss J Irwin	Senior Employment Relations Advisor	Royal College of Nursing
Ms G Jacomb	Claims and Complaints Manager	Harrogate Healthcare NHS Trust
Mr P James	European Development Director	CHKS Warwickshire

Mr W Jory	Ophthalmic Surgeon	England and Canada
Mrs M Lavin-Smith	Director of Professional Conduct	UKCC
Dr V Lawton	Specialist Registrar in Obstetrics and Gynaecology	St Mary's Hospital Manchester
Professor A Mansfield	Vice President	Royal College of Surgeons
Mrs S McDermott	Deputy Director of Nursing and Quality	Chesterfield and North Derbyshire Royal Hospital
Mr A Moors	Senior Registrar in Obstetrics and Gynaecology	Southampton General Hospital
Miss S J Mountfield	Specialist Registrar in Obstetrics and Gynaecology	Royal Hampshire County Hospital Winchester
Mr N Naftalin	Consultant Gynaecologist Medical Director	The Leicester Royal Infirmary
Miss I Nisbet	Director of Fitness to Practise	General Medical Council
Ms L Norman	Staff Nurse	Oxford Radcliffe Hospital

Miss A Page QC		London
Dr G Panting	Head of Policy and External Relations	Medical Protection Society London
Mrs A Peddar	Chief Executive	Royal Devon and Exeter Health Care NHS Trust
Mr A Pickersgill	Specialist Registrar in Obstetrics and Gynaecology	Billinge Hospital Wigan
Professor Sir Michael Rawlings	Chairman	National Institute for Clinical Excellence
Mr N Rigby	General Surgeon & former Executive Director British Columbia Medical Association	Canada
Dr A Rimmer	Consultant Occupational Health Physician	Sheffield Health Authority
Miss C Roberts	Assistant Director Women and Children's Services	Conquest Hospital Sussex

Dr A Scotland	Director of Medical Education and Research	Chelsea and Westminster Hospital
Ms H Scott	Deputy Health Service Ombudsman	
Mr I Semmons	Honorary Company Secretary	Patients' Association Harrow
Professor R Shaw	President	Royal College of Obstetricians and Gynaecologists
Dr D Skeggs	Chairman Accreditation Committee & Consultant Clinical Oncologist	Cromwell Hospital London
Miss E Slade QC		London
Dr D Snashall	Clinical Director Occupational Health Department	Guy's and St Thomas' Hospital Trust London
Dr R Steel	Chairman of Preliminary Proceedings Committee	General Medical Council

Mr R Sumerling	Solicitor	Le Brasseur J Tickle London
Dr C Tomkins	Professional Services Director	Medical Defence Union London
Professor T Treasure	Professor of Cardiothoracic Surgery	University of London
Mr Andrew Vallance-Owen	Group Medical Director	BUPA
Mr S Walker	Chief Executive	NHS Litigation Authority

APPENDIX 4

SUMMARY OF RECOMMENDATIONS

INCIDENT REPORTING

(i) *The present clinical or critical incident forms should be renamed Incident Reports because they should cover all aspects of care in hospital.*

(ii) *Each Royal College should identify a minimum list of untoward* ***clinical*** *events which should trigger the completion of an incident report. Basic decision making which is outside the norm should also be covered by the system.*

(iii) *Each Trust should develop a list of untoward* ***non-clinical*** *events which should trigger the filling in of an incident report.*

(iv) *The person completing the form should generally identify themselves.*

(v) *Any NHS employee should be required to complete incident report forms if he or she is aware of an untoward event. Diligent and conscientious completion of forms is essential to the effectiveness of the system.*

(vi) *The person in overall charge of incident reporting, the Clinical Risk Manager, must ensure that forms are completed whenever an identified trigger event has occurred or whenever an incident has occurred which is outside the normal or expected. This requires that the person in charge of incident reporting is pro-active, exercises initiative, and goes out into the hospital to ensure that the system is working in practice in every Directorate. The calibre of the person and the status he or she has within the NHS Trust is vital to the effectiveness of the system. The Clinical Risk Manager should be directly answerable to the Chief Executive of the NHS Trust and should be a member of the Clinical Governance Committee of the NHS Trust.*

(vii) *Completed forms must be collected, considered and acted upon by a named individual within each Directorate. That person must be a clinician who commands the respect of other members of the Directorate so that problems can be picked up and acted upon urgently if necessary. The person must be allotted time within his or her contract to carry out this task.*

(viii) *Discussion should take place regularly at Directorate meetings as to the various untoward events that have been recorded; as to any subsequent investigation or audit; and as to how practice should be altered. It is vital that the person in charge of incident reporting within the Directorate ensures that any change in practice decided upon is fully implemented within the Directorate. It is also vital that staff who have completed forms are informed of what steps have been taken as a result.*

(ix) *The Clinical Risk Manager must liaise closely with the person in charge of complaints and claims to ensure that problems are identified early, and any necessary change in practice is introduced and then properly monitored.*

AUDIT

(i) *All doctors, including consultants, must participate in clinical audit and must cooperate with the demands of audit in the Directorate in which they work.*

(ii) *Audit requires thought and deliberation, and time for audit should be allowed for within every doctor's contract.*

(iii) *The consultant who is the lead clinician for audit in each Directorate should ensure that appropriate topics are chosen for audit, data is collected conscientiously and is valid, the results are discussed, deficiencies are identified, changes in practice are formulated promptly and properly disseminated, and a date is set for re-audit to ensure that any deficiencies previously identified have been rectified. The consultant who leads audit in each Directorate is a key figure in the provision of*

quality care to patients, and needs adequate time as part of his or her contract to carry out these tasks.

(iv) *Each NHS Trust must have appointed a clinician to be the Head of Audit who should chair the audit committee, comprising the lead consultants in audit of each Directorate. The Head of Audit should co-ordinate and organise effective audit throughout the Trust, should be answerable directly to the Chief Executive and be a member of the Clinical Governance Committee of the NHS Trust. He or she must have the drive and enthusiasm to want to ensure that clinical audit is effective and is seen to be effective throughout the Trust. It is essential that the Head of Audit is given an identified period of time within the working week to carry out audit responsibilities properly.*

(v) *We are of the view that the Department of Health should consider ways to audit the longterm outcome of patients after hospital inpatient care. Collaboration between NHS Trusts and Primary Care Groups would be essential, and lay people should be involved in such audit particularly when considering patients' expectations against outcome.*

COMPLAINTS AND CLAIMS

(i) *All complaints and claims should be managed by the same department within a NHS Trust. One person, the Complaints and Claims Manager, should be in charge of the Complaints and Claims Department, being answerable to the Chief Executive and being a member of the Clinical Governance Committee of the NHS Trust.*

(ii) *The role of the Complaints and Claims Manager is pivotal. The person needs to be a good listener, receptive, responsive and able to go quickly to the heart of the concern. Such a person needs to be able to command the respect of all Trust employees, including doctors, and to be able to deal sensitively with patient's concerns. The role should be given to someone who is keen to do the job. It requires interest, initiative and a pro-active approach.*

(iii) *A flexible and responsive approach to complaints is vital and it is essential that the main cause of complaint is responded to head on.*

(iv) *Absence of an incident report in respect of a complaint or claim should prompt investigation to ensure that the incident reporting system is working effectively.*

(v) *All employees in a NHS Trust should on appointment be trained in dealing with on-the-spot complaints and responding to other complaints. We also consider that further training should be given to all employees from time to time, which would serve to re-inforce the culture of openness.*

(vi) *Patients who have concerns about their care must be able to raise the matter while they are in the hospital and be given a full and proper response at the time.*

(vii) *If a doctor or other person providing care to a patient realises that something has "gone wrong", or the outcome is not as intended, a full explanation needs to be given by a person who is able to speak authoritatively about the problem.*

(viii) *Whenever the Complaints and Claims Manager is alerted to the fact that someone has not responded properly to a complaint at the time or when a subsequent complaint is made, he or she must raise the matter with the Chief Executive.*

(ix) *If a patient still has a concern after the complaint has been responded to with sensitivity and fairness and after proper investigation, then the patient should be advised that he or she may take the complaint to the Health Service Ombudsman.*

(x) *The current system of referral to an Independent Review Panel should be abolished.*

(xi) *Legal Claims will be referred to the Trust's legal advisors but the Complaints and Claims Manager should have input into the initial investigations and should*

remain involved in the management of the claim.

(xii) *The Complaints and Claims Manager of a NHS Trust must work closely with the Clinical Risk Manager to ensure that problems are identified early, and any necessary change in practice is introduced and then properly monitored.*

APPRAISAL

(i) *There should be an annual appraisal of all consultants, which should cover Continuing Professional Development and assessment of performance. Incident reporting, clinical audit and complaints and claims involving the consultant's work should all form part of the appraisal.*

(ii) *Appraisal of consultants should normally be carried out by a consultant of the same specialty, who will generally be the Clinical Director, so that the process is undertaken by someone who understands the work of the consultant.*

(iii) *The Clinical Director of each Directorate should also be appraised annually and this should be carried out by the Medical Director of the Trust in conjunction with a consultant from the same specialty as the Clinical Director.*

(iv) *Consultants need training in what is required of them when they act as appraisers, and in what is required of them when they are being appraised, and they need to be allowed time within their working commitments to carry out such appraisal or to be appraised themselves.*

(v) *It should be the responsibility of a NHS Trust's Medical Director, who is answerable to the Chief Executive, and a member of the Clinical Governance Committee, to ensure that an effective system of appraisal is in place so that he or she is alerted to any problem about a doctor's clinical performance, and can ensure that doctors employed by the Trust are keeping their knowledge and skills up to date.*

USE OF DATA

(i) *We recommend that the Department of Health should consider whether a national system of data collection could be devised so that benchmarks can be identified for a whole range of medical and surgical specialties.*

(ii) *The collection and analysis of data both by NHS Trusts and nationally is of importance in the whole question of provision of good quality care. In our view it is vital that each Directorate and NHS Trust ensures that full and accurate data is collected.*

(iii) *Every Directorate in a NHS Trust should identify someone who is interested in the task, who understands the importance of the accuracy of data and understands the problems associated with that particular area of medicine.*

(iv) *The data collected by each Directorate should be reviewed by the Clinical Director so that any areas of concern may be identified and rectified.*

(v) *Every NHS Trust should have a head of Information Technology whose job is to ensure that full and accurate data is collected across the Trust and to work with clinicians and management to identify areas of concern and improve the quality of care provided to patients. The head of Information Technology will also be responsible for ensuring that all relevant data is provided for national consideration so that, for example, benchmarks can be established in which doctors will have confidence.*

(vi) *The Clinical Governance Committee of the NHS Trust should review the data collected across the Trust, to ensure that all Directorates are performing well.*

LIAISON BETWEEN NHS TRUSTS AND GPs

(i) *A climate of openness in the NHS must be fostered by GPs and other healthcare professionals as well as by doctors and others working in hospitals.*

(ii) *Every NHS Trust, at both Trust and Directorate level, should monitor GP referrals so that patterns or change in patterns of referral can be identified, and any GP concerns dealt with.*

(iii) *There is a need for Clinical Liaison Groups to be established in every area, whose members should include consultants employed by the local NHS Trust and GPs working in the locality. The Group should meet regularly and should formulate a procedure for bringing concerns of the Committee or of individuals to the attention of the Medical Director or, in an appropriate case, to the Chief Executive of the Trust.*

(iv) *GPs and others working to provide patient care in the community should be told how they can contact the Medical Director of a NHS Trust when they have concerns about a doctor employed by the Trust.*

(v) *GPs should be reminded of their duties to patients under the Patients' Charter.*

WHISTLEBLOWING

(i) *There should be a confidential Hotline in every NHS Trust, which can be used to notify concerns about an employee to an appropriate person. A record should be kept of all such telephone calls.*

(ii) *The person who receives the calls on the Hotline, who need not necessarily be part of the management team, must be sympathetic, responsive and command respect within the NHS Trust. In our view it is essential that the person who*

receives the calls has all those qualities, as the role is vital to the proper and efficient running of a Trust, and to the protection of patients.

(iii) *The person who responds to Hotline calls should be answerable to a non-executive Director of the NHS Trust who will be responsible for ensuring that concerns raised via the Hotline are properly followed up.*

(iv) *The NHS Trust should provide support for the person who has the courage to whistleblow.*

(v) *Both the GMC and the UKCC should be made prescribed bodies under S.43 of the Employment Rights Act 1996 as amended by the Public Interest Disclosure Act 1998, to whom an employee may disclose information without incurring disciplinary measures by the employing Trust.*

(vi) *Where malice is demonstrated by a person who whistleblows, then he or she should be made the subject of strict disciplinary procedures.*

CLINICAL GOVERNANCE IN THE PRIVATE SECTOR

(i) *As NHS consultants are permitted to carry out private work, it is vital that their private work should not* ***in any way*** *prejudice (i) patient care in either sector or (ii) the proper fulfilment of their contractual obligations to their employing NHS Trust.*

(ii) *The Chief Executive or General Manager of each private hospital should be responsible for the quality of care provided in that hospital, and should ensure that all components of Clinical Governance are followed in the private sector just as in the NHS.*

(iii) *It should be a condition of admitting rights being granted by a private hospital to a NHS consultant or former NHS consultant that he or she should agree to whatever Clinical Governance procedures the hospital establishes from time to time.*

(iv) *It should be a condition of a consultant's admitting rights at a private hospital that he or she should be readily available to advise and/or attend his or her patients, or should have arranged cover from a consultant of the same specialty who also has admitting rights at the hospital.*

(v) *A similar complaints and claims procedure should be adopted by the private sector to that which we have recommended for the NHS.*

(vi) *There should be only one Ombudsman for all Health matters.*

(vii) *If there is concern in a private hospital about the clinical performance of a consultant who has admitting rights at the hospital, then the private hospital should be entitled to require the consultant concerned to supply relevant information for example audit information, about his or her practice in the NHS and in other private hospitals where he or she works.*

(viii) *If there is concern in a NHS hospital about the clinical performance of a consultant who has admitting rights at one or more private hospitals, then the NHS Trust should be entitled to require the doctor concerned to supply relevant information, for example audit information, about his or her practice in those private hospitals.*

DISCIPLINARY PROCEDURES

(i) *The present disciplinary process governed by HC(90)9 should be abolished.*

(ii) *There needs to be uniformity of approach about disciplinary matters nationally throughout the NHS.*

(iii) ***A DOCTOR'S CONDUCT***

All issues relating to a doctor's conduct should be determined by a NHS Trust's own internal employment procedures.

(iv) ***A DOCTOR'S CLINICAL PERFORMANCE***

(a) *There should be one central, national and independent Assessment and Support Centre to which NHS Trusts would normally refer doctors about whose clinical performance they have concerns. The national Centre would co-ordinate and manage such referrals.*

(b) *Referral of a doctor to the centre by a NHS Trust should be made as soon as there are real concerns about the doctor's performance. We cannot emphasise too strongly the need for early referral so that any potential problems are corrected to the benefit of patients, the NHS Trust and the doctor. We would envisage that referral should be made long before patients are put at risk and that therefore there will be no need to suspend the doctor. However if patients are considered to be at risk then the Centre would advise the NHS Trust to suspend the doctor pending the Centre's assessment.*

(c) *Where a doctor is suspended pending investigation of his clinical performance, he or she should not be permitted to work elsewhere within the NHS or within the private sector.*

(d) *Referral to the Centre should also be made if two or more doctors working in the same NHS Trust are involved in a serious functional dispute which jeopardises the service being provided to patients.*

(e) *If a doctor is unwilling to cooperate in the referral and/or subsequent investigation, that should be a disciplinary matter which would be dealt with under the normal "conduct" terms of his or her employment. The Trust should be entitled to suspend and/or dismiss a doctor for refusal to cooperate.*

(f) *On referral, the Centre should then contact the appropriate Royal College and ask for the names of relevant experts who would provide the rapid response necessary to investigate the doctor's performance about which the Trust has expressed concern.*

(g) *The investigating team should include a lay member, and perhaps a GP, and all members of the team need to be trained by the Centre to ensure uniformity of approach and consistency.*

(h) *After investigating the concerns, the Team would draw up a written report including its recommendations and would supply them to the doctor, the NHS Trust and the Centre simultaneously. It would be for the Trust and the doctor to implement any recommendation, but the Centre would need to ensure that its recommendation had been carried out and to ensure that the doctor's performance was monitored thereafter.*

(i) *if the Centre's report and recommendation is that the doctor's performance is serious and intractable, then the Trust should be able to rely on that evidence to dismiss the doctor.*

(v) *Once a doctor is dismissed by a Trust, his or her pay should terminate as applies to all other NHS employees.*

ALERT LETTERS

(i) *Alert letters need to be issued whenever a doctor is suspended or dismissed from his employment and there is a concern about safety to patients, other staff or the doctor himself.*

(ii) *Although in a later section we recommend that every Health Authority or NHS Trust which is considering employing a doctor should seek information about the*

doctor from the Trust by which he or she was most recently employed, it is even more vital where an alert letter is issued regarding the doctor.

(iii) *Any information provided by a previous employer must be full, accurate and in writing.*

THE GENERAL MEDICAL COUNCIL

Professional Conduct Proceedings

(i) *A hearing before the Professional Conduct Committee of the GMC should be determined on the civil standard of proof, on the strong balance of probabilities. It should not be seen or conducted as a criminal trial.*

(ii) *In order to ensure that the proceedings are carried out fairly and independently, a Circuit Judge or experienced Recorder of the Crown Court should sit as the Chairman. One of the panel members should be a person who practises in the same speciality as the doctor before the Committee. The panel should continue to have lay members and training of all members is essential.*

(iii) *Committee members must declare any interest they have in the proceedings, for example that they know the doctor concerned or they know one of the witnesses.*

(iv) *Witnesses should be given adequate support before, during and after the hearing.*

(v) *It is vital that timetables are set by the GMC and adhered to.*

(vi) *Whenever a doctor is referred by a NHS Trust to the GMC for any reason, the doctor should be notified at once by the GMC of its involvement and why the doctor has been referred.*

(vii) *The Medical Act should be amended to allow the Professional Conduct Committee, when it erases a doctor's name from the Medical Register, to determine at that time the minimum period of erasure which it is felt to be appropriate.*

Restoration to the Medical Register

(i) *Where a person whose name has been erased from the Medical Register applies to be restored to the Register the same standard of proof should apply as to the original proceedings and the burden of proof should be on the applicant.*

(ii) *The Committee should be able to make a provisional declaration as to whether the applicant might be restored to the Register at some time in the future and, if it makes such a declaration, it should then grant conditional registration in order to allow re-training and assessment of the doctor under direct supervision.*

Performance Procedures

(i) *The GMC Professional Performance Procedures will be unnecessary, if and when the proposed new national Assessment and Support Centre is set up, and should thereafter be abolished.*

REFERENCES

(i) *Consideration should be given to setting up a central system whereby every doctors' employment history is recorded as to the name of the employer and the length of employment.*

(ii) *Every Health Authority or NHS Trust must seek a reference about a doctor whom they are considering employing, from the employing body who most recently*

employed the doctor. The reference should cover the doctor's work record for his previous employer and any gaps in service should be fully investigated by the prospective employer.

(iii) *Every Health Authority or NHS Trust must also seek a reference about a doctor whom they are considering employing, from a professional colleague of the doctor, who has first hand and up-to-date knowledge of the doctor's clinical skills and professional performance.*

(iv) *When a doctor supplies a reference for a colleague it is essential that the obligations imposed by the GMC in Good Medical Practice are adhered to.*

(v) *Any reference must be full, accurate and in writing.*

(vi) *The Department of Health should devise separate structured reference forms to be used as models by the employing body and professional referees, which could then be modified as circumstances dictate.*

(vii) *Doctors who seek a new position should be prepared to make available to their prospective employer their Professional Development Plans.*

CHAPERONES

(i) *All obstetric and gynaecological units should adopt the guidelines proposed by the Royal College of Obstetricians and Gynaecologists in 1997, which include:*

> *(a) a full explanation of the reasons for an intimate examination should be given to patients and their verbal consent obtained before such an examination is carried out;*
> *(b) all patients should be asked if they would like a chaperone present while undergoing an intimate examination.*

CONSENT FORMS

(i) *We recommend that the Department of Health should consider, with other interested bodies, the whole question of consent to surgery.*

OCCUPATIONAL HEALTH AND THE THREE WISE MEN COMMITTEES

(i) *The role of occupational health for doctors is important for the proper provision of care to patients and should be encouraged.*

(ii) *If a doctor is not performing his or her job well, consideration should always be given as to whether referral to an occupational health physician might discover an underlying health problem.*

(iii) *Formal arrangements should be established between local Trusts to ensure that the full range of occupational health care is available to all employees, including doctors.*

(iv) *Three wise men committees should be abolished.*

(v) *Consideration should be given by each Trust that has a Professional Standards Advisory Group or Committee as to whether, if the Occupational Health Department is used properly, there is any need for such groups or committees.*

(vi) *A direct contact line needs to be established to the Medical Director of each Trust so that* ***anyone*** *who has concerns about a doctor's health and well being, in the widest sense, should inform the Medical Director.*

(vii) *Every student who qualifies as a doctor should be screened by the*

Occupational Health Department and such screening should also take place whenever a doctor changes employer.

(viii) *We endorse the recommendation of the Bullock Report that a system should be devised whereby occupational health records follow healthcare professionals (which would include doctors) from one employment to another.*

MEDICAL STUDENTS

(i) *An offer from a Medical School to study medicine should always be conditional on the student passing an occupational health screen.*

(ii) *Ethics and the duties of a doctor should be taught throughout a medical student's training so that they are second nature to a student when he or she qualifies. We recommend that the Council of Heads of Medical Schools and the GMC should together decide how best to emphasise the importance of ethics and the duties of a doctor, so that every student is fully aware of their responsibilities as a doctor before they qualify.*

DEALING WITH A MAJOR CLINICAL INCIDENT

(i) *Whenever a major clinical incident has occurred as a result of failures by those who work within a NHS Trust, and where a number of patients are involved, such patients should be offered a consultation by a consultant of the appropriate specialty who is independent of the NHS Trust concerned.*

(ii) *The Department of Health should consider providing guidance to NHS Trusts as to how to deal with a major clinical incident.*