Independent investigation into governance arrangements in the paediatric haematology and oncology service at Cambridge University Hospitals NHS Foundation Trust following the Myles Bradbury case

A report for Cambridge University Hospitals NHS Foundation Trust

October 2015
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1. Introduction

1.1 Dr Myles Bradbury was employed as a paediatric haematologist in the paediatric haematology and oncology service at Cambridge University Hospitals (CUH) NHS Foundation Trust (the trust). In November 2013, the family of a patient raised a concern about possible inappropriate behaviour by Dr Bradbury. Senior staff were alerted at once. He was immediately removed from clinical duties, then excluded from clinical duty the following day, and did not return to the trust. Following investigations by the police, Dr Bradbury was formally charged in July 2014 with 11 offences against children under his care. Following further investigation, he pleaded guilty in September 2014 to 25 sexual offences against 18 children who had been his patients, as well as to charges of voyeurism and possession of indecent images. He was sentenced to a total of 22 years’ imprisonment, with the judge emphasising the seriousness of the breach of trust that these offences displayed.

1.2 Dr Bradbury appealed against the length of his sentence, and on 12 June 2015 the Court of Appeal, while upholding the length of the sentence, restructured it to 16 years’ imprisonment and six years on licence.

1.3 Following the conviction of Dr Bradbury, the trust commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out an independent investigation into governance arrangements within its paediatric haematology and oncology service.

1.4 The investigation team was led by Lucy Scott-Moncrieff, supported by Barry Morris and administrative staff from Verita. The team is referred to as “we” from this point on in the report. We were assisted by advice from Donald Findlater director of research and development at the Lucy Faithfull Foundation, Dr Mike Bewick, former deputy medical director NHS England, and Jane Held chair of both the Leeds Safeguarding Board and the Birmingham Safeguarding Children Board.

1.5 The purpose of the independent investigation is to establish how Dr Bradbury was able to carry out his activities, how his offending behaviour went undetected for so long, and what lessons there are to be learnt for the service, the trust and the wider NHS, with the aim of ensuring that services today are safe and appropriately governed so that children are safeguarded.
1.6 The trust has remained in contact with the local safeguarding children board (LSCB), the body responsible for recommendations for serious cases reviews (SCR). LSCB is of the view that the investigation undertaken by Verita was sufficient for the lessons learned to have been identified without the need for an SCR.

1.7 The trust is one of the largest in the UK. It comprises Addenbrooke’s Hospital (general and specialist care) and the Rosie Hospital, which offers women’s and maternity care. It has about 7,600 (full-time equivalent) staff, 1,000 beds, and an annual income of £661 million.

1.8 As well as delivering care through Addenbrooke’s and the Rosie, the trust is also:

- a leading national centre for specialist treatment for rare or complex conditions;
- a government-designated biomedical research centre;
- one of only five academic health science centres in the UK;
- a university teaching hospital with a worldwide reputation; and
- a partner in the development of the Cambridge Biomedical Campus.

1.9 Addenbrooke’s has a dedicated unit for children with cancer and blood disorders. This treats children with solid tumours and those with malignant blood diseases such as leukaemia. It also treats children with non-malignant blood disorders such as haemophilia. The hospital is a tertiary centre for paediatric oncology and haematology; it sees patients needing its specialist input from a catchment area covering the east of England. The unit consists of an inpatient ward and a linked unit for outpatient appointments for children needing day treatment who do not require inpatient admission.

1.10 The inpatient ward is called C2 and the outpatient/day patient part of the unit is called the paediatric day unit (PDU).

1.11 The PDU is where Dr Bradbury committed his offences.
2. Terms of reference

2.1 The trust started an internal investigation into Dr Bradbury’s activities but abandoned this in favour of an independent investigation. The independent investigation was commissioned by the chief executive on behalf of the trust board. Its terms of reference state:

1. The investigation team will:

   • Produce and comment on a detailed timeline setting out key events relating to Dr Bradbury focusing on the period 2009 - 2013 (but will consider earlier events if necessary).

   • Set out the relevant governance arrangements in place for the paediatric haematology and oncology department from April 2009 to August 2013 and report on the extent to which they were complied with. This will include reviewing:

     o All relevant policies including chaperone policy, appointments policy and case allocation policy
     o The quality of safeguarding training and its uptake
     o The safer recruitment practice
     o Annual appraisal of Dr Bradbury and others involved in the service

   • Identify and comment on what was known about Dr Bradbury’s inappropriate behaviour, when and by whom, including review of pre-employment checks.

   • Identify and comment on any action taken in respect of Dr Bradbury’s inappropriate behaviour.

   • Inform patients/families of the investigation and engage with those patients/families who wish to contribute.

   • Comment on any changes already made to the governance arrangements in the light of matters concerning Dr Bradbury.
• Report on any other relevant matters that arise in the course of the review.

• Provide a written report containing clear recommendations aimed at learning any lessons from these events.

2. It is not the role of this investigation to review the 18 cases (used in the criminal case) of abuse individually. Aspects of individuals’ treatment may be reviewed as part of this investigation when identifying themes in Dr Bradbury’s offending and whether the trust’s systems and processes were, in any way, a contributory factor in the offences.
3. **Approach and methodology**

3.1 The police investigation of Dr Bradbury and his subsequent sentencing took place during an unprecedented period of public debate and concern about the sexual abuse and exploitation of children. In 2012 revelations about Jimmy Savile in a TV programme led to the setting up of Operation Yewtree, which resulted in hundreds of allegations of historical child sexual abuse being made against not only Savile but also many other individuals, some of them household names. Prosecutions arising from these allegations have been taking place ever since, and some well-known individuals have been found guilty and imprisoned.

3.2 At the same time, evidence has been emerging of organised and extensive sexual abuse and exploitation of children and young people by gangs and groups across the country. This sort of abuse came to national and international attention with the publication of Professor Alexis Jay’s report on abuse in Rotherham, published in August 2014.

3.3 During 2014 and 2015 Lucy Scott-Moncrieff, with Verita’s assistance, was writing a report commissioned by the Secretary of State for Education on the extent and nature of child sexual abuse in schools and children’s homes, and how the authorities recognised and dealt with the problems *The risks of sexual abuse and child sexual exploitation for schools and children’s homes post-Savile*.

3.4 As a result of this work, as well as the reports of the various investigations published during the past three years and the evidence at the trials arising from Operation Yewtree, we came to this investigation well aware of the ways in which evidence of child sexual abuse could be ignored, overlooked or suppressed. We knew that there had been no official suspicion of Dr Bradbury before the family raised a concern in November 2013, and we were alert to the possibility that there might have been earlier evidence that had been ignored, overlooked or suppressed.

3.5 We considered published reports of previous reviews following the convictions of senior health staff for sexual offences committed on their patients. We noted the tactics they used to offend for some considerable time without detection. We looked for evidence of such tactics by Dr Bradbury. In section 12 we set out the concerns raised in those
reports and consider their relevance to Dr Bradbury’s behaviour and the trust’s systems and processes.

3.6 In the course of our investigation we identified or were told of a number of matters that, in retrospect, could be seen as clues to Dr Bradbury’s criminal behaviour. Much of our questioning therefore focused on what his colleagues knew or deduced, or should have known or deduced, about these matters. We have set out these behaviours and the way in which they were seen at the time in section 8.

3.7 In writing our report we are acutely aware of the sensitivities of present and past patients of the paediatric oncology service at Addenbrooke’s, and their families. As we explain in section 7, some families whose children may have been abused by Dr Bradbury have chosen not to seek clarification, to protect their children. The trust and the police have respected this choice, as do we, and we have attempted to reflect this in the way we have written the report. We have not given specific details of the areas from which Dr Bradbury’s patients were drawn, nor details of the nature of the assaults carried out by Dr Bradbury, except to say that they were presented as necessary physical examinations. For the avoidance of doubt, we can confirm that they did not involve penetration of any kind.

3.8 Of course all these details are known to the trust and the police, who have both told us that they will willingly respond to any query from any patient, or the family of any patient who was treated by Dr Bradbury.

3.9 We sought an interview with Dr Bradbury, via his solicitor, to obtain information relevant to our terms of reference: we wanted to give him an opportunity to comment on what others had said about his behaviour, with a view to informing the recommendations we were asked to make to learn lessons from these events’.

3.10 Dr Bradbury agreed to our request and we interviewed him in prison, after his appeal was heard and towards the end of our investigation.

3.11 We interviewed all the consultants on the PDU, CUH’s safeguarding lead and the other staff listed at appendix A. We wrote to all the other staff on the unit, inviting them to contact us if they felt they had any information relevant to the terms of reference.
3.12 We reviewed a significant number of policies and other documents (details set out in appendix B).

3.13 We interviewed a senior nurse from the general paediatric outpatients department to discover whether relevant practices on the PDU were similar in that unit, and, if not, why not.

3.14 The interviewees were told that they could be accompanied by a colleague or a friend, or a member of a professional body or trade union. With the agreement of the interviewees, the interviews were recorded and a transcript sent to them. This enabled them to verify the accuracy of what was said, and propose amendments to the transcript to ensure that it reflected what they intended to say.

3.15 We wrote, via the hospital, to the patients, or the families of patients who had been treated by Dr Bradbury since his appointment as a consultant at CUH in 2008. We received responses from 11 families, to whom we sent a brief questionnaire (see appendix C). We received five responses to the questionnaire, as a result of which we interviewed the families of three patients. Where the questionnaire responses did not suggest that the family could shed any light on our terms of reference, but indicated that the family was looking for support or answers to questions about their child’s experience at the hospital, we referred them to the trust.

3.16 We visited Birmingham Children’s Hospital (where Dr Bradbury had previously worked) and interviewed a consultant in the oncology department about policies and procedures there.

3.17 We interviewed senior staff at the General Medical Council and spoke to a senior member of the Royal College of Paediatrics and Child Health to discuss how it publishes information for hospitals and doctors on lessons it learns from their work.

3.18 We met Donald Findlater, an expert from the Lucy Faithfull Foundation, a registered child protection charity which works across the UK to prevent child sexual abuse.
3.19 We invited Professor Mike Bewick and Jane Held to review our findings from their own expert perspective and to comment on the extent to which the trust and its staff complied with good professional practice and required NHS standards.

3.20 We reviewed the trust’s online safeguarding training, one component of the trust’s safeguarding training programme.

3.21 We read all the documents listed in appendix B.

3.22 The main body of this report is split into sections setting out the timeline of key events (section 5); a description of children’s cancer services offered by CUH (section 6); a description of events after a concern was raised about Dr Bradbury’s behaviour (section 7); governance arrangements (section 8); other behaviour by Dr Bradbury that could have facilitated abuse (section 9); a summary of safeguarding arrangements (section 10); a summary of the changes made by the trust since Dr Bradbury’s exclusion (section 11); lessons learned from other relevant investigations (section 12); an interview with Dr Bradbury (section 13) and finally our analysis and conclusions (section 14).
4. Executive summary and recommendations

4.1 Dr Myles Bradbury was employed as a paediatric haematologist in the oncology team at Cambridge University Hospitals NHS Foundation Trust (the trust). In November 2013, the family of a patient raised a concern about possible inappropriate behaviour by Dr Bradbury. Senior staff were alerted at once. He was excluded from clinical duties the following day, and did not return to the trust. In September 2014, Dr Bradbury pleaded guilty to 25 sexual offences against 18 children who had been his patients, as well as to charges of voyeurism and possession of indecent images. He was sentenced to a total of 22 years’ imprisonment, with the judge emphasising the seriousness of the breach of trust that these offences displayed. Subsequently, on appeal, his sentence was restructured to 16 years’ imprisonment and six years on licence.

4.2 Dr Bradbury’s known victims were patients of the paediatric haematology and oncology service, and the offences took place at the paediatric day unit (PDU) at Addenbrooke’s Hospital. His victims were adolescent boys and the sexual offences took place under the guise of necessary medical treatment: genital examination is routine for some cancers, and Dr Bradbury committed his offences by carrying out unnecessary genital examinations.

4.3 In fulfilling our terms of reference we sought to answer the following questions.

- Were any concerns raised about Dr Bradbury’s behavior prior to the concern that led to his arrest, and, if so, what action was taken in response?
- Was there any evidence of suspicious behaviour by Dr Bradbury prior to his exclusion, and, if so, was it noticed?
- If there was evidence of suspicious behavior and it was not noticed, should it have been?
- Were trust policies intended to safeguard children in place? If so, were they robust and were they complied with in Dr Bradbury’s case?
- Was safeguarding part of everyday business: i.e. did the environment have a ‘safe’ culture, with safeguarding threaded through everything everyone did?
- What changes has the trust made to its policies and practices since Dr Bradbury’s arrest? Are further changes needed?
- Did the trust act properly once a concern was raised about Dr Bradbury’s conduct?
Were any concerns raised about Dr Bradbury’s behavior prior to the concern that led to his arrest, and, if so, what action was taken in response?

4.4 None of the interviewees to whom we spoke, who included the families of victims as well as trust staff, had raised any concern about Dr Bradbury’s behaviour with the trust or with anyone else, nor were they aware of anyone else raising a concern. Detective Sergeant Fasey, the police liaison officer in the case, was not aware that any of the families interviewed by the police had said that they had raised a concern. After Dr Bradbury’s arrest, the trust set up a helpline for patients’ families to contact. None of those who contacted the helpline said that they had raised concerns, although one mother felt uncomfortable that Dr Bradbury spoke to her son rather than herself, another mother was suspicious of Dr Bradbury’s attempts to see her son without her being present, and one father thought that Dr Bradbury was suspiciously over-friendly and “too nice”. Most family callers to the helpline were full of praise for Dr Bradbury.

Was there any evidence of suspicious behaviour by Dr Bradbury prior to his exclusion, and, if so, was it noticed?

4.5 The PDU is open on weekdays, and has clinics every morning and some afternoons. Quite often the morning clinic list goes over into the afternoon. Routine appointments are booked into clinics, and all clinic appointments are discussed at pre- and post-clinic meetings. Sometimes routine appointments are fixed for non-clinic times: for example, if a child is coming from a distance to see another specialist, the appointment at the PDU will be arranged so that the patient does not have to make two journeys. Out-of-clinic appointments might also be made so that children did not have to miss something important at school.

4.6 In addition, emergency appointments are accommodated throughout the working day.

4.7 Routine appointments were made by the clinic clerks, but emergency appointments could be made directly with a named consultant or duty doctor.

4.8 Some staff noticed that Dr Bradbury was more likely than his colleagues to see patients out of normal clinic hours, although still during the normal opening hours of the
PDU. His explanation was that he was accommodating the needs of his patients, and this explanation was accepted and generally regarded as praiseworthy.

4.9 An adult was expected to accompany a child to every appointment with a doctor, except that when a child turned 14, he or she could request a private discussion with the doctor with no adult present, as part of the transition to adult services at the age of 16. The hospital’s chaperone policy required either a family member or another professional to chaperone any intimate examination. Intimate examinations take place with the patient on the couch in the consulting room, behind a curtain, so that no one glancing into the room or opening the door unexpectedly will see them.

4.10 Dr Bradbury breached both these policies, firstly by seeing children on their own when they were under 14, and secondly by carrying out intimate examinations during some of those appointments. He also took advantage of the chaperone policy by carrying out criminal intimate examinations on patients behind the curtain with their family member in the room but on the other side of the curtain.

4.11 We questioned staff about how this could have happened without any concern being raised. We were told, and were able to see for ourselves, that the PDU is a busy unit, with people coming and going the whole time, and with children playing with toys or with their friends, or visiting the toilet, and not necessarily with their parents. There is also a room with games in it for teenage patients to pass the time. It would therefore be unsurprising to see adults without their older children at any given moment. In addition, all staff have their own tasks, and it was no one’s job to monitor the policy. At interview some staff told us that they thought the policy was more for the protection of the professionals than the patients.

4.12 The design of the consulting room doors made it difficult to see who was in there without getting very close and peering, and in any event, if a doctor and patient were behind the curtain it would not be possible to determine whether another adult was there or not.

4.13 No child or adult ever raised any query or concern about Dr Bradbury’s behaviour.

4.14 Dr Bradbury was very friendly with patients, and this was noticed not only by his patients and their families but also by some of his colleagues. One of his colleagues
thought that perhaps this was a sign of neediness: Dr Bradbury had told him that he was rather lonely, as he had split up with his girlfriend in Birmingham and was having to start afresh in a new district. However, none of his colleagues saw anything sinister in his behaviour. Although, as mentioned in 4.4, one father was suspicious of this friendliness, he expressed no concern about it at the time.

4.15 After Dr Bradbury’s exclusion, families told staff at the trust that he had given his mobile phone number to patients and their families, but staff were not aware of this before his exclusion.

4.16 Staff did not notice that Dr Bradbury was seeing some patients unnecessarily, and much more frequently than their stage of treatment required. They did not notice this because he made appointments directly with the families, and made appointments out of clinic times, or for different clinics. This meant that staff at routine clinics were not aware of how often these patients was attending, and some of these appointments did not lead to pre- and post-clinic discussions with the whole team.

4.17 Dr Bradbury’s consultant colleagues noticed that he was reluctant to have medical students with him when he saw patients on the PDU. His excuse was that he was very busy, and that he did not like students to be present when he was having difficult conversations with families. These reasons were accepted as legitimate.

4.18 He was also noted sometimes to be bad-tempered with junior staff, and we explored if this might have been to deter discussion or comment on any unusual behaviour. However, many staff told us that he was fine with them, and we were also assured that anyone who had a concern would have raised it with a senior colleague, even if not with Dr Bradbury himself.

If there was evidence of suspicious behaviour and it was not noticed, should it have been?

4.19 Dr Bradbury manipulated the appointments system and the chaperone and transition policies to a considerable extent. Some of this manipulation was noticed by colleagues, but they did not see it as manipulation and accepted Dr Bradbury’s plausible explanations for his conduct. We established that it was no one’s job to monitor any of
these practices or policies for unusual behavior or non-compliance. We were told that patients and families were not given information on the policies or practices, so were in no position to notice any breaches.

4.20 We consider that the staff on the PDU are not to blame for failing to be suspicious of Dr Bradbury’s behaviour. However, we consider that policies and practices can be improved to minimise the likelihood of such behaviour by any healthcare professional in future, as set out in our recommendations.

Were trust policies intended to safeguard children in place? If so, were they robust and were they complied with in Dr Bradbury’s case?

4.21 We considered the relevant trust policies.

*Safeguarding training*

4.22 All staff undergo safeguarding training in accordance with NHS guidelines. Dr Bradbury fulfilled his training obligations. There is a high take-up of safeguarding training, and its effectiveness was evident in the trust’s immediate and robust response to a concern being raised about Dr Bradbury’s conduct. The online training does not include content in relation to identifying someone who may specifically target jobs where they have easy access to vulnerable groups, but we were told by the chief nurse that face-to-face training for more senior staff does include this. We make a recommendation about strengthening this training.

*Safeguarding governance arrangements*

4.23 The trust has robust and effective safeguarding governance arrangements, going to board level.
Safer recruitment policy

4.24 The trust has a safer recruitment policy in accordance with NHS guidance, and this policy was followed in Dr Bradbury’s case.

Appraisal policy

4.25 The trust has a suitable and robust appraisal policy which was followed in Dr Bradbury’s case.

Chaperone policy

4.26 The policy at the time Dr Bradbury was working at the trust was not sufficiently robust, was not enforced, was not monitored and was not understood by families. We make a recommendation about this.

Transition policy

4.27 The trust’s transition policy is satisfactory, but it was not monitored, and since patients and families were not aware of its purpose and limits, they were in no position to notice that it was being breached by Dr Bradbury. We make a recommendation on this.

Appointments policy

4.28 The appointments policy allows for flexibility to accommodate the needs of long-term patients. Dr Bradbury took advantage of this flexibility to conceal his offending. It is possible to retain the flexibility while minimising the risk of the system being abused, and we make a recommendation on this.
Was safeguarding part of everyday business: i.e. did the environment have a ‘safe’
culture, with safeguarding threaded through everything everyone did?

4.29 We found evidence of a strong safeguarding culture in that there was a wide
commitment to safeguarding and the trust appeared to engage wholeheartedly with the
Cambridgeshire LSCB. The speed with which an expressed concern by a family was
responded to, and the engagement of staff with this response is further evidence of this
commitment. However the effectiveness of this was weakened by the lack of
understanding and awareness of the possibility of abuse by a respected colleague.

What changes has the trust made to its policies and practices since Dr Bradbury’s
arrest? Are further changes needed?

4.30 Unrelated to Dr Bradbury’s arrest and conviction, the trust has put in place a new
electronic case management and appointments system, which should make it easier to
monitor compliance with chaperoning and more difficult to engage in unusual patterns of
appointment.

4.31 The trust has amended its chaperone policy so as to minimise the opportunity for
any healthcare professional to abuse a child. We consider that in some circumstances the
current policy is so restrictive as to be unworkable, and unhelpful to good clinical care.
We make a recommendation on this.

4.32 The flexibility of the current appointments system is a virtue which should not be
lost. To ensure that all appointments are looked at by the team, we make a
recommendation to ensure that all appointments are subject to discussion at pre- and
post-clinic meetings.

4.33 The trust is considering how best to engage and communicate with patients on
safeguarding issues, and has been awaiting our report before finalising its policies in this
area. We make recommendations on this.
Did the trust act properly once a concern was raised about Dr Bradbury’s conduct?

4.34 The family of a patient raised a query about Dr Bradbury’s conduct on 27 November 2013. The concern was immediately escalated to the medical director. Dr Bradbury was sent home and the local authority was contacted in accordance with the safeguarding policy. The local authority contacted the police.

4.35 Dr Bradbury had an interview at the trust on 28 November at which he was informed that he was restricted with immediate effect from having any patient contact, from undertaking clinical work or attending any clinical area while the concerns raised were dealt with. He never returned to the hospital except for formal interviews or to hand over case notes, on which occasions he was escorted.

4.36 The trust promptly set up a safeguarding group, chaired by the chief nurse to deal with the issues arising from Dr Bradbury’s alleged activities. The group, which included a liaison officer from the Cambridgeshire police child abuse investigation unit and the LADO¹, met weekly, and made decisions on identifying possible victims, supporting patients and families; supporting staff, and liaising with the shared care hospitals, the police, the local authority, the GMC, and Dr Bradbury’s previous employer.

4.37 Although in general we found no fault in the trust’s communication strategy and its implementation, we agree with its retrospective recognition that it did not contact all the families whose children might have had contact with Dr Bradbury.

4.38 The trust cooperated fully with the police investigation, in accordance with good practice, even though this limited their opportunities to support patients and families as much as they wished.

4.39 It also liaised effectively with local children’s services through the LADO and with the Cambridgeshire LSCB.

¹ The Local Authority Designated Officer (LADO) works within Children’s Services and should be alerted to all cases in which it is alleged that a person who works with children has:
• behaved in a way that has harmed, or may have harmed, a child;
• possibly committed a criminal offence against children, or related to a child; or
• behaved towards a child or children in a way that indicates s/he is unsuitable to work with children.
4.40 We found that, apart from the problem identified in paragraph 4.37 above, the trust acted properly, decisively, efficiently and effectively once a concern was raised.

4.41 We concluded that if the service, the trust and the NHS want to raise the safeguarding standard to cover all children in all situations and all settings, a culture change is needed, centring on the empowerment of patients and their parents and carers.

4.42 We therefore consider that our recommendations on providing information, encouraging questioning and enabling discussion online between staff, patients and families to be recommendations most likely to improve safeguarding in any setting where they are adopted. The discussion is particularly important as it ensures that policies and practices remain under active consideration over time, and that new patients and their families can see how staff respond to queries or opinions put forward by existing patients and families.

4.43 Developing the best way to do this without damaging the trust between staff on the one hand and patients and their families on the other will require thought and care, but there are already examples of good practice that can be drawn upon.

Recommendations

R1 The trust should preserve all relevant records of Dr Bradbury’s patients and of its joint investigation with the police, so that anyone treated by Dr Bradbury between 2009 and 2013 can seek further information in adulthood, if they wish to do so.

R2 The trust should consult and agree on the principles that should apply on providing patients or their families with personal mobile numbers, and ensure that all staff receive information and/or training on those principles.

R3 The trust should consult with the Cambridgeshire LSCB to ensure that its information to patients, training of staff and expectations of staff behaviour are in accordance with current best safeguarding practice.
R4 The trust should consult patients and families about the desirability of setting up an online resource for patients, families and staff to provide information and facilitate communication.

R5 The chaperone policy should be reviewed again to take account of the varying treatment needs of inpatients in the absence of their families. The new policy should offer guidance on how to develop the thoughtfulness and heightened awareness mentioned by the trust’s medical director in section 9.

R6 The trust should include good practice on creating a safe environment into its safeguarding training at all levels.

R7 The trust should suggest to NHS England, the Royal Colleges, other professional associations for healthcare workers, and the LSCBs that their guidance supports such training.

R8 The possibility of using EPIC, the trust’s electronic case management system, to identify unusual patterns of treatment by individuals that require further investigation should be kept under regular review by the trust.

R9 The trust should ensure that all patients seen on the PDU are discussed by a clinic team before or after each appointment, whether or not their appointment is during clinic hours.

R10 The safeguarding leads and non-executive director with safeguarding responsibility should carry out an assessment of the value of having consulting room doors with vertical glass panels.

R11 The trust should invite NHS England, the Royal Colleges and Local Children’s Safeguarding Boards to consult on creating a national curriculum and/or guidance on safeguarding training.

R12 The trust should invite NHS England to consult on creating guidance on the areas to be covered and principles to be reflected in chaperone policies.
R13 The trust should invite NHS England to review the efficacy of its systems for disseminating lessons learned from investigations that are relevant to safeguarding patients.

R14 If the trust does not have a trained, accredited managerial lead with responsibility for implementation of its chaperone policy, it should consider creating such a role.

R15 Once the chaperone policy is revised to ensure it is workable in all situations, the trust should consider how best to enforce it.

R16 The trust should consider how best to inform doctors and medical students of the help available to them if they have inappropriate sexual thoughts about patients. It should also discuss with NHS England whether national guidance should be issued.
5. **Timeline/narrative**

5.1 In 1996 Dr Bradbury qualified as a doctor. His CV is at appendix D.

5.2 Between August 1996 and January 2007, Dr Bradbury worked in various hospitals as a house officer, senior house officer and specialist registrar. During this period, police in Toronto investigated a number of potentially indecent films/images being sold on the Internet using Canadian servers. In August 2005 Dr Bradbury bought one of these videos, containing images of naked people, including children, which the Canadian police did not classify as indecent at that time.

5.3 Between January 2007 and October 2007, Dr Bradbury was a locum consultant paediatric haematologist at CUH. This was his first role as a consultant.

5.4 From October 2007 to November 2008, Dr Bradbury joined Birmingham Children’s Hospital as a consultant paediatric haematologist. This was his first permanent consultant job.

5.5 In November 2008 Dr Bradbury re-joined CUH, this time as a permanent consultant paediatric haematologist.

5.6 In 2010, the video Dr Bradbury bought in 2005 was reclassified as “Level 2 indecent”, and Interpol was advised of the purchasers in 94 countries.

5.7 In July 2012, Interpol provided the Child Exploitation and Online Protection Centre (CEOP)\(^2\) with a list of possible UK purchasers of the video.

5.8 On 13 November 2013, CEOP shared this information with the police, including the Suffolk police. Dr Bradbury lived in Suffolk.

5.9 On 25 November 2013, Child X had an outpatient appointment with Dr Bradbury.

5.10 On 27 November 2013, a family member of Child X phoned the PDU to voice concerns about Dr Bradbury’s actions at the outpatient appointment two days previously.

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\(^2\) CEOP is an organisation of the National Crime Agency.
The trust then contacted the local authority designated officer (LADO)\(^3\) and informed the medical director.

5.11 On 28 November 2013, Dr Bradbury was asked not to attend work in the morning. He was called to a formal meeting at which he was restricted with immediate effect from undertaking clinical practice, having any contact with patients or attending any clinical area.

5.12 On 5 December 2013, the trust referred Dr Bradbury to the General Medical Council (GMC)\(^4\).

5.13 On 12 December 2013, Dr Bradbury was formally excluded from work.

5.14 On 18 December 2013, Dr Bradbury was arrested and bailed by Suffolk police in relation to the video.

5.15 On 23 December 2013, Suffolk police informed the trust of Dr Bradbury’s arrest, which was the first the trust knew of the video or the investigation.

5.16 On 30 December 2013, Dr Bradbury was interviewed, arrested and bailed in relation to the concern raised about Child X. Bail conditions imposed that he must have no unsupervised access to anyone under the age of 18 and must live at an address in Nottingham.

5.17 Interim suspension from the medical register by the GMC was issued on 14 January 2014.

5.18 On 19 March 2014, Dr Bradbury was dismissed from employment by the trust.

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\(^3\) A local authority designated officer works within children’s services and should be alerted to all cases in which it is alleged that a person who works with children has possibly committed a criminal offence against a child.

\(^4\) The General Medical Council is the independent regulator of doctors and medical students in the UK. It decides which doctors are qualified to work in the UK; oversees medical education and training; sets the standards that doctors need to follow; makes sure that they continue to meet these standards throughout their careers, and takes action when they believe a doctor may be putting the safety of patients, or the public’s confidence in doctors, at risk.
5.19 In the week commencing 30 June 2014, 181 families of patients undergoing active treatment were called by the trust clinical team and on 2 July 2014 letters were sent to the families of 822 patients informing them of the allegations against Dr Bradbury.

5.20 On 4 July 2014, Dr Bradbury appeared at magistrates’ court and was charged with 11 counts of sexual offences. The case was adjourned to 15 September 2014.

5.21 The trust activated its communications plan and set up the patient and public helpline.

5.22 On 15 September 2014, Dr Bradbury appeared at Cambridge Crown Court and faced 27 charges of sexual offences. He pleaded guilty to 25 of them involving 18 victims.

5.23 On 1 December 2014, Dr Bradbury was sentenced to 22 years’ imprisonment.

5.24 On 28 January 2015, Dr Bradbury was struck off the medical register by the GMC.

5.25 On 12 June 2015, his sentence was restructured to 16 years’ imprisonment and six years on licence.

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5 See paragraphs 7.13 to 7.29.
6. Paediatric haematology and oncology services at the trust

6.1 In order to understand the context in which Dr Bradbury was working, we have set out below how this service operates at the trust.

Patients

6.2 The PDU provides outpatient and day patient services to children with cancer and non-malignant blood disorders from a catchment area that covers the east of England. The unit is a tertiary centre, which means that children who do not live within the trust catchment area will also receive care from their local hospital: this is known as shared care. All of these children will also have GPs.

6.3 Their disorders range from solid tumours to cancers of the blood and non-cancerous blood disorders. Children with non-cancerous blood diseases are routinely seen on the PDU because that is where the paediatric haematologists are based.

6.4 The unit takes patients from birth to the age of 16, when they transfer to adult services. Sometimes, if a patient is having treatment that will end before they are 17 they will stay on the PDU until they finish their treatment, to avoid unnecessary disruption.

6.5 The PDU has a six-bedded unit for children and young people who need a bed for a day but do not need to stay overnight.

6.6 In 2003 the paediatric haematology and oncology service treated 159 patients, and in 2013, 394.

Treatment

6.7 At any one time there will be a mixture of children coming in for planned routine outpatient appointments and chemotherapy, as well as those attending at short notice who are unwell or need blood transfusions, or who have been brought in by anxious parents. Sometimes parents will come in without their child for a discussion, often a very difficult one, with a consultant. One consultant commented:
“There is a lot of activity in different spheres which kind of adds to its complexity.”

6.8 The day patients in the six-bedded unit receive treatments including scans that require sedation, blood transfusions, the giving of various medicines as infusions (through a drip), and endocrine tests.

6.9 There are several stages of engagement between patients and the unit: receiving treatment; check-ups immediately after receiving treatment; future check-ups; and long-term follow-up.

6.10 A consultant explained:

“They [the patients] all follow a similar sort of plan but each one is on a slightly different protocol and different length. So yes, the most labour-intensive bit is right at the beginning when they are first diagnosed and depending on what they have presented with there will be a number of investigations which might be - if it’s a leukaemia/haematology investigation - blood investigations. If it’s a solid tumour, it’ll be scans and surgical biopsies, etc. At the end of that obviously a diagnosis is made in a multidisciplinary setting and the plan for treatment is made, then there’s discussions with the family to take them through what the diagnosis is; what the treatment is going to be. It’s really dependent on the clinical condition of the child how long that episode lasts for and how much of it as an inpatient and how much of it as an outpatient. So there are some children whose diagnosis is made and who are with us for maybe a month or even longer without going home at all during that initial phase and others where it’s almost all done as an outpatient. So there is a bit of variation. Then they continue through their chemotherapy plan, there might be admissions for infections or for further surgery and when treatment is complete they move into follow-up. We have follow-up guidelines where according to the diagnosis, the frequency of visits and what is needed at each visit, e.g. scans may vary. But over time the frequency of visits decreases. Occasionally if a parent is concerned about a child they will come back to clinic sooner to be seen than their scheduled appointment.

It’s dependent on what they’ve got, and how unwell they are; sometimes coming in and out for blocks of chemotherapy but they come through PDU and into the
ward for again a variable length of time. So some children will have nine courses given every three weeks; others will have maintenance chemotherapy, which is given as an outpatient, and then come in for a block. So the protocols are very varied.”

Comment

The variation in the necessary frequency of appointments depends on a number of factors, such that the only people who will have an idea of what the frequency should be for a particular child, will be those involved in that child’s care, or those who have been kept informed of their progress.

The need for appointments can also be determined by reviewing a child’s records, but the practice of the PDU does not require such reviews to take place. We deal with the review of records in more detail later in the report.

6.11 Each week the unit has four morning treatment clinics, on Monday, Tuesday, Thursday and Friday, covering solid tumours and malignant haematology and one on Wednesday for non-malignant haematology.

6.12 The oncologists are not involved in the treatment of the children with non-malignant blood disorders and so do not attend the Wednesday clinic.

6.13 Most clinics are scheduled for the morning between 9.30am and 12.30pm, but there are a few afternoon clinics, for which appointments will be booked through until 5pm. These are for long-term follow-up, and also for joint clinics with consultants in other specialisms.

6.14 The service also has regular multidisciplinary clinics for the different specialisms where diagnostic and treatment decisions are made by professionals, including oncologists, nurses, pathologists, radiologists, surgeons and neurologists. The pattern of oncology and malignant haematology diagnoses reflects the distribution of diseases seen nationally, approximately 25-30 per cent of patients have leukaemia, 20-25 per cent have brain tumours and the rest have other solid tumours. This division is reflected in the
organisation of care through three distinct clinico-pathological multi-disciplinary teams (MDTs): neuro-oncology, ‘solid tumour’ and malignant haematology. Decisions made at these MDT meetings inform the treatment offered to the patient at the treatment clinics.

6.15 The treatment clinics are all consultant-led, in that patients are listed to see their consultant at the appropriate point in their treatment. Sometimes consultants are not able to attend a clinic, perhaps because of an emergency, or if they are working elsewhere or on holiday, in which case, depending on the needs of the patient, another consultant, a more junior doctor or a clinical nurse specialist (CNS) will see the patient. However, if the consultant particularly wants to see the patient, perhaps because an important decision needs to be made, he or she lets the staff know, and an appointment is booked for a clinic where the consultant will be available.

6.16 Although the inpatient ward (C2) is separated from the PDU by a locked door that can be opened only by staff with an electronic key, patients move easily between the inpatient, day patient and outpatient areas. As a consultant explained:

“We separate them but there is a lot of movement between those three areas. And we separate them geographically because we try to use the beds flexibly like every other department in the hospital. Beds are short so we will end up seeing children in the day unit, starting their treatment there and then moving them over at seven o’clock at night so that we don’t waste beds. So there is a lot of movement.”

Comment

This shows that patients coming on to the PDU from the community are all monitored and diarised, whether their attendance is for a routine appointment or to deal with an immediate concern.

6.17 In addition, there is a hostel, Kingston House, where children who need daily treatment but not a hospital bed can stay while, attending the PDU during the day.
6.18  There are six day patient beds on the PDU and 17 inpatient beds on C2. When Dr Bradbury was working on the unit there were four consulting rooms; there are now five.

Staff

6.19  During the second period that Dr Bradbury was working at the trust (November 2008 to November 2013), there were three full-time and two part-time oncology consultants who treated children with solid cancerous tumours, and two haematology consultants, including Dr Bradbury, who treated children with malignant (cancerous) and non-malignant (non-cancerous) blood diseases. Malignant blood diseases include leukaemia, lymphoma and myeloma. Non-malignant blood diseases include haemophilia, sickle cell anaemia and aplastic anaemia.

6.20  New patients were allocated to consultants according to their diagnosis and where they lived. So, for instance, children with malignant blood diseases would be allocated to Dr Bradbury if they were referred from certain district general hospitals within the tertiary catchment area and to the other haematologist if they were referred from other district general hospitals in the tertiary catchment area. Children with such diseases who lived in the trust catchment area would be allocated to one or other of the consultants on an ad hoc basis to keep the consultants’ caseloads approximately the same. Children with non-malignant blood diseases would be allocated to one or other of the two haematologists to try to keep their caseloads evenly matched rather than by geographical criteria.

6.21  In addition to the consultants, there were six junior doctors: three registrars in training and three junior senior house officers (SHOs6). Their work was described to us by a consultant thus:

“There is one registrar attached to the ward all the time, so they will be running the ward with the consultant in the week. And there’s one attached to the day unit. So they will sometimes see some patients in the PDU. They’ll often be doing some of the procedures, so we run a general anaesthetic lumbar puncture and bone marrow list four times a week, so they will be involved in that; or going up

6 Registrars are doctors in the final stage of their training; senior house officers (SHOs) are those in the stage before registrars.
to theatre to do similar things when a child is going to theatre for a biopsy - we might need bone marrow at the same time so they will go and do that. They're responsible for helping write up the chemotherapy, fielding calls from outside hospitals, seeing some children that come up acutely unwell, they'll often be seen by the registrar first, so we almost have a team of juniors working on the ward and a team working in PDU. But then even they cross-cover each other a bit. So one is often teaching or one is changing to nights - they will switch and cover the area of greatest need.”

6.22 The service provides tertiary level services to the population of the east of England in association with 12 district general hospitals around the region.

6.23 The paediatric haematology and oncology team is multidisciplinary, and includes specialist nurses, the research team (responsible for registration, data management and input, reporting of serious adverse events, etc, for clinical trials), allied healthcare professionals (physiotherapy, speech and language therapy, occupational therapy, audiologists), teachers, CLIC Sargent social workers⁷, counsellors and clerical staff.

6.24 There are two receptionists on the PDU, one working four days a week and one for one day a week, and an experienced volunteer who works two mornings a week. The main receptionist told us that her role was making appointments and ensuring the smooth running of the PDU. The volunteer explained that she helps the staff by collecting files, letting patients in if a receptionist is not at the desk, tidying the kitchen, making tea for the nurses, and generally helping support the staff as requested. She does not spend time with patients or their families, and her contact with them is limited to saying hello.

6.25 Each child has a named consultant, as explained above, but there is also a consultant on-call each week.

6.26 This means that new patients are usually seen by the on-call consultant before being allocated to a named consultant.

⁷ CLIC (Cancer and Leukaemia in Childhood) Sargent is the UK’s leading cancer charity for children and young people, and their families. It provides clinical, practical, financial and emotional support to help them cope with cancer and get the most out of life.
6.27 The oncology and haematology consultants are able to cover for each other if need be, either during clinics or in emergencies. A consultant explained:

“That has to happen as we’re cross-covering each other’s patients out of hours. So at least, even if we don’t know them intimately, in terms of every last detail, we will know who they are, what they like and roughly where they are in treatment.”

The PDU

6.28 A plan of the layout of the PDU is attached as appendix E.

6.29 The unit has two entrances/exits: a main door leading to the grounds of the hospital and an internal door leading to the inpatient ward. The internal door can be opened only by staff members with an electronic pass.

6.30 The PDU has a waiting area, five consulting rooms, a day treatment room, and a room for teenagers to go to while they are waiting. There are toys and play equipment in the waiting area and in the consulting rooms.

6.31 The unit is open, and staffed, from about 7am to 7pm, Monday to Friday. After the receptionist leaves at 5.30pm there are nurses on duty until the last patient leaves and the outside door of the unit is locked.

6.32 Consultants told us that the PDU might be used outside these hours if they needed to talk to the family of an inpatient and wanted somewhere quiet and private to do so. The cleaners would also work at the PDU outside its opening hours. In both cases access would be from the ward.

6.33 During the period when Dr Bradbury was working on the PDU, patients’ notes were still mainly on paper, and were kept on the PDU between appointments and visits.

Comment

This meant that both clinical and non-clinical staff could access notes fairly easily.
7. What happened once a concern was raised about Dr Bradbury’s behaviour

7.1 On 25 November 2013 Dr Bradbury saw an 11-year-old boy, Child X, in his clinic and, during a meeting with no one else present, he carried out an intimate physical examination and recorded this in the boy’s notes.

7.2 On his way home, the boy described what had occurred during the examination, which caused his family some concern. As a result, on 27 November his grandmother rang the PDU and spoke to the receptionist, a long-standing and very experienced member of the team. The grandmother described what had happened and asked whether this was a necessary and normal part of her grandson’s treatment. She explained that if it was, her question need be taken no further, but they needed a satisfactory explanation on this point. The receptionist, very properly, informed the grandmother that she did not know the answer but would contact someone who would and then contact the family.

7.3 The receptionist then contacted one of the nurses on the PDU, who did not think that the examination, as described to her, was orthodox; immediately realised that this needed investigating and contacted a senior paediatric oncologist consultant. The consultant contacted the divisional director and they called Dr Bradbury in to tell him of the concern that had been raised and to inform him that this would need to be investigated under the trust’s safeguarding policy and that he should go home and wait to be contacted. They then contacted the LADO, who contacted the police.

7.4 From this point, the trust had three matters to deal with: Dr Bradbury; helping the police investigation and supporting patients and their families as events unfolded.

Dr Bradbury

7.5 Dr Bradbury was called in to a meeting at the hospital on 28 November and advised that with immediate effect he was restricted from undertaking clinical practice, having any contact with patients or attending any clinical area while the concerns raised were investigated. He has never returned to the hospital except for formal interviews and to handover case files, during which he was escorted.
7.6 On 12 December he was formally excluded and reported to the GMC; in January he was suspended from the medical register by the GMC and in March he was dismissed by the trust, since his GMC suspension meant that he was unable to carry out the duties for which he was employed.

7.7 During the time that he was restricted and then excluded, the trust continued to offer him support from the occupational health service.

Finding

F1 Dr Bradbury was prohibited from access to patients immediately after a concern was raised by the family of a patient.

Supporting patients and their families

7.8 Dr Bradbury was initially arrested on 30 December 2013, so from that point on the trust knew that the police and the Crown Prosecution Service (CPS) believed that he had committed offences against at least one patient and therefore it needed to be ready to respond appropriately.

7.9 The trust set up a safeguarding group specifically to deal with all the issues arising from Dr Bradbury’s alleged activities. The group met weekly, and had its first meeting on 3 January 2014. DS Shane Fasey from the Cambridgeshire police child abuse investigation unit was a regular attender at these meetings. He was the officer contacted by the LADO on 27 November and was the liaison officer between the police and the trust throughout the criminal investigation. The LADO was also a member of this group, and was closely involved in its activities even though she did not attend all its meetings.

7.10 The chief nurse was chair of the group, and also attended the monthly meetings of the Cambridgeshire LSCB, where she provided updates on the investigation. She also had two ad hoc meetings with the LSCB to discuss the investigation.

7.11 The LSCB has its own guidance on interagency issues in complex child abuse investigations. This guidance assumes that the police and social services are running the
investigation together, rather than, as in this case, the police and the trust. However both the LADO and the LSCB ensured that, as far as was relevant, the guidance was complied with For instance, the LADO was in direct contact with the police in relation to contacting Dr Bradbury’s previous employers and organisations in which he had previously been involved.

7.12 Matters for discussion and decision at the safeguarding group included: supporting staff; how best to liaise with shared care hospitals; how and when to communicate with patients and families; setting up a helpline; looking through patients’ notes for other possible concerns; liaising with the LADO; reviewing the chaperone policy; liaising with the GMC; liaising with Suffolk police on their investigation; reviewing the HR policy arrangements for Dr Bradbury; and communicating with Birmingham Children’s Hospital, where Dr Bradbury had previously worked.

7.13 For communicating with patients and families, the trust created a three-stage process comprising a contingency plan to use in case of leaks, a prior warning for patients and their families before the news about Dr Bradbury became public, and a helpline once the news became public.

7.14 The police did not want news of what was happening to become public before they were ready, and prior to the CPS decision whether or not to charge, since this could compromise their investigation. The trust had one communication plan to use if there was a leak of information (which in the event there was not), and another to use in a planned way once Dr Bradbury was charged and had to go to court, when the news would become public.

7.15 As a first stage, the trust identified all the patients for whom Dr Bradbury was the named consultant, and any others whom he had treated at any time on the PDU. The total came to more than 800 patients. Within this group the trust identified 181 patients who had been receiving treatment or follow up from Dr Bradbury at the time of his exclusion.

7.16 The trust looked at the records of all children where any suspicions had been raised but the focus was on outpatient records as it was the records of his conduct in outpatients that provided cause for concern.
7.17 In the week beginning 30 June 2014 senior members of the service rang the families of the 181 patients to let them know that Dr Bradbury was shortly due to appear in court and why, and to offer them support. On 2 July letters were sent out to the families of the other patients in the group of 800 (see appendix F).

7.18 The safeguarding group discussed with clinicians whether to alert an even wider group, for instance all those who had been treated by the paediatric oncology and haematology service, but decided that, on balance, such a letter might do more harm than good, as it might create unnecessary alarm.

7.19 Both the letters and the calls were intended to forewarn patients and families of the pending news, give them information about where they could find out more, and help them contact the police if they were concerned a crime could have been committed. This source of information was a helpline, which went live when the letters went out and the phone calls were made.

7.20 The mother of a child who had been seen by Dr Bradbury as an inpatient told us that her family did not receive a letter or a phone call from the trust. On the morning that the news broke, she was contacted by another parent who had received the letter. She felt that this was a significant failing by the trust, as her child was in the age bracket of Dr Bradbury’s victims, and, like other children with long-stay admissions, had frequently been examined by Dr Bradbury. She spoke to her son, who said that Dr Bradbury had never done or said anything to make him feel uncomfortable, but he was upset because:

“I have been touched by a paedophile.”

7.21 Some time later, the boy told his parents that he had been under the influence of painkillers to such an extent that he could not say if any abuse had occurred or not. His mother also told us that:

“He’s just struggling with life a little bit. Me and my husband feel that even if he right now felt there was something, he wouldn’t tell us about it, and we wouldn’t drag something up that would make his life even more difficult. He’s already struggling with the fact that somebody he trusted and put faith into has done this, whether he’s done it to him or not, he’s done it to other children.”
7.22 She had spoken to another consultant about all this, and he had explained that, since the examinations had been necessary, it was impossible to tell if they had included any abuse, and since her son had been an inpatient, not all examinations would have been recorded, which she understood:

“People sometimes going past would just pop in and say ‘how are you feeling’, and have a feel of his tummy or whatever.”

7.23 The helpline was advertised on the trust website and in the local paper. The trust also provided an email address for those who preferred to use that means of communication. It had an arrangement with the NSPCC that people could contact the charity if they preferred not to contact the trust, and the NSPCC’s contact details were also provided.

7.24 The helpline went live while the police investigation was still going on, so those staffing it had to comply very carefully with guidance on how to answer the expected questions about what was happening, who was involved, whether they should contact the police and so on. Callers were also told that, if they were worried that a crime might have been committed, they didn’t have to provide any details, and that the trust would simply pass their information to the police.

7.25 Not everyone who contacted the helpline wanted to be put in touch with the police. Many were extremely anxious about what might have happened to their child and wanted a conversation with a consultant to talk this through, and in those cases they were phoned back so that conversation could take place.

7.26 The chief nurse told us that there had been two complaints from parents stating they had not received prior warning of Dr Bradbury’s appearance in court and that they felt they should have had this. One had a child who had been a patient of another doctor, and who knew the team and the PDU very well, and another had a child who had seen Dr Bradbury on occasion as an inpatient.

7.27 The chief nurse told us that, with the benefit of hindsight, it may have been a good idea to send a letter to the wider group of patients using the paediatric services, providing information but reassuring them that they had no need to worry. However this had been
considered and discussed at length with the clinical team involved in the case and at the time had been considered likely to cause greater anxiety than reassurance.

7.28 We have looked at the script provided to the helpline staff, the letter sent to patients and their families and the notes of the conversations callers had with helpline staff.

7.29 Only two complaints have been received by the trust about the level of communication.

Findings

F2 We consider that the communication plan was generally well designed and implemented.

F3 The evidence of the mother referred to at 7.20 above reinforces the view that a letter should have been sent to all the patients of the paediatric oncology and haematology service and their families. The failure to send such a letter was not an oversight, and was intended to avoid causing unnecessary anxiety. However, the trust seems not to have considered that any contact between Dr Bradbury and a patient could reasonably cause upset once news of his activities became public.

F4 The trust was as helpful as it could be to patients and families within the constraints imposed by the needs of the police investigation.

F5 The trust complied with the Cambridgeshire LSCB guidance where relevant and kept children’s services and the LSCB informed of developments through its close and regular contact with LADO and LSCB.

Assisting the police investigation

7.30 We interviewed Detective Sergeant Shane Fasey, who was on duty at the child abuse investigation unit in Cambridge when a call was received from the LADO who had been contacted by the trust. He attended the initial meeting with the LADO to discuss the
allegation against Dr Bradbury, and was involved in the police investigation throughout, including being the police liaison officer with the trust.

7.31 He explained to us that the first matter that had to be established was whether the alleged conduct amounted to a criminal offence or whether it was simply a matter of professional misconduct that should be dealt with by the GMC. The police and the CPS brought in their own medical expert to advise them on this.

Comment

One of the great problems of this case was the difficulty of determining whether crimes had been committed in a context where physical examinations were a routine aspect of treatment.

7.32 Meanwhile, the police were working with the trust to make sure that it did not do anything that might compromise any criminal investigation. As Detective Sergeant Fasey told us:

“We worked with them from the outset and vice versa they worked with us, because for criminal cases it is difficult if there is to be an internal investigation and lots of staff interviewed. Those staff may well be witness to what subsequently becomes a criminal investigation. Therefore, if they have already been interviewed by somebody else about it and then to be interviewed by the police, their evidence could arguably have been tainted in some way beforehand because everyone is aware of it. So it is a case of working with the hospital to try to limit the amount of knowledge of the case, while allowing them to be able to do everything they need to. The major concern from Addenbrooke’s, so far as I could tell, was the patient care.”

7.33 Hospital staff told us about the great difficulty they experienced in holding back from talking to colleagues, patients and their families until Dr Bradbury was charged. Dr Bradbury’s patients wanted to know why he wasn’t available. He was a well-regarded clinician and many patients and their families had great faith in his abilities and were worried and puzzled that he was not available to see them. Naturally, they asked why he
was not at work and when he would be back, and staff told us how uncomfortable they felt having to prevaricate. They knew that these patients and families would need a lot of support when the truth was revealed, and felt that it was wrong to be unable to start providing this support and help from the outset.

7.34 Some of these patients were referred to the police when it became clear from conversations with them and their families that Dr Bradbury’s treatment fitted the emerging pattern of abuse.

Comment

Not all the staff on the ward and in the PDU knew what was happening, and they too had to be kept in the dark, which put a further burden on those of their colleagues who were having to keep the secret.

7.35 In 2006 a memorandum of understanding was agreed by the NHS, the Association of Chief Police Officers (ACPO) and the Health and Safety Executive as to how patient safety incidents in NHS facilities that involve death or “serious untoward harm” should be investigated. The memorandum provides a protocol to promote effective joint working. It does not define “serious untoward harm”, but the context makes it clear that the term refers to any medical accident causing physical harm. The protocol has obvious relevance to any criminal investigation involving the police and the NHS, and we have therefore considered the extent to which the collaboration between the police and the trust complied with the memorandum where appropriate.

7.36 The memorandum provides that:

- the police and trust should have a liaison group to manage the investigations of the incident;
- the trust should not do anything to potentially prejudice any criminal investigation;
- information should be shared as necessary, limited by the needs of the criminal investigation; and

• a communications strategy should be agreed for dealing with patients, relatives, other organisations and the media.

Finding

F6 The actions of the trust, in their liaison with the police, conformed to the memorandum of understanding.

7.37 A matter that caused particular concern was the way in which possible further victims were to be contacted. The trust, which was identifying these possible further victims through the process described below, felt that its staff had a role in raising these concerns with the patients and families concerned. However, the police were insistent that they had to make first contact, and the trust accepted their position based, as it was, on the police’s expertise in handling such situations.

7.38 The Department of Health produced guidelines to support the memorandum of understanding. The guidelines cover a situation where there is a conflict between the needs of the police’s criminal investigation and the NHS responsibility to ensure patient safety, and emphasises that the obligations to ensure patient safety have to take priority with the NHS, but that as far as possible the criminal investigation should not be jeopardized.

Finding

F7 The wish of the trust staff to make initial contact with the families of possible victims was understandable and a reflection of their wish to care for their patients. However, such contact was not a patient safety issue, and therefore they were right to defer to the police request that initial contact should be from the police.

7.39 The police also advised the trust that it needed to do some checking of records, and explained what the trust should be looking for, which was boys whose records suggested they had had unnecessary pubertal examinations.

7.40 Detective Sergeant Fasey told us that the police did not think it necessary to look at the records of all Dr Bradbury’s patients, or to contact the families of all his patients to ask them about his behaviour, particularly at a time when a decision had not yet been made as to whether he was going to be charged at all. The thinking was that:

“It was clearly going to be a situation whereby, if he was charged with anything, it would become public and we would then get information back from Addenbrooke’s and from other patients who call in, saying ‘That has happened to me as well’.”

7.41 Potential victims were identified through looking at records, and then consultants went through the records that concerned them with the police to explain why they were concerned about what the records showed. The number of cases was then reduced where the police felt the evidence was not strong enough, and also when families decided that they did not want their children to be questioned about possible abuse. The police were aware that the victims would not have known that they had been abused, and their families could well decide that it was in the children’s best interests not to have the subject raised at all.

7.42 Detective Sergeant Fasey acknowledged that, as a result of the way the police decided to deal with this case, they cannot know how many victims there were, if any, over and above those on the charge sheet against Dr Bradbury. However, he was certain that the police looked carefully at every case where families did want possible abuse to be investigated, and he confirmed that if cases come to light in future, they will be looked at to see if further charges should be brought.

7.43 Other possible victims were identified through the helpline, as explained below.

Finding

F8 We consider that the trust was right to be guided by the police in how possible victims should be identified and their cases prosecuted. The police acted with great
sensitivity in allowing families to decide whether they wanted to have possible abuse investigated. However, it is possible that, in years to come, former patients of Dr Bradbury will want to see if they might have been victims, and we have accordingly made a recommendation about the preservation of records.

**Recommendation**

**R1** The trust should preserve all relevant records of Dr Bradbury’s patients and of its joint investigation with the police, so that anyone treated by Dr Bradbury between 2009 and 2013 can seek further information in adulthood, if they wish to do so.

**7.44** There is still some uncertainty about whether Dr Bradbury is guilty of all the charges that he faced. Although he pleaded guilty to most of them, he pleaded not guilty to some, and these have been allowed to lie on the file. This means that he has not faced trial on those charges to which he pleaded not guilty, and probably never will.

**7.45** When we interviewed Dr Bradbury, he told us that he had pleaded not guilty to some charges because he was not guilty of them.

**Comment**

*Dr Bradbury’s unsupported word is not evidence that crimes were not committed in these cases. However, the fact that he pleaded guilty to the majority of the charges that he faced lends some weight to his assertion.*

**7.46** At the same time as this police investigation was taking place, Suffolk police were pursuing their investigation into a video with indecent images that Dr Bradbury had bought from Canada in 2005. In July 2012 CEOP was sent details by Interpol of UK residents who had bought the video. In November 2013 this information was shared with police forces around the country, including the police in Suffolk, where Dr Bradbury lived.
7.47 It was sheer coincidence that Suffolk police caught up with Dr Bradbury just as his crimes at CUH were coming to light. Trust staff told us of their great concern that CEOP had been so slow to pass the information on to Suffolk, as, if it had done so when first received, Dr Bradbury might have been stopped in his tracks 16 months earlier than was the case.

7.48 In pursuit of their own investigation, Suffolk police searched Dr Bradbury’s house, and found another disk with indecent images on it, apparently downloaded from the internet, and two camera pens which contained images of unidentifiable children taken at recognisable sites at CUH.

7.49 The police investigations were subsequently brought together, and the charges against Dr Bradbury dealt with crimes uncovered during both investigations.

7.50 We asked Detective Sergeant Fasey about the level of cooperation the police received from the trust, and he told us:

“The cooperation of Addenbrooke’s - absolutely top of the scale, brilliant. They thoroughly respected the requests of the police.... They have been totally on board with the investigation all the way through. They have stepped back when they have needed to, they have stayed quiet when they have needed to, but they have equally raised their concerns saying, we need to speak with the patients, we need to deal with this, how can we get this sorted so it doesn’t undermine your investigation at the same time?”

7.51 He also commented:

“Without Addenbrooke’s, this would have been almost impossible to have controlled in the way we did and, if we did not have the control that we had, we would not have achieved the results that we did.”

7.52 He was also impressed with the way the trust dealt with the helpline, set up when the news about Dr Bradbury became public knowledge:

“I have dealt with a number of cases of abuse of trust. However, the setting and the surroundings of the investigation have been quite unique, which is why it has
been so helpful to have Addenbrooke’s working with us in the way they did... They worked with us to set up the triage process, the set of questions that would ultimately, without undermining the investigation, identify any other potential victims, who could then be referred across to a police helpline.

“The aim was we needed to provide parents and patients with information but, at the same time, make an assessment on the questions they ask and the answers they are given as to whether or not a crime is likely to have occurred. If it has, the information gets transferred across to the police and we generate our response. If it has not, Addenbrooke’s retain the contact with that patient and the family and resolve whatever problems they have identified.”

7.53 We asked Detective Sergeant Fasey if the families the police had spoken to had mentioned having raised concerns about Dr Bradbury with anyone else, and he said they had not.

7.54 Detective Sergeant Fasey is an experienced child protection police officer, so we asked him if his contact with the trust had revealed to him any occasion where he had thought the trust had done the wrong thing, or failed to do the right thing.

7.55 He told us:

“Not from my perspective. I didn’t pick up any glaring moments where you sit and think, ‘Oh dear, this is where it’s gone wrong’. Because Dr Bradbury has made no comment, the difficulty is in not understanding his view but I would say that, from the team having spoken to a number of the parents, it is more a case that Dr Bradbury appears to have manipulated the system to create opportunities for his abuse, as opposed to there having been slack policies in place. It is difficult because I can’t really comment on hospital policies as they are not my speciality.”

Finding

F9 The trust cooperated fully with the police in this investigation, while doing everything it could to support patients, their families, and the staff of the paediatric oncology service.
8. Governance arrangements and Dr Bradbury’s compliance

8.1 The PDU sits within Division E, one of the five divisions of the trust, and in common with other divisions has its own divisional director, associate director of operations and divisional lead nurse.

8.2 The terms of reference require us to report on the relevant governance arrangements for the paediatric oncology department during Dr Bradbury’s employment as a consultant, and to report on the extent to which they were complied with. We do this below, and also report on whether any non-compliance was recognised and dealt with. Where there was unrecognised non-compliance, we comment on whether this assisted Dr Bradbury in the commission of his crimes and whether any individuals or groups of staff were culpable for their failure to recognise non-compliance with policy.

8.3 The trust has overarching safeguarding arrangements and policies (discussed in section 10.) In addition there are governance arrangements relevant to Dr Bradbury’s activities. These are:

- chaperone policy;
- transition policy; and
- appointments system.

Chaperone policy

8.4 The chaperone policy in place while Dr Bradbury was working at the trust defines a chaperone as “an individual who for propriety accompanies another.” It required that a chaperone be present during all intimate examinations, but did not specify whether the chaperone had to be a professional or whether it could be a family member. Distinctions were drawn between intimate examinations, where there must be a chaperone, and intimate personal care, where a chaperone will not normally be necessary, but may be required if the professional or patient wishes it. The policy provides that, prior to an intimate examination or procedure taking place, it should be explained to the patient, who should be given the opportunity to ask questions. There is no mention of any special provision for children and young people, and therefore no reference to any arrangements
for those being prepared to transition to adult services, nor to arrangements for chaperoning children at appointments that did not involve an intimate examination.

8.5 There was an expectation that children would be accompanied by an adult at all appointments except when the transition policy applied (see below), but the reason for this would often not be “for propriety” in the normal sense of the word, but because they were children.

8.6 A consultant told us:

“Sometimes we have to say to parents ‘That blood test is going to be more distressing for you than it is for the child. You’re anxious. Why don’t you just go out and have a quick coffee, or stand outside’. There’s plenty of people in the room - one person holding, one person blowing bubbles, you’re never in a situation where you’re on your own.”

Comment

The lack of clarity about the role of the parent in different situations added to the lack of clarity about the chaperone policy.

8.7 The details of the chaperone policy in place at the time Dr Bradbury was at work, and subsequent changes to it, are set out in section 11.

8.8 Dr Bradbury took advantage of the chaperone policy and its limitations. Generally, parents were expected to accompany their children to appointments, including acting as chaperone on the occasions when intimate examinations were carried out with the doctor and patient behind a curtain round the examination couch. If a fellow healthcare worker was acting as chaperone during an intimate examination they would have been behind the curtain with Dr Bradbury and the patient. However, when the patient was an adolescent and a parent was acting as chaperone, the parent would often not go behind the curtain, because of a natural desire not to embarrass the adolescent child. Dr Bradbury took advantage of this sensitivity. He also took advantage of the ambiguity around the need for a chaperone for children not having an intimate examination.
8.9 Staff did not explain the chaperone policy to patients or families before or during appointments. Some staff were not aware of the details of the written policy, although the concept of chaperoning was understood by all. Many staff thought that chaperoning was primarily to protect clinicians from accusations of improper behaviour rather than to protect patients. Staff assumed that clinicians would comply with it to protect themselves, so they had no sense that compliance with the policy needed to be monitored.

8.10 A consultant explained to us that throughout his career he had understood that the concept of chaperoning was “to enable you to do what you need to do safely for you and for the patient.” The guidance he had received, even before chaperone policies were formally introduced, was that it was for the doctor to decide when a chaperone was needed and to then arrange for one to attend: “so the onus has been on doctors to demonstrate that they are practising appropriately.”

8.11 A clinical nurse specialist (CNS) told us that part of her role was to be present when a consultant was having a difficult conversation with a patient’s family, so that she could respond to any queries the family might subsequently have about the meeting. She recalled that Dr Bradbury:

“...often used to say it was going to be a difficult conversation, and I’d say ‘Can you remember to ask me into the consultation, I’d like to sit in’. You can’t be sitting in clinic waiting for the consultation to happen because there’s so much to do. And he normally would not remember, or very rarely remember, or sometimes I would say ‘Can I come in?’ And he’d say something to put you off.”

Comment

If a CNS attends a difficult conversation between a consultant and a patient or patient’s family, he or she is fulfilling an important role, but not that of a chaperone.
8.12 The CNS also told us:

“The parents always went in with them. I was never aware of seeing parents outside without a child. You sometimes see parents without their children, but they don’t have their children sitting on their laps, but that’s because they’re playing on their Game Boy or they have gone to talk to somebody else or they’re playing in the Wendy house.”

8.13 We asked if a doctor with a patient in a consulting room would ever be interrupted. They told us:

“If the curtain is drawn then you assume that there is an examination going on and you would not enter except in a dire emergency.”

Comment

This would have given Dr Bradbury confidence that he was unlikely to be interrupted.

Finding

F10 The chaperone policy and its purpose were not properly known and understood by patients, families or some staff.

F11 Dr Bradbury did not comply with the chaperone policy, and this was not noticed by colleagues on the PDU. There was no formal system for monitoring compliance with this policy.

Transition policy

8.14 The PDU, in common with other paediatric units at CUH and elsewhere, has a transition policy. This policy applies to children who will be transferring to adult services when they reach the age of 16. The policy in place when Dr Bradbury was working at the trust was dated 2006.
8.15 The purpose of the policy is to facilitate the move from a situation where the patient’s family is in charge of his or her care to one where the patient is competent and confident to be supported by the parents but in charge of his or her own care. To prepare patients for this change, the transition policy allows 14- and 15-year-olds to have private conversations with their doctors without their parents or a professional chaperone being present, if they wish to do so. This is considered particularly relevant to children with cancer, as their pubertal development may be affected, and so they may have questions about their sexual development or fertility that they would not want to discuss with their parents or with others present.

8.16 The transition policy allows a child to have a private conversation with his or her doctor. It does not allow a child to be intimately examined in private.

Comment

The implication of the transition policy is that younger children should have an adult with them on all appointments. However, this is only an implication and was not explicitly stated here or elsewhere.

8.17 Although the transition policy was intended to be applied only in cases where the patients were aged at least 14, Dr Bradbury sometimes saw much younger children without a chaperone. Child X was only 11 when Dr Bradbury examined him on his own.

8.18 The mother of one patient told us:

“[The PDU] is very busy, but I do know on a couple of occasions, at least once, [my son] was examined [by Dr Bradbury] before I got in the room. Most of the others, if not all of the others, had a nurse with them or a clinical specialist, or something, looking back, on a few occasions, Myles didn’t, he definitely didn’t have people with him, and I’ve since thought, how on earth has that happened? My saving grace was that [my son] had any opportunity throughout all of those appointments to say, ‘I don’t want to go in on my own, come with me’, and I know that he would have said that... or, he was disappointed if he didn’t see Myles or
anything like that... He had a lot of respect for him, you see, they had this bond, which you assume is a healthy bond, he respected him...”

8.19 The same mother gave us an example of how Dr Bradbury built his relationship with her son:

“When the children have an NG [nasogastric] tube that goes through their nose down into their stomach, they choke when it’s being put in, and [my son] loves his science and he was saying ‘What about the gag reflex, Myles, if you do this apparently it stops you gagging’, and he said ‘Why would that be?’ Myles said ‘I’m not sure, I’ll think about it’. Next time we came back, he gave him an explanation which went straight over my head, but he said, ‘Right, come on, we’re going to patent this’. So you would never think that he was doing anything like that.”

8.20 Parents and carers were not provided with the transition policy. Staff were aware of the policy but no formal monitoring of it was carried out. The policy was not seen as part of the safeguarding framework because it was intended only to deal with private conversations that took place with the consent of parents or carers, rather than allowing private examinations.

8.21 As a receptionist told us:

“The parent would be sitting in the waiting area, allowing their child to be seen. So if they’re giving consent, I wouldn’t have thought there was anything wrong with it, and they came out happy enough, and left happy.”

8.22 A consultant told us of an occasion where she noticed, or was told, that a boy was with Dr Bradbury without his parents being there and asked Dr Bradbury to explain:

“When I said to him ‘So what was going on?’, he said, ‘Oh no - he just had some questions - he’s being bullied at school, and he just wanted to talk to me on his own and his mum was happy’, and I didn’t think any more about that because I thought actually he’s a young boy wanting to talk to the doctor on his own. His parents are happy that he did that. I never, ever dreamed that he was examining children on his own.”
Comment

The quote above demonstrates that at least one colleague did raise questions with Dr Bradbury on an informal basis as and when something was drawn to their attention, exactly as they would have done with other colleagues in a similar situation. It is not surprising that Dr Bradbury’s answer allayed their concern.

8.23 Interviewees also explained that it was not obvious if a child was in a consulting room alone with a doctor. The waiting area of the PDU is not like a normal hospital or GP waiting room, where children sit and wait with their parents or carers. Patients may be at the unit for hours, and may be playing with the toys, playing with their friends away from their parents or carers, going to the toilet, in a separate teenagers’ room or being weighed and measured. The staff will be busy moving around the unit and it will not surprise them to see parents without their older children nearby.

8.24 The consulting rooms have glass panels in them at eye level, so someone can only see into the room by getting close to the door. Generally someone will only look through the panel to see if the doctor can be interrupted. The panel can be screened for privacy, but even if it is not, a glance through the panel would be unlikely to reveal anything untoward.

8.25 The consulting rooms each have a desk and chair for the doctor, chairs for patients and families and an examination couch around which a curtain can be drawn during an examination, so that those in the visitors’ chairs or looking through the panel cannot see who is behind the curtain. This means that someone looking in and seeing the curtain drawn and no visible parent would not know if a parent was chaperoning the child behind the curtain. Furthermore, even if the person looking in had noticed that the parent was not in the room, they would still not know whether a professional chaperone was behind the curtain.

Findings

F12 Although the transition policy was intended only to allow teenagers to have private discussions with their consultants, the fact that families and patients were not aware of
the details of the policy meant that no alarm bells rang when examinations also took place in private, even when families and patients were aware this was happening.

**F13** Dr Bradbury did not comply with the transition policy, in that he used it to see children much younger than 14, and used it as cover to carry out physical examinations in private. These breaches were not noticed by colleagues on the PDU.

**Appointments and attendance system, including case allocation**

8.26 One of the markers of Dr Bradbury’s offending, discovered after concerns were raised, was that he saw some patients more frequently than their treatment required. He managed to conceal this by taking advantage of the appointments, attendance and case allocation system.

8.27 The clinics for malignant blood disorders ran alongside the clinics for solid tumours on Mondays, Tuesdays, Thursdays and Fridays. Wednesday was the day for non-malignant blood disorders.

8.28 The other haematologist explained how he and Dr Bradbury divided their work:

“We did completely separate leukaemia clinics. So his leukaemia clinics were on Monday/Tuesday. Mine were Thursday/Friday. So the oncologists shared the clinic with him Monday/Tuesday, so they would be more au fait with his leukaemia patients. The Wednesday clinic was our busiest clinic of the week and that was purely haematology patients so we both saw those patients. And in theory we would have known each other’s patients, we would have cross-covered each other’s patients. In practice, there were some families who drifted more towards him or towards me. So families that I had seen before he arrived often wanted to see me rather than him. But he was very charming and a lot of families liked him and wanted to see him. And so they consistently saw him. So even though each of them were assigned to one or other of us as their named consultant, in practice that often didn’t really mean anything because we shared the patients.”
8.29 The mother of a boy who had had an emergency inpatient admission when Dr Bradbury was on duty told us:

“We never realised that people got a named consultant till probably a good three months down the line.

Q. Did he not get a named consultant, or he got a named consultant but you were never told who it was?

A. I don’t actually know the truthful answer to that, I think it might have been another parent, I couldn’t even tell you exactly when it was, but I remember somebody saying it, ‘Who is [your son’s] consultant?’ We always referred to it as Myles, because we genuinely believed he was the one that we had met, and we thought it worked like that, also, for the first maybe week or two, he seemed the person that we saw most regularly. But I’ve also learnt now, being a bit more experienced, it’s also their patterns of shift, just because they all go and see their own, it’s whoever goes and visits that patient that day.”

8.30 One of the oncology consultants told us:

“Although we have our own named patients for whom we will set the treatment plan, we will have major discussions if there’s a change of treatment plan, if something is going wrong/not responding to treatment, when patients are coming up and down for treatment courses they may not see me but one of the other members of the team. But from day to day, there will be a number of us as consultants that will input into a patient’s care - either acutely or in clinic.”

Finding

F14 This flexibility meant that by changing the days and times on which Dr Bradbury saw some of his patients he could conceal the frequency of the appointments from those most likely to notice that the frequency was unusual.
8.31 When a patient was seen by his or her consultant, the next appointment was made for a future clinic. This may be a few days or months later, depending on the exact diagnosis and the stage the patient has reached. At the end of a clinic appointment, the consultant would give the parent or carer a piece of paper with the date of the next appointment on it, which would be given to a receptionist who would put the appointment in the diary. Later it would be transferred to the hospital information support system (HISS) electronic diary in place at that time. There would then be a meeting at the end of the clinic so that everyone present would know what was happening with the patients, and to check that further appointments had been made.

8.32 The clinical nurse specialists attached to the unit could also make appointments for a child or family to see a consultant.

8.33 Each working day, the nurse on duty produced a list for the following day’s clinic, ensured that the patients’ files were collected from the storage room on the PDU where they were normally kept, and checked that the results of any tests ordered at the previous appointment were available. Before the clinic started, all those involved in it, had a pre-clinic meeting at which they ran through the list of patients, what their issues were and what they were going to have done that morning. Those attending included consultants, junior doctors, nurses who have prepared the clinic list, the duty CNS, often a pharmacist and someone from the trials team, sometimes a physiotherapist, a counsellor or psychologist, members of the Brainbow team\(^{10}\), a CLIC Sargent worker\(^{11}\) and any medical student who was joining the clinic.

8.34 If these children had been given clinic appointments, the pre- and post-clinic meetings would have quickly identified that something was wrong. As a consultant told us:

“We’ve thought long and hard about this. How did he do it? And I think why he managed it in the way he did is because we have pre- and post-clinic meetings. Because we know the patients. If Child X was featuring on the clinic list on a Monday or a Tuesday that I sit in every week and he had been off treatment for

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\(^{10}\) The Brainbow team is a multidisciplinary team, funded by three charities, consisting of physiotherapists, a speech and language therapist, occupational therapist and clinical psychologists. It offers a rehabilitation service in the east of England for children with brain tumours.

\(^{11}\) CLIC Sargent is a cancer charity supporting children and young people with cancer and their families.
two years and he was coming up every month, I would say ‘Why are they coming again? What’s all this about? What’s the problem?’... So certainly when we started understanding what was happening, what we discovered was that it was clear that they were seen sometimes on a Monday - sometimes on a Tuesday - sometimes on a Thursday. So he would turn up to the Thursday clinic saying ‘I’ve asked them to come up today because it’s already busy on Monday and they have something they want to see me about’. I suppose that’s not questioned because children did come up at other times. And sometimes they would come, looking at the timings they arrived, in the afternoons, outside clinic or they would come right at the end of a clinic and not therefore be on a clinic list. So they would turn up at two o’clock and then we would not necessarily see them or know anything about them.

“They wouldn’t be on the list as a clinic patient and they would skip the post-clinic meeting and there was a cohort of patients which - because they were moving around, coming at different times, different days of the week - I don’t think anybody had the full picture - if they came every Tuesday we would have said ‘Why is that child coming again?’”

**Comment**

*Dr Bradbury avoided having some of his patients reviewed in these pre- and post-clinic meetings by telephoning parents directly to make appointments and then not informing his secretary or the administrators that he had done so. This meant that the appointments were not put on the clinic list and were not discussed by the team at the pre- or post-clinic meetings. He was able to do this without arousing suspicion because it was not unusual for children to be seen outside normal clinic times.*

8.35 A consultant explained to us the circumstances in which non-clinic appointments might be made or children might attend without an appointment being in the diary:

“Most of those come up outside clinic times because they are unwell. So we will get a phone call to say somebody’s not very well and we know where they are in their chemotherapy schedule and we’ll say they need to come up and be seen. They might just say they’re wheezing or they might just need a blood transfusion
or something and so they will come up, be seen, and have a blood count. So it’s usually that sort of traffic.

“Occasionally we will see patients outside clinic when we know there are going to have to be lengthy discussions, so either a new patient, more usually a child whose disease has relapsed; if you see them in clinic it’s too tight a time. You haven’t got enough time to give them so we ask them to come at the end of the clinic or in an afternoon - usually with one of the CNS team and where you know that you have got as much time as you need to be able to talk through what we are going to do. Occasionally we will see them outside clinic times where they have got investigations booked and the investigations can’t be within the clinic time so maybe they’ve got a scan booked and it happens to be on a Wednesday afternoon or a Thursday afternoon and we say we will see them at the same time rather than expect them to come up at another time. So there’s a lot of that sort of thing.

“We also have to remember the children often live geographically a very long way away, so we do try to accommodate them in one day where possible. For both schooling issues and travelling issues and everything else...

“Other people may be coming in to see them too, so it may be a child who is having a scan done, we know the next thing will be surgery, so during that visit we will have tied up the time according to the other people that need to see them so maybe it’s the surgeon who is going to need to talk to the family about surgery or a neurosurgeon about a shunt procedure or something and those would be outside the routine times based around the availability of the patient, the staff, and any tests that need to be done.”

8.36 A consultant also explained that clinic times were not rigidly adhered to: some children who attended clinic in the morning might need to wait until the afternoon for scans and tests that had been ordered during the clinic meeting:

“... and many of the children that come into clinic in the morning, if their appointment is 12:30 - it [the clinic] usually doesn’t finish until 14:00 hours and then of course the children are having treatment so they will be there all day. So even though there might not be clinics going on in the afternoon, there will be
lots of kids around and parents around waiting while their blood transfusion finishes. You know they may have six hours of chemotherapy so they may not be ready to go home until five, which is why the day unit is open until seven at night. So even though there may not be booked appointments and clinics in the afternoon, there will be activity - planned activity and people.”

8.37 One of the ward clerks who occasionally covers the PDU in the absence of the regular receptionist told us that sometimes Dr Bradbury would tell her of appointments at the last minute, saying that a patient “wants to come at six o’clock and now I need the notes.” He would say that the patient was coming late so as to not miss school, and the clerk simply accepted this, although it was a nuisance having to go and get the notes late in the afternoon.

8.38 When the medical notes were inspected after Dr Bradbury had been excluded from the hospital, some of them had no entry relating to a particular appointment, so if that appointment had not been put in the diary, there would have been no evidence that the appointment had taken place.

8.39 One of the receptionists explained that sometimes Dr Bradbury would tell her that a patient would be coming in who was not in the diary, but that he didn’t need her to get the notes or to make the next appointment. She told us he would say: “Don’t worry about the next appointment, I’ll sort it out.” Her impression was that he was trying not to inconvenience her. However, despite his suggestion that she need not do anything about these appointments, she always recorded them. She said: “It was my job because I recorded everyone who was coming onto the unit who was coming in late.”

8.40 These ad hoc appointments made by Dr Bradbury directly with patients or their families were recorded only as a result of the diligence of the receptionists, who recorded the attendance of all patients to the unit that they knew about, whether or not they had a pre-arranged appointment showing in the diary.

8.41 The clinic clerk told us she noticed nothing unusual in the frequency with which Dr Bradbury saw some patients, but she did notice that he was seeing patients out of his clinic times often enough to cause problems some afternoons as he was using consulting rooms intended for afternoon clinics.
8.42 She mentioned this to the other haematologist. He told us:

“The clinic clerk told me a couple of times that he [Dr Bradbury] was seeing patients in the afternoons, which I have to say infuriated me because this was the man who said he was too busy to do anything else - do any laboratory reporting - but he had enough time to be seeing families, supposedly because it was more convenient for the family to be seen after school. And so this was more of a time management issue and we had robust discussions about that... and usually it ended up saying he would agree and said he would stop seeing them in the afternoons and I used to check up. At the time [the ward clerk] had a written diary and so anyone could book in someone at any time for any clinic and then [the ward clerk] would transfer that name into the electronic HISS appointments system. So I would look - occasionally pick up the diary and just look through the next few weeks and just see if there was anybody he booked in for an afternoon clinic. Unfortunately I now realise that that's not how he did it. He never booked them in in advance in the diary anyway. He had his own system. Patients would text him or phone him on his private mobile and he would make an appointment then”\(^\text{12}\).

8.43 During our interview with Dr Bradbury he told us he gave his number to families and not to patients. Families would sometimes ring him to organise appointments.

8.44 A consultant told us:

“There were a number of haemophilia patients who he would raise the issue of puberty with and use that as a justification to do examinations. In the January/February after he was caught, we started looking through case notes. I was shocked how obvious it was looking at those notes that there was something amiss. And even subsequently one of the registrars said to me before she knew that there was an issue about him: ‘He seems to be awfully focused on puberty'\(^\text{13}\). It was somebody with a blood disorder. So it was very obvious when you looked at his notes that there was a pubertal assessment on each page. And I am sure if I had seen that I would have thought why - why is he doing this? But a lot of these

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\(^\text{12}\) See paragraph 9.12 for an explanation of what was known of Dr Bradbury giving his mobile number to patients.

\(^\text{13}\) The registrar noticed this after Dr Bradbury had been suspended but before it became common knowledge.
boys weren’t in those Wednesday clinics. So he may have started off there and then he moved them into his afternoon sessions when there was nobody else around. And a lot of them never came back to those.

Q: So if they had gone on being seen in the Wednesday clinics then almost by automatic function, you would have picked up on some of them?

A: Me or one of the registrars would have picked up and thought that it was a bit odd.... But the ones he was targeting he took out from either the Monday, Tuesday or the Wednesday clinic and then he had this arrangement that he would see them in the afternoons.”

8.45 A nurse told us that when she was responsible for going through the clinic list at the pre-clinic meeting she recalls Dr Bradbury asking her not to read out the names of patients he was due to see later in the day, because the other haematologist did not like him seeing patients at that time. She thought he was seeing patients out of normal clinic times because he:

“... was sort of bending over backwards to try and accommodate these children, who of course had missed a lot of school in the past. I didn’t think anything particular at the time except that it was odd perhaps that he said that comment but I don’t think I registered it. I didn’t take it any further in my thought processes, really.”

8.46 She told us she read out the names anyway, because:

“That’s my role. People needed to know who was coming.”

8.47 We asked the nurse if a nurse or junior doctor would always look at the notes of the patients mentioned at the pre-clinic meeting, and she said that this would not necessarily happen, since some of these children would not be receiving active treatment, and might just be listed for routine follow-up, so there would be no discussion of their treatment when their name was mentioned at the pre-clinic meeting. Long-term follow-up appointments do not usually include intimate examinations.

14 The other haematologist attended the Wednesday clinics with Dr Bradbury, but otherwise did not share clinic days.
8.48 She also explained that these children would not necessarily be seen by nurses before their appointment with the doctor:

“There are so many children coming through that if they were off-treatment it wasn’t always necessary that we saw them. We did initially but because of the volume of patients that are coming through we don’t necessarily get involved with the children off treatment.”

8.49 Another consultant told us:

“I wasn’t aware of the manner in which he [Dr Bradbury] was seeing children outside of his clinic times. I knew he would see children at various times - families at various times. But that didn’t raise any alarms for me because for some of them he presented it as being accommodating of the family circumstances. And that seemed on the face of it to be a compassionate and appropriate thing to do. I was not aware that he didn’t book patients in, sometimes didn’t make notes, didn’t write letters, didn’t have any correspondence. This only became clear afterwards going through things...

“From time to time I will see a family after their work. I will see a child late, after school. But that’s not out of hours - that’s just making an appointment fit the family. But it’s a full appointment, it’s booked in, it’s scheduled. There’s appropriate people there. I will always do it in conjunction with a clinical nurse specialist relevant to that child.

“You document it in the standard way and you write the letters to the GP and you inform people of what went on. I don’t consider that to be out of hours.”

8.50 Another doctor who was frequently on the PDU told us that she noticed Dr Bradbury was often on the unit in the afternoon, but she did not notice if he was seeing patients or had just been using a spare consulting room to catch up with his paperwork or have a private meeting with a family. Dr Bradbury shared an office with two other people, so it seemed quite natural to this doctor that he would seek out a vacant room on the PDU in the afternoon if he needed peace and quiet or privacy. This doctor also told us that she understood that Dr Bradbury and the other haematologist were busier than the other
consultants as there were only the two of them to deal with an increasing leukaemia and haematology workload.

8.51 Other nurses confirmed that Dr Bradbury often saw patients at non-clinic times, but saw nothing sinister in this, as he seemed to be doing this for the benefit of the children, so that they did not miss school.

8.52 Dr Bradbury told us that his willingness to see children at short notice and out of normal clinic times arose from his wish to help them and their families, rather than for any ulterior motive.

Comment

Dr Bradbury was not the only clinician to see patients at times other than during his clinics, but he seemed to do so more than most of his colleagues.

8.53 The consultants explained to us that when they had looked through the records of Dr Bradbury’s patients, they had identified a number who were seen far more frequently than their condition at the time required. For instance, children who should have been receiving three- or six-month check-ups were being seen monthly, with the spurious justification to parents that this was to check their pubertal development.

8.54 We explored whether these irregularities should have been noticed.

8.55 We asked if the clinic clerks should have picked up that some children were seen far more often than was necessary. We were told that the range of appointment frequencies for each patient made it impossible to notice this without a detailed knowledge of the child’s condition and stage of treatment, neither of which would have been known to clinic clerks.

8.56 We asked if families should have been aware of the unusual number of appointments, and were told that families were not given written information on what to expect by way of appointments and check-ups at each stage of treatment.
8.57 Consultants explained that they and junior doctors involved with clinics would not be aware of the frequency with which some children were seen, since the children were not on the clinic lists, which was not, in itself, a cause for alarm because it was not unusual and there were good reasons for seeing children out of clinic hours.

Comment

These children are all long-term patients, and the staff understand that it is important that they should carry on with their lives as normally as possible while receiving the treatment that they need. Clinics that take place during school term time necessarily involve patients missing school. Dr Bradbury’s willingness to see patients after school, but still within the opening hours of the PDU, was seen as going the extra mile for his patients, rather than doing something odd or untoward. This apparent willingness to adapt his work to his patients’ needs was seen as part of his commitment to, and engagement with, his patients and their families.

8.58 Dr Bradbury’s “Job Plan 2013/14”, which set out his various responsibilities and how much time he should spend on them over the course of a year, allocated just over an hour a week to a variety of activities which included seeing “patients/parents outside normal clinic times.”

Comment

This confirms that there was nothing inherently of concern in Dr Bradbury seeing patients out of clinic hours.

8.59 Consultants told us that Dr Bradbury also exploited the fact that he was one of only two paediatric haematologists working on the unit, so when he told his colleagues that he had to see patients out of clinic hours as his workload was so heavy, most of them would not be in a position to challenge this. He would also use his particular expertise to justify certain patients always being seen by him, rather than by another member of the team. As one consultant put it:
“The way that we run clinics is that whoever comes in first, really which families come in first, there’s a team of us. Yes, ideally you see your patient, but if somebody else’s patient has been waiting that bit longer then it’s right that that patient gets seen before your patient. If you specifically needed to see your patient because it was a difficult discussion or it was a new patient you needed to build up a relationship with initially so that they had trust in you initially, then you wouldn’t leave that for another consultant. So it’s reasonable to select patients...”

8.60 After Dr Bradbury was suspended, his patients were allocated to other doctors and seen in clinic in the normal way, with their appointments being prepared for by junior doctors looking through case notes. A nurse recalled:

“A couple of registrars went through before the wider team found out why he wasn’t here, and there were comments made about the number of times Dr Bradbury had documented about pubertal staging within the notes. I assume that he assumed he could get away with that, because these children never came through clinic, their notes were never prepped.”

8.61 This nurse was also aware of the quite legitimate reasons why some patients were being seen out of normal clinic times:

“There was one patient who had a really rough ride and was still not well at all, and I knew that Myles would see him quite regularly but, clinically, that would seem to make sense, he would be up at the hospital for other appointments and things would fit together. These families are also trying to keep their own lives going, so that didn’t ring any alarm bells... we would sometimes comment that we wished our other colleagues would be slightly more flexible in the way that Dr Bradbury was, because he was more flexible about the children. Some of these teenagers miss so much school but, with hindsight, none of us ever in a million years imagined that he was examining these children.”

8.62 She also explained that, unless she was asked to arrange for tests to be done, or to contact people, she would have no reason to make an entry in a patient’s records.
Finding

F15 The appointments system was open to abuse and was abused by Dr Bradbury. None of the staff on the PDU were aware of the range of ways in which he arranged appointments to conceal the frequency with which he saw some patients.
9. Other behaviour by Dr Bradbury which did, or could have, facilitated abuse

Disguised nature of offences

9.1 Intimate examinations are an integral part of the care and treatment of children with certain cancers, and are essential for boys with leukaemia, since the cancer can affect their testes. In fact, the trust’s protocol for treating boys with suspected leukaemia requires that their testes are examined at the first meeting with a consultant, to make sure they are normal in size and shape.

9.2 A consultant told us:

“You don’t need to keep examining them during treatment but you do need to examine intermittently because it’s a site of relapse so - I don’t know - different people would have a differing opinion - but I would have thought that every few months would be reasonable in a child that you are following up for that particular sort of leukaemia, that you’d quickly check them. But then when they’re old enough you would say, ‘Have you been checking down below?’

Maybe more parents could do this, but probably they would sometimes prefer it if their doctor did it rather than the parents. It’s variable.”

Finding

F16 The records show that Dr Bradbury not only carried out unnecessary examinations but also introduced unnecessary elements into some of them. Dr Bradbury had an excellent reputation as a skilful and committed clinician who got on well with his patients and their families, and their trust in his skill and integrity meant that they did not question the frequency or nature of these examinations.
“Grooming” families

9.3 Once Dr Bradbury’s arrest was made public and families were contacted by the hospital, the ways in which he had manipulated and groomed families were revealed.

9.4 One consultant described what she was told by parents:

“Many of them felt that he had used many visits to build up a rapport with both parent and child. All of them said - we really liked him. We thought he was a wonderful doctor. We trusted him implicitly. For some of them, they were being seen on their own and they had no qualms about that because the boys were happy to go in. They came out happy. When they came out, they thought that he was allowing them to grow up and take control of their lives themselves and for long-term conditions they thought that was very positive. They were completely on board with it. And then horrified when all this had happened.

“And then I suppose it was the shock and disbelief that somebody that they completely trusted and trusted with their child, never ever questioned - that they could have misread it, misjudged it; a huge amount of guilt, that they had allowed this to happen. And the grief actually, a lot of them saying ‘We thought we knew this person and part of our tears and anxiety are that we are grieving the person we thought was wonderful’. I remember one mother who said ‘I have been saying for months, we are so lucky, because it’s such a difficult thing to manage all of this, but our consultant is really helpful, he sees me out of hours. We couldn’t wish for a nicer more committed doctor’. And she said ‘And now I realise it was all lies, all lies. And I was taken in hook, line and sinker’.”

9.5 Another consultant told us:

“It became clear that families had been introduced to what they considered to be standard practice that is just unrecognisable. So for example, families had been (at an early stage) introduced to the idea that it was essential for him to see their child alone. And the reasons given, that the families gave me, were that their child would be under medical care for the rest of their life and it was very important for them to have a trust of doctors and that was why he needed to see them alone. This was just totally unrecognisable as any sort of policy. Families
have said that he was very insistent to this to the point almost of pushing them to say that this was essential - that they must agree to it, even when they felt a bit uncomfortable about it. And clearly he managed to introduced this way of working with families to the extent that they were willing - no, not willing - they were coerced into going along with it.

Several of them have said ‘I felt uncomfortable at the time. It didn’t seem quite right but...’

“And all of them talked about how well he got on with their children and so they respected his professional status and at the same time they recognised the importance of him for the treatment of their child and so if it was the price they had to pay to make it all work for their child then...”

9.6 The mother of a patient told us:

“We were put in a situation that nobody would ever want to be in, but we just went with what everybody said - if they told us dangling upside down from a tree would help at the weekend, that’s exactly what we would have done.”

9.7 The mother of another boy explained:

“I think the problem is that Dr Bradbury, and I guess it’s all part of the grooming side of things, that he developed a persona where you felt you couldn’t. With him you couldn’t ask things. He was just different in the way that he would walk through the department. He would kind of walk through and the other doctors would just bustle through ready to get on with their jobs. He would stop and talk to people, make a big fuss of them and then go onto the next person. It was almost like you felt, ‘Oh, he’s going to notice me’. He was just very clever...”

9.8 A consultant told us that Dr Bradbury’s behaviour did not leak out even when some children were receiving care from other consultants as well as him. He gave an example:

“This patient who was admitted when I was on call had a very unusual form of [cancer] and we thought initially that it might be more of a [solid tumour] spectrum and ultimately ended up being treated on the leukaemia spectrum. So I
was heavily involved with this family at the beginning and spent a lot of time with them. And obviously we have maintained the links, even though it was Myles who ended up treating the patient. So I had a very good working relationship with them but what Myles seemed to have been able to do was to take his personal involvement with families in terms of gaining their trust, to a whole different level. So that the children trusted him. He had a wall in his office and - this is not with hindsight - I remember looking at his wall and his wall was covered with letters from children and - you know - best doctor in the world - Myles is my best friend - just covered in them. So I remember thinking ‘My goodness, I’ve got none of those on my wall. What is this guy doing that is so fantastic for these families? By implication what is it that I’m not doing?’

Q This particular child, were you ever seeing them at the same time? Did you ever see this child and the family while Myles was the named doctor?

A: Only on call, and occasionally there would be a discussion that we had and we would take our turns on call with that. So, yes. I continued to see the family, which is why when all of this broke we divided up the families.

Q: And they never said to you ‘Gosh it’s very different with you. Myles never talks to us, he only talks to our boy’?

A: No. Because it was a pattern for some of the children - although we all work as a team, he would work very hard to make it clear that he was their main doctor and he would see them over and over and over again. They would see him almost exclusively. And so we were just the extras.”

9.9 The other haematologist told us:

“He was very plausible and he worked very hard at gaining the trust and friendship from those families and there was one thing, looking back, that I would say was - I don’t say it was abnormal, but I noted that he did spend an awful lot of time ingratiating himself into the affections of families. So there were times when he would just spend a lot of time talking about football with the teenage boys. If they were having procedures or blood transfusions, he might come after
clinic and just chat to them in the six-bedded bay I showed you, and just socialise, just chat to them, which I took to be just a sign that he was a bit needy.

“When he first came back after he had been to Birmingham, and when he came back in 2009 he did say he was quite lonely and he had split up with his girlfriend and he was starting off afresh in a new area, so I took it to be that he just wanted to socialise with people. And he was drawn to families with boys and again with his background in the scouts and interest in football. It didn’t seem sinister, it just seemed very plausible.”

9.10 He also told us that the medical records showed that it was boys from the non-malignant clinic on Wednesdays\(^{15}\) that Dr Bradbury first targeted and arranged to see on different afternoons because “they would not have had opportunity to meet other professionals nor know what a normal examination was.”

Not maintaining professional boundaries

9.11 After Dr Bradbury’s exclusion, discussions with families of boys who had been treated by him revealed that he had given patients and their families his private mobile number, and had made private calls to both patients and parents.

9.12 Dr Bradbury told us that he gave his mobile number to certain families where the child had complex needs and where he believed that the family would be able to help their child remain at home if they could phone him easily for advice. He told us that he did not give his number to his child patients, nor did he ever speak to them on the phone.

9.13 A consultant told us:

“I had no idea he was handing out his own telephone number. I knew that he was quite at ease with his patients. I don’t think I had picked up that there were boundary issues until afterwards and then afterwards it all started coming out and we were saying ‘How come we didn’t know this?’”

\(^{15}\) As these were for non-cancerous blood disorders, none of the oncologists attended the clinic.
9.14 Another consultant told us that he would be alert to the possibility of a problem if he saw such behaviour in future:

“A doctor who contacts patients outside of work for ostensibly work-related things. That would ring an alarm bell. But it didn’t ring an alarm bell [at the time]. I don’t often make appointments for my patients. Now we have a system, you write an order, somebody else makes the appointment, the patient comes. I don’t tell families to do the appointmenting, but that would concern me now.”

Comment

There is a discrepancy between the information given by families that Dr Bradbury gave his mobile number to patients as well as their families and his assertion to us that he did not give it to patients but only to some families.

Either way, this behaviour clearly allowed Dr Bradbury to circumvent the formal appointments system.

9.15 We spoke to Dr Jag Ahluwalia, medical director of the trust, about Dr Bradbury’s professed reason for giving some families his number, and about his willingness to see children out of normal clinic times.

9.16 Dr Ahluwalia accepted that Dr Bradbury was by no means the only consultant to do this, and that it was not an inherently suspicious thing to do, but generally he considers it to be undesirable, since it fosters a dependency culture, either in the patient or in the family, which makes it difficult for the team to deliver care and services because “if that consultant happens to be on leave they have built up this ‘only x can treat me’.”

9.17 He explained that generally the families of outpatients are given information about what to do in different circumstances:

“For example: ‘Contact the ward if it’s for the following conditions’, or ‘Go via your general practitioner for the following conditions’, or ‘If it’s a shared cared child who’s based in Colchester, or wherever, start with the shared care centre first’.
“However, there are a subset of our children and a subset of our adult patients, where for certain conditions they have rapid open access because their condition deteriorates quickly.”

9.18 He explained that these patients will have direct access to the wards, and none of them needs their consultant’s mobile number to gain this access:

“You should be contacting the duty consultant about an acute crisis. However, I would expect, then, the acute crisis consultant, if there were some strategic long-term decisions to be made about that child’s on-going treatment on the next working day to talk to the nominated consultant.

Q. Yes. So are you saying that, leaving aside the offending aspect of it, that giving out your mobile phone number to the families of patients indicates an over-involvement or going a bit too far in terms of offering a service?

A. Yes. I am saying that as a doctor now, not as the medical director, if you like. I wouldn’t go that far because I think that’s creating an over-dependency on me, whereas we should be fostering a relationship of trust and rapport that’s with the service...

I don’t like any service where that particular aspect of the service is only delivered by one consultant because then we are dependent upon goodwill and good health. If they are ill or they are away for three weeks, who would look after the service?”

9.19 Dr Ahluwalia recognised that there are circumstances where this principle would not prevail:

“We do have, clearly, subsets of patients, transplant patients and others, where they do have rapid access to their transplant coordinator, and things like that, who are often a senior nurse and so forth, but that is for their particular vocation.

Q. Yes, but that’s a post rather than an individual thing, isn’t it?
A. Yes, but I could be wrong. It is a big service hospital, as you know, and there will be subsets of services where they may have a slightly more dedicated approach. In the neonatal unit, our neonatal outreach programme for the parents of the babies who we send home with nasogastric feeding, that are just two or three weeks early, they will have the contact mobile phone numbers of the nurses running that service. Some befriend them and become close friends, but that’s after the period of treatment.

I don’t recall ever giving out my mobile phone number, a live treatment relationship, but I have said to parents, if you need to contact me I am available through the switchboard and that’s a bit of a detachment there. I know another hospital in London who have gone so far as to give the on-call mobile phone number, not the private mobile phone number, but the on-call mobile phone number of the service consultant to parents of children who were so-called ‘frequent attenders’, and that has been very positive. In giving the mobile phone number to their parents they don’t come in as often. They know if they are really in trouble they can phone and they’ve stopped coming. So there are some upsides to that, but they are to do with what’s the intention here? My discomfort is with why are we creating this particular dependency, which I personally regard as unhealthy.”

9.20 We note that the introductory material provided to Dr Bradbury when he joined the trust made it clear that he should not use trust phones to make private calls, but did not contain any advice or prohibition on using personal phones for work calls.

Finding

F17 There are no hard-and-fast rules about whether doctors can or should give their mobile numbers to patients or their families.
Recommendation

R2 The trust should consult and agree on the principles that should apply on providing patients or their families with personal mobile numbers, and ensure that all staff receive information and/or training on those principles.

9.21 Dr Bradbury also became friendly with the family of a boy he had treated while he was a locum. This did not emerge until shortly before his return to the trust, and Dr Bradbury freely acknowledged the friendship when asked about it by the doctor then treating the boy.

9.22 This doctor told us:

“I don’t know if it was before or after the interview in 2008 when he agreed to come back, I heard from one of the (I think) nurse specialists that she’d heard through the grapevine that he was seeing this family socially, and had actually gone on holiday with them. And I raised this with the clinical director at the time and said this is a bit difficult, he’s put himself in a difficult position here and so I had arranged to tackle him when he came back and as soon as he came he did confess that he had been seeing this family socially so he was in a difficult position and he wouldn’t be able to see this boy in clinic any more. So it was made very clear then that I would be the only one treating this boy medically.”

Comment

Our expert advisers considered this situation and felt that a relationship with an ex-patient’s family did not constitute a boundary violation and the trust dealt appropriately with the information it was given.

9.23 GMC guidelines on inappropriate relationships refer explicitly to sexual or improper emotional relationships, recognising the possibility that these might arise in the context of social relationships. There is nothing to prevent doctors from having social relationships with current or former patients or their families, although in doing so doctors must not
abuse their professional position. GMC guidance since 2006 has indicated a number of factors that may be relevant in deciding whether a relationship with a former patient is likely to be seen as an abuse of position. The current guidance for example states that this is more likely where a doctor is a psychiatrist or a paediatrician.

9.24 Another consultant told us that after Dr Bradbury returned to the trust he raised concerns with her about the way his colleague was managing the same boy’s treatment, and explained that the boy had been his patient when he had been there as a locum, and that he had kept in touch with him and his family after he left the trust. She said Dr Bradbury had said that when he returned to the trust the other doctor was in charge of the boy’s treatment:

“And then he then said something like ‘But [the boy] feels that he can’t talk to [his new doctor] as well and that perhaps he’s not quite as up to speed with where [the boy] is in his treatment as I was, because I knew [the boy] very well. I got to know him very well. He just feels more confident with me’. And I said ‘Well then you just need to talk to [the treating doctor] about it, don’t you, and perhaps explain what [the boy] is feeling, but actually you’re not his doctor, [he is] his doctor and [he] has to remain his doctor if you’re friendly with the family. So you’ve either got to talk to [your colleague] and explain it or you’ve got to get [the boy] to talk to [him] about it. There are only two routes’. And he said ‘Right’. And that was all that was said.

Q: And so actually that comes across as him being quite aware that he mustn’t treat [the boy]?

A: Well it came across to me that he came back and said ‘I can’t continue to look after him’, which is what I would have expected. But it wasn’t until afterwards that I realised that [the new doctor] said ‘Oh no, no – I said when I knew that he was a friend - sorry you can’t look after him’.”

9.25 Dr Bradbury told us during his interview that he became friends with this family because he had shared interests with the mother, with whom he had a platonic relationship. He recalled that he had always known that he could not play any part in the boy’s treatment when he returned to the trust after working in Birmingham.
Finding

F18 Dr Bradbury was open about his friendship with this boy and his family, which did not breach GMC guidelines. He did not treat the boy during the period when he committed his other offences, and his colleagues thought that his main friendship was with the boy’s mother. Dr Bradbury confirmed that to us.

“Too busy” to teach

9.26 Addenbrooke’s is a teaching hospital, and Dr Bradbury had an obligation, as did other consultants, to assist in the training of junior doctors, including students.

9.27 A consultant told us:

“He [Dr Bradbury] did participate in the teaching programme and the haematology SpRs 16 that came through, he would often do sessions with them on the microscope. But that’s because he could fulfil that obligation easily in his office. But he was not very keen to take medical students into clinic. He’d often say ‘Oh, I’ve got a lot of complicated family discussion this morning, can you take them? I’m going to be very tight for time.’ So quite often he wouldn’t take clinical medical students and [another consultant] and I would take them. At the time I didn’t really give it a thought as both [the other consultant] and I quite like to have students.

Q: And the medical students, if you take a medical student that means they’re sitting in with you during your consultation?

A: Yes - you’re talking to them, telling what you’re doing, and you’re talking to them about the condition, etc.”

9.28 Another consultant, referred to above, confirmed this account and added:

16 An SpR is a specialist registrar, the level below consultant and still in training.
“The illusion of busy-ness was something that we accepted, because it came up in many different fora and maybe it was all carefully crafted but it worked. We don’t have anything to do with the benign haematology workload, but we have the figures to show that that workload was going up and up, and he would consistently say - and in fact both haematologists would say - that the workload was going up and up and he would frequently say ‘There’s no time in clinics to see all these patients; we’ve got to slot them in when we can, and that’s why I’m so busy’. And that was his justification for bringing even non-cancer patients to that clinic which wouldn’t be expected, but he would say, ‘Well, you know, the pressure is so much. If we don’t see these patients they will all breach. We’ve got to see them’.”

9.29 Dr Bradbury confirmed to us that he was often reluctant to have medical students sitting in on appointments with patients and their families. He said that this was not to engineer being alone behind the curtain with a child, but rather because it interrupted the flow and environment of the clinic. Cambridge students tended to ask a lot of demanding questions, which he considered were disruptive to the necessary doctor/patient communication. However, he was always willing to have students accompany him on ward rounds or bedside teaching, which were more formal occasions where teaching was accepted by all as a necessary part of the process.

Comment

Whatever Dr Bradbury’s motives, his unwillingness to have medical students with him in clinic increased his opportunities for private access to patients.

9.30 One of his colleagues was not impressed by Dr Bradbury’s claims to be so busy:

“According to him he was the busiest consultant in the department. He was one of these people who could fill his day with quite a small number of tasks and still seem to be really busy. But he just wasn’t productive… Anything to do with paperwork he would find some excuse not to be involved with.”

9.31 However, he did not think that there was anything sinister in Dr Bradbury’s unwillingness to do his share, but simply thought that he was lazy, although clinically competent.
9.32 Dr Bradbury’s most recent appraisal had no negative comments about his productivity.

Dr Bradbury’s manner

9.33 Several staff told us that Dr Bradbury could be abrupt and critical of junior colleagues, and there were occasions when consultant colleagues had to have a quiet word with him about this. However, there was never any behaviour that would have justified a complaint, and the traditional hierarchy was such that most of those treated in this way simply put up with it and/or tried to ignore it, on the basis that it was not unusual consultant behaviour.

9.34 A senior nurse said to us:

“People have said things to me that I’ve picked up on as unusual. But nobody has said that they suspected him. For example, the things that I picked up on were that he would never have a student to work with him, and he would always whisk in and say ‘Oh I’m far too busy’ and the student would work with someone else. And one of the consultants said to me that he always insisted on having a specific room. But I’ve worked with consultants who are very pernickety and very set in their ways and like their instruments set out in a certain way and would be very snotty with you if they weren’t. But they’re not things that are major. I think it’s quite unusual for a consultant not to work with a student because that is teaching - is part of their role. But the other things you could dismiss as a sort of a personality quirk.”

Comment

We do not know if there was anything deliberate about Dr Bradbury’s occasionally unpleasant behaviour; certainly his behaviour resulted in him being left alone as far as possible by those he criticised.

9.35 We asked if fear of reprisal could have led to concerns by juniors being suppressed. A consultant told us that if anyone had had concerns about Dr Bradbury:
“...the nature of our team is such that they wouldn’t have tackled him about it but they would have come to one of us and said ‘I’m really bothered because Myles is seeing patients on his own and I’m sure there’s nothing in it and probably nothing improper going on but it doesn’t seem right’.”

9.36 We spoke to doctors who had been junior doctors when Dr Bradbury had been at the trust, and they told us that generally he was pleasant, and although he could sometimes be snappy, he was no worse than other consultants in this regard. They admired his knowledge and professionalism and found him ready to help when asked.

Comment

The good impression that Dr Bradbury made on these doctors does not undermine the perception of others to whom he was less friendly and helpful. Rather, it shows that he was capable of both pleasant and unpleasant behaviour.
10. Safeguarding

Governance

10.1 Trust board responsibility for safeguarding sits with the chief nurse. She told us that two safeguarding teams operate in the trust, one for children and one for adults, and they come together under an overarching safeguarding committee to review common themes and actions. For both children and adults services, there is a post of named nurse, named midwife and named doctor for safeguarding.

10.2 The trust board receives a biannual report which is a combined adult and children’s safeguarding report.

10.3 The current chief nurse told us she instituted this new system soon after she took up the substantive post in March 2014:

“The process I put in place was the twice-yearly combined report and a quarterly update. The quarterly update goes via our quality committee and then to the board. Over the period of the MB case the board had a monthly update in the private session. There is also a weekly slot on our senior management team [SMT] executive meeting around safeguarding.

“...We meet quarterly as an overarching steering group. This informs my weekly and monthly meetings, SMT and quality committee. There is a quarterly report to the quality committee and board and a biannual report to the board.”

The quality and uptake of safeguarding training

10.4 We interviewed key individuals with responsibility for safeguarding at the trust. They explained the trust’s safeguarding structure and policies, including training, and the implementation of those policies. At the time Dr Bradbury was excluded, in November 2013, the executive safeguarding lead (chief nurse) had been in post since August 2013, having moved from another trust where she had had a similar role. She was an interim appointment until March 2014, when she took the permanent position.
10.5 She told us that when she arrived there were two safeguarding teams, one for adults and one for children, and that they were dealing with a significant number of safeguarding issues. She explained that many of the concerns arose from people coming through the emergency department (ED), with staff observing children and adults who appeared to be at risk of or who may have suffered abuse or neglect. She felt that the teams were effective in taking concerns forward in accordance with hospital policy and she laid out the governance structure that led from the named staff with safeguarding responsibilities up to the board. Although she introduced some changes to strengthen the structure and resources within the team, she had always been satisfied that safeguarding was and is given a proper level of priority at the trust:

“Staff at the trust receive safeguarding training in accordance with national guidelines, and generally the take-up is very good, although there have been problems with take-up by junior doctors who are only at the trust for six months or so and may have done very similar training at a previous hospital. All the training has to be validated by the LSCB every three years and so the level 3 is something that we’ve put together but has been validated by the LSCB as fit for purpose and given staff the competencies that they need in their clinical practice.”

10.6 We discussed the safeguarding training with the medical director at Addenbrookes, who is also the responsible officer for revalidation in the trust. Revalidation is a GMC process by which all licensed doctors are required to demonstrate on a regular basis that they are up-to-date and fit to practice in their chosen field and able to provide a good level of care in line with ‘Good medical practice’. For some doctors e.g. paediatricians, psychiatrists and GPs that will mean being able to demonstrate an appropriate level of safeguarding training to be able to address the safeguarding issues they are likely to encounter in their role. Other doctors may find that their employers set local mandatory requirements for safeguarding training which will feed in to their appraisal and revalidation process.

10.7 Revalidation is a fairly new requirement, introduced in December 2012. However the obligation to keep up to date and undertake appropriate training and development is not new. It underpins ‘Good medical practice’ and is highlighted in other GMC guidance including the advice for doctors in leadership and management roles.
10.8 As responsible officer, Dr Ahluwalia has to report to the trust board and to the GMC on whether doctors undertaking revalidation have met the necessary criteria, including safeguarding training. He told us that the advent of revalidation has led to a very high take-up of safeguarding training, even in those medical specialisms where doctors were unconvinced of the need for it. He told us that the take-up rate for consultants is now “in the high 90s” and that the lack of a perfect 100 per cent at any one time can be attributed to consultants joining the trust after having done the training in a previous role.

10.9 There are plans to allow people who have done accredited training in a previous post to be “passported” when they join the trust, but this has not yet happened. Dr Ahluwalia explained that although all safeguarding training has to cover specified topics, trusts can, and often do, develop their own training to suit their own circumstances. This means that there is no consistency across trusts, and therefore no way of allowing doctors or other staff to show, when they move from one trust to another, that the training they did in the first trust covers all the areas needed by the second one.

10.10 Dr Bradbury was moving towards the time for mandatory revalidation when he was suspended, but the process had not started by the time he was excluded.

10.11 All staff have safeguarding training at a level determined by the amount and nature of their contact with patients. Some of the training is face-to-face, and some of it is online. We reviewed some of the online training. When Dr Bradbury was working at the trust the ‘Safeguarding Children training policy’ required the safeguarding children management committee to oversee “the development of a corporate training strategy in compliance with recommendations from the Department of Health in Working Together to Safeguard Children (2013) and Safeguarding Children and Young People: Roles and Competencies for Heathcare Staff, Intercollegiate Document September (2010) that is complementary to the county training programme and for monitoring uptake of mandatory training.” The chief nurse confirmed to us that current training complies with the latest versions of these documents, including the training programme of the Cambridge LSCB.

10.12 Both the online and the face-to-face training focus on identifying children who might be at risk of harm, and what a member of staff should do if he or she had a safeguarding concern.
10.13 The training that we reviewed does not include any information or guidance on monitoring colleagues for behaviour likely to harm children. The chief nurse told us that face to face training includes content in relation to identifying a perpetrator who may specifically target jobs where they have easy access to vulnerable groups.

10.14 Safeguarding Children: Roles and Competencies of Healthcare Staff was published in 2014 by the Royal College of Paediatrics and Child Health on behalf of all the Royal Colleges and other professional associations of health care workers, and replaced an earlier document that would have been current during Dr Bradbury’s employment, which we have not seen. Sixty pages of this document set out the knowledge, skills, attitudes and values that health care staff at all levels, in all settings, should have. There are five levels, according to the seniority of the health care worker and the extent and nature of their contact with children. The detail is exhaustive, and admirable, but we were only able to find two references that had relevance to the behaviour of Dr Bradbury:

“Level 2 training covers all non-clinical and clinical staff who have any contact with children, young people and/or parents/carers, and one of the core competencies expected of such staff is that they are ‘clear about own and colleagues’ roles, responsibilities, and professional boundaries, including professional abuse and raising concerns about the conduct of colleagues’

Level 3 training for a children’s nurse, child and adolescent mental health nurse, forensic nurse, Midwife, school nurse and Health Visitor requires them to ‘understand how to manage allegations of child abuse by professionals’ as part of their clinical knowledge.”

Comment

The fact that there are only two brief, and somewhat ambiguous, references to abuse by professionals and raising concerns about colleagues in such a lengthy and detailed document seems to show that abuse by a health care professional is still seen as unlikely, and was probably seen as even less likely at the time Dr Bradbury was employed.
10.15 Although the safeguarding policy and training are relatively silent on the risk of abuse by a colleague, all staff, as part of their induction and training, are encouraged to speak up if they believe a colleague may be at risk of causing a harm, accidentally or negligently. Examples might be a surgeon with a tremor caused by illness, or a nurse suffering from emotional stress and consequently forgetting important tasks, or a specialist taking a clinic after a lunch time drinking session.

10.16 Staff told us that abnormal behaviour, such as spending an unusually long time on a task with a patient, would, if noticed, result in enquiry. However, the enquiry would be more likely to be into whether the staff member was having problems, not whether the patient was at risk. And of course such an enquiry will only take place if the abnormal behaviour is noticed.

10.17 We discussed the lack of any training on identifying possibly abusive staff with Dr Ahluwalia. He said:

“I think the difficulty here is if one were to talk about safeguarding and behaviours that might be potentially grooming or out of the ordinary, I think they’re more difficult and subtle to detect; and there isn’t a uniformity of what the right signals are for it. It depends where you are in your experience and your role in the hospital whether you’re in a position to even determine whether something’s odd, or whether you should challenge. Whereas, for things like smelling of alcohol, I think that every member of our staff will know if you smell of drink on duty there’s a problem. It’s a much more binary function, I think.

Q. Yes, and, of course, the other difficulty is that what goes on in hospitals relies on trust, doesn’t it, and you don’t want to do anything that is going to destroy that trust.

A. Absolutely. I’ve looked back on the Bradbury case, although I’m a paediatrician by background, now I am a neonatal intensive care consultant. To a degree I have beaten myself up over it, and so have his paediatric oncology colleagues, but I think they were all groomed along the way. We were duped… For alerting to things such as alcohol, I’ve had just within the last year a colleague raise concerns about a consultant colleague smelling of alcohol and it was acted upon straightaway, even though previously concern about an individual had fizzled
out because of the lack of evidence and so forth. They are happy to alert me to that sort of stuff... whenever I am in front of junior doctors who are just about to become consultants, I give a lecture regularly on governance and doctors in difficulty, that’s got alcohol and stuff in there and safeguarding, but detecting patterns of odd behaviour... [is] more difficult, particularly if you are a junior nurse, say, in a clinic and the consultant says, ‘No, this is part of my routine. This is how I do it’.”

Safeguarding culture

10.18 Safeguarding policies and practices are necessary elements of a safe environment, but are not sufficient. A safe environment also requires a safeguarding culture, in which safeguarding is threaded through everything that everyone does.

10.19 It is difficult to be sure of the nature of the safeguarding culture during the time Dr Bradbury was working at the hospital, particularly as significant personnel have changed since then. On the one hand, the confusion and lack of rigour about the chaperone policy suggests a less than vigilant safeguarding culture, but on the other hand the hospital’s rapid and professional response to the concern being raised by Child X’s family was exemplary and suggests a strong safeguarding culture.

10.20 The trust’s safeguarding policies and governance arrangements are in accordance with government guidance in Working together to Safeguard Children 2013. The individuals with designated safeguarding responsibilities: the chief nurse, the designated non-executive director and the named doctors and nurses, all spoke confidently and knowledgeably about their roles and responsibilities.

10.21 The chief nurse told us of the trust’s close engagement with the Cambridgeshire LSCB, and of the audit and assurance processes that are engaged in to ensure that they maintain standards. For instance, all safeguarding concerns are monitored every month to make sure that there is no drift, and they monitor the action plan that is created when they carry out their safeguarding self-assessment, as required by the LSCB.
Information for patients and families

10.22 We discussed what further measures could be put in place that would not damage trust but would reduce risk. The doctors and managers at the trust to whom we spoke explained that they had given a great deal of thought to this, and apart from raising the awareness of patients and families as to what they could expect, they would also be improving staff training:

“Our education will now focus much more within teams to be looking at how often patients need to be chaperoned and what are the nature of the examinations. I guess it will be a much less trusting environment than people have been in before.”

10.23 The staff recognised that the instinctively protective impulses of families can help to provide better safeguards for children. But there are inevitable difficulties to be resolved, for example when children simply do not want their parents in the room when a doctor or nurse is examining them.

10.24 The chief nurse told us:

“one of the things that I have focused on going forward is about communication with families and I think that has to be our greatest strength that it becomes not just us, ‘Addenbrooke’s’, but a much greater responsibility for the NHS to say in the most unfrightening way to families, you can challenge and question. We have these policies, procedures, training and programmes but when you come into hospital, with a child for example, don’t hand them over. We need to make it easy and normal such that if a consultant or any health care worker wants to see a child on their own, families feel comfortable and able to challenge and are aware of what they can expect from safeguarding policies. And that’s one of the things that I feel we have to do as an NHS organisation, is to say - it’s okay to question. Like we have done for a long time with hand hygiene now - it’s okay to say to the consultant ‘Have you washed your hands?’ It’s okay to say ‘Why are you going in on your own with my child?’ And even if they say - well your child’s 17 and he doesn’t want you there, then you can say - is that normal? That’s very difficult for people but we have to make it easy for them to do that. I have thought about this non-
stop and to me it’s the only true way. Chaperone policies - all of those things - this has got to be by partnership.”

10.25 We spoke to the clinical psychologist and the counsellor who work on the PDU, and they also agreed that patients and families need to know what to expect, what is a normal examination, and that it is always acceptable to question any suggested treatment.

10.26 Another consultant told us:

“I have thought very hard about how we could have prevented this and it’s giving the families the information - this is what to expect in a normal outpatient appointment. You will see the doctor. You will see the nurse who will measure your height and weight. You will see the doctor with your mum and dad. You’ll have an examination with your mum and dad there, and then you may have a blood test with the phlebotomist. And you just map out this is what happens and this is what to expect when you come to hospital. I think that’s missing. There are policies and there were policies for chaperoning before and its common sense. The GMC is very clear on chaperoning. We all know what’s right and what isn’t. But the families don’t, and you trust the doctor.

“In simple terms I think what is needed is some form of information, whether it’s on the hospital website or leaflets that we give to families, to describe this is what a normal consultation consists of.”

10.27 The families we spoke to had their own thoughts on what would and would not work.

10.28 Although not dismissive of the value of more information about the chaperone and transition policies, they were somewhat sceptical about their efficacy. One mother pointed out that she had been chaperoning her child when Dr Bradbury sexually assaulted her daughter by slipping his hand under her top and then explaining that he had been doing a puberty check.

“I just felt uncomfortable. I remember walking out of the examination room and kind of pausing and knowing that [another consultant] who we were also seeing, was in the next room and kind of wanting to say something to him. But... I also
didn’t want to upset Dr Bradbury. That’s what it was; I didn’t want to upset him. I didn’t want to criticise him or question his professionalism.”

10.29 She also told us she felt there was a difference between raising a formal complaint and having a conversation about whether what had happened was normal and acceptable. She felt that it would have been helpful if there had been information, perhaps on a poster on the PDU, telling parents who to go to or what to do if they had a concern about treatment not amounting to a complaint: “I didn’t want to make a complaint. I know they have PALS [Patient Advice and Liaison Services], don’t they? I didn’t want to go there but I just wanted to say, ‘Was this okay?’”

10.30 Her other suggestion was that explaining what was going to happen, and seeking specific consent, would provide a barrier to abuse:

“I think the thing is it needs to say that consent will always be asked because then I think I would have felt that perhaps I could have said, ‘Actually, you didn’t ask’. I might have gone and said something that way, that, ‘Actually you made [my daughter] feel very uncomfortable because you didn’t ask her if it was okay’.”

10.31 She felt that the explanation prior to the request for consent should be quite specific, stating exactly what the doctor was going to do and why, rather than simply asking for consent to carry out an examination. She also felt that information about what the normal pattern of treatment is for a particular condition would help parents query apparent deviations from the pattern.

10.32 The mother of another patient agreed that consent was an important issue, and also thought that it would have been helpful to have been put in touch with other families in an online forum when her son was first diagnosed. She felt able to ask questions of staff, including counsellors and social workers at the hospital, but she felt the more sources of information and support, the better.

10.33 The chief nurse told us that the trust has been reviewing its communications with patients and their families, and is awaiting our report before finalising any new communication policy or practice.
Finding

F19 All those using the trust’s services need information, in an age-appropriate form, about:

- the trust’s relevant policies, including safeguarding, consent, chaperoning, transition and complaints;
- where to get more information;
- the behaviour to be expected from staff;
- the expectation that patients and families will question and be curious about care and treatment proposals;
- the circumstances in which a child under 16 will be allowed to make their own decisions on medical matters, known as Gillick competence; and
- contact details of external organisations such as the NSPCC and Childline.

Recommendations

R3 The trust should consult with the Cambridgeshire LSCB to ensure that its information to patients, training of staff and expectations of staff behaviour are in accordance with current best safeguarding practice.

R4 The trust should consult patients and families about the desirability of setting up an online resource for patients, families and staff to provide information and facilitate communication.

Did the trust comply with the safeguarding policy as soon as a concern was raised?

10.34 Dr Bradbury is not the first health care worker to sexually abuse his patients, and there are reports and other literature analysing how other offenders carried out their

17 Gillick competence “…whether or not a child is capable of giving the necessary consent will depend on the child’s maturity and understanding and the nature of the consent required. The child must be capable of making a reasonable assessment of the advantages and disadvantages of the treatment proposed, so the consent, if given, can be properly and fairly described as true consent.” (Gillick v West Norfolk, 1984)
crimes, how they got away with them and what the warning signs were that might have alerted colleagues to what was going on. We deal with this in more detail in section 11.

10.35 The most basic and obvious warning sign is that complaints are made, or concerns expressed, but that these are subsequently ignored, dismissed or suppressed.

10.36 We asked all our interviewees who had had direct contact with PDU patients if anyone had ever raised a concern of any kind about Dr Bradbury. This included all the PDU staff whom we interviewed, as well as the families and the police liaison officer. Our letters to the staff we did not interview and to all patients or families who had been in contact with Dr Bradbury specifically invited them to contact us if they had ever expressed any concern about Dr Bradbury.

10.37 We also looked at the notes of the callers to the helpline set up once the allegations against Dr Bradbury were made public.

10.38 We established that two families had complained that Dr Bradbury was not giving their children the attention they needed. In both cases the children were receiving shared care at the local hospital, but Dr Bradbury was not attending outreach clinics, and so not seeing these children as often as he should. However, apart from this, no one had complained or raised a concern about Dr Bradbury. The police liaison officer informed us that (apart from the family of Child X) none of the children or families interviewed by the police during their investigation had said that they had raised a concern before being contacted by the police.

10.39 A consultant also told us that after Dr Bradbury was suspended, but before this was made public, two patients expressed concerns about Dr Bradbury:

“It was after MB had been suspended and he came up to an appointment and I think we had already identified this boy on a list as somebody who had been coming often and shouldn’t have been, and he came up for his appointment and he didn’t want to be seen. He didn’t want to come to appointments any more and then he said that he didn’t like coming any more. He didn’t see the point in coming any more. He didn’t like Myles. He didn’t want to be seen by him. And then another mother, I think who also appeared after he had been suspended but before we’d even contacted families at all, who said ‘I don’t know what goes on in
this clinic, but let me tell you - he’s not coming in on his own any more - he
doesn’t like it’. So there were two patients that came up before it was actually
made public but after [Dr Bradbury] had been suspended and we knew what had
been going on.”

10.40 Dr Bradbury told us that no one had ever raised any concern with him about his
treatment of his patients.

Findings

F20 Despite detailed questioning and examination of records, we found no evidence
that concerns had been raised before Child X’s family did so, let alone that any such
congerns had been ignored, dismissed or suppressed.

F21 As soon as a possible concern was raised by Child X’s family, action was taken in
accordance with the trust’s safeguarding policy. The receptionist with whom the concern
was raised escalated it immediately, and the appropriate clinicians and managers were
informed promptly. Dr Bradbury was told to go home, and the LADO was informed of the
concern.

F22 All of this was in accordance with the trust’s safeguarding policy.

Conclusion

10.41 From the moment a concern was raised, trust employees acted promptly and
properly in accordance with the policy. Particular credit goes to the receptionist who took
the original phone call and the nurse to whom she reported it for their immediate
understanding of the need to invoke the safeguarding procedure.

Implementation of the safer recruitment policy

10.42 All NHS organisations have to carry out pre-employment checks on all job
applicants to check their identity, their right to work, their employment history, their
health, their qualifications and whether they have a criminal record or are in some other way unsuitable to work with vulnerable people.

*Comment*

These checks can pick up only what is known or suspected about a job applicant, and are no guarantee of suitability.

10.43 The safer recruitment policy at the trust conforms with NHS policy.

10.44 Below we set out the details of what the policy requires, and the extent to which the policy was complied with in Dr Bradbury’s case, when he joined as a permanent consultant in 2008.

*Verification of identity*

“It is the responsibility of the medical staffing department to ensure that the identity of all candidates and their right to work in the UK is verified at interview.”

10.45 Dr Bradbury submitted his passport and driving licence.

*Right to work in the UK*

10.46 Dr Bradbury’s identity as a British citizen gives him the right to work in the UK.

*Disclosure and barring service (DBS) - Safeguarding children and vulnerable adults*

“The trust has a legal obligation to safeguard all children and vulnerable adults from risk of harm whilst in the care of the trust. All medical and dental posts within the trust are subject to a satisfactory enhanced DBS disclosure.”
10.47 Dr Bradbury’s satisfactory DBS clearance was returned to the trust before he started work in November 2008.

**Employment history and reference checks**

“NHS Employers recommend at least three years of previous employment and/or training verification should be in place. The appointing officer must carefully explore any gaps in employment history with the applicant at interview.

“Two references should be sought; unless an individual has been with one employer for five years or more, in which case one reference may be sufficient. At least one reference should be from the applicant’s current or most recent employer.

“For healthcare professionals, references should be obtained from their clinical line manager, medical director, or supervising consultant. Where this is not possible, references should be obtained from their postgraduate dean, educational supervisor, or other relevant professional lead. All references must be obtained in writing.

“For the purposes of checking employment history, references must provide details on dates of employment and the position held.”

10.48 Dr Bradbury had three references: one from a consultant colleague at Birmingham Children’s Hospital, where he was working when he applied for the job in Cambridge, and two from consultants at Cambridge with whom he had worked when he was a locum prior to his move to Birmingham.

10.49 All these references complied with the requirements of the policy and recommended him without reservation.
Professional registration checks

“Medical staffing must check the following three areas with the General Medical Council/General Dental Council as appropriate:

“Whether the applicant is registered, with a licence to practise, to carry out the proposed role.

“Whether the registration is subject to any current suspensions, conditions, undertakings or warnings which might affect the duties proposed.

“Whether the applicant has investigations against them about their fitness to practise that the regulatory body has a duty to disclose.”

10.50 The checks with the GMC revealed no issues.

Occupational health clearance

“All medical and dental posts are Category 1, requiring completion of a pre-employment health screening clearance comprising of a Health Declaration Form and Immunisation/Infection Screening Questionnaire (ISQ):

Health Declaration Form

“Prospective employees offered a conditional offer of employment will be sent a Health Declaration Form with their conditional offer letter. (Note: It is legal to request such information after an offer of employment, not before). They will be asked to return the form directly to medical staffing. This form requests:

• information regarding health and/or disability where this might impact on the ability to perform the job role and whether adaptations and adjustments might be necessary, and
• absence due to sickness during the past two years.”
10.51 The completed form shows no health or disability issues.

“b) Immunisation/Infection Screening Questionnaire (ISQ)”

10.52 Dr Bradbury was required to have an immunisation booster before his employment started.

Finding

F23 The trust fully complied with its safer recruitment policy with regard to Dr Bradbury's employment, and none of the checks, references or documents revealed anything of any concern.

Appraisal

10.53 The trust carries out annual appraisals of medical staff, and doctors are also subject to mandatory re-validation every five years.

10.54 Annual appraisals form part of the mandatory revalidation, and sometimes include a 360-degree survey\(^ {18} \).

10.55 We have seen the 360-degree survey for Dr Bradbury completed in early 2013. It was completed by 14 colleagues who worked with him, consisting of: four doctors in substantive posts, three doctors in training posts, four nurses, one administrator/receptionist/secretary and two non-clinical managers. All 360-degree surveys are completed anonymously. Dr Bradbury gets high scores with generally positive comments. He is described as respectful, responsive, approachable, easy to communicate with, dynamic, supportive, and passionate about delivering excellent patient care.

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\(^ {18} \) A 360-degree survey is feedback that comes from members of an employee's immediate work circle. Most often, 360-degree feedback will include direct feedback from an employee's subordinates, peers (colleagues), and supervisor(s), as well as a self-evaluation.
The only less than positive comment was: “I think pressure of work occasionally makes it difficult for Dr Bradbury to be consistently helpful and supportive. However he is always helpful and supportive to me personally.”

To the question “Have you ever seen this consultant behave in a way that you thought professionally unacceptable?” one person ticked the box to say he or she had seen such behaviour “once in the last year”, but did not provide a comment.

To the question “Would you recommend this consultant to a member of your family who had a problem in their area of expertise?” all respondents ticked the box “Yes, without reservation”.

In a comparison with other consultants, on a scoring scheme from 1 (lowest) to 8 (highest), Dr Bradbury mainly scored sevens and eights, with some sixes and a few fives and fours. He scored best on his clinical skills and personal qualities and worst on communication skills and timeliness and efficiency.

All taking part in the survey considered that he was fit to practice.

Dr Ahluwalia told us that if a member of staff had a serious concern about a colleague, an anonymous comment on an appraisal form would be a completely inadequate method of raising a concern. All staff know that concerns must be brought to the attention of a manager at once. He therefore thought that it was unlikely that the box tick referred to in 10.58 above was an expression of serious concern.

Comment

This makes sense; anonymously ticking a box on an appraisal form is a very roundabout and inadequate way of raising a serious concern about a colleague.

Dr Bradbury's self-assessment was confident but also reasonably modest, in that he mainly scored himself as “good/effective/a significant contributor” rather than “very good/very effective/a very significant contributor”, but he did not acknowledge any specific failings or faults.
Finding

F24 This was a satisfactory 360-degree feedback appraisal. Although there are one or two criticisms, all those taking part thought that Dr Bradbury was fit to practice and many praised him.

F25 The person who identified an occasion when Dr Bradbury had behaved unprofessionally did not provide any detail, and concluded, along with every other contributor to the appraisal, that he was fit to practice.
11. Changes made by the trust

11.1 Since Dr Bradbury’s exclusion from the trust, it has made several changes that have an impact on paediatric services. The chaperone policy has been revised and appointment letters for clinics have changed.

Chaperone and transition policies

11.2 The trust has redrafted its chaperone policy, and has sought advice on best practice from other trusts. The new policy is at appendix G and sets out that it is still possible for family members to chaperone a child, but it stipulates that if an examination is being carried out, there must be a professional chaperone. Consultants confirmed to us that now a professional chaperone would be behind the curtain during an examination.

11.3 The trust has a new electronic patient record system, EPIC. Every time doctors enter information about a consultation, they have to tick a box to say if there was a chaperone in the room, and if there was, his or her name has to be recorded before the entry can be closed.

11.4 We looked at two chaperone policies that were in place during Dr Bradbury's time as a consultant; one dated March 2010 and the other, updated after three years in accordance with good practice, dated April 2013.

11.5 The 2010 policy requires that a chaperone be present during all intimate examinations, but does not specify whether the chaperone has to be a professional or can be a family member. Distinctions are drawn between intimate examinations, where there must be a chaperone, and intimate personal care, where a chaperone will not normally be necessary, but may be required if the professional or the patient wishes it. The policy provides that, prior to an intimate examination or procedure taking place, it should be explained to the patient, who should be given the opportunity to ask questions.

11.6 There is no mention of any special provision for children and young people, and no reference to any arrangements for those being prepared for transition to adult services.
11.7 The 2013 policy is almost identical apart from an additional link to the privacy and dignity policy.

**Findings**

**F26** Dr Bradbury committed some of his offences when alone with his patients, and some with a family member in the room, even, on one occasion that we know of, with the mother behind the curtain. The chaperone policy would have put some obstacles in his way if it had been applied, as he would not have examined children in the absence of their parents and he would have had to tell the child what he was planning to do. Parents, if they had heard this, would have been more aware of what was happening and more likely to be concerned.

**F27** However, the lack of any specific provision for children, the lack of any reference to transition arrangements, and the apparent lack of information to patients and families about the chaperone policy, made it easy for Dr Bradbury to get round the protection it offered.

11.8 The GMC published updated guidance for doctors on intimate examinations and chaperoning in 2013. This states:

“**Intimate examinations**

Intimate examinations can be embarrassing or distressing for patients and whenever you examine a patient you should be sensitive to what they may think of as intimate. This is likely to include examinations of breasts, genitalia and rectum, but could also include any examination where it is necessary to touch or even be close to the patient.

In this guidance, we highlight some of the issues involved in carrying out intimate examinations. This must not deter you from carrying out intimate examinations when necessary. You must follow this guidance and make detailed and accurate records at the time of the examination, or as soon as possible afterwards. Before conducting an intimate examination, you should:
a. explain to the patient why an examination is necessary and give the patient an opportunity to ask questions
b. explain what the examination will involve, in a way the patient can understand, so that the patient has a clear idea of what to expect, including any pain or discomfort
c. get the patient’s permission before the examination and record that the patient has given it
d. offer the patient a chaperone (see paragraphs 8-13 below)
e. if dealing with a child or young person you must assess their capacity to consent to the examination if they lack the capacity to consent, you should seek their parent’s consent
f. give the patient privacy to undress and dress, and keep them covered as much as possible to maintain their dignity; do not help the patient to remove clothing unless they have asked you to, or you have checked with them that they want you to help.

6. During the examination, you must follow the guidance in Consent: patients and doctors making decisions together. In particular you should:

   a. explain what you are going to do before you do it and, if this differs from what you have told the patient before, explain why and seek the patient’s permission
   b. stop the examination if the patient asks you to
   c. keep discussion relevant and don’t make unnecessary personal comments.

Chaperones

“8. When you carry out an intimate examination, you should offer the patient the option of having an impartial observer (a chaperone) present wherever possible. This applies whether or not you are the same gender as the patient.

9. A chaperone should usually be a health professional and you must be satisfied that the chaperone will:

   a. be sensitive and respect the patient’s dignity and confidentiality
b. reassure the patient if they show signs of distress or discomfort

c. be familiar with the procedures involved in a routine intimate examination

d. stay for the whole examination and be able to see what the doctor is doing, if practical

e. be prepared to raise concerns if they are concerned about the doctor’s behaviour or actions.

10. A relative or friend of the patient is not an impartial observer and so would not usually be a suitable chaperone, but you should comply with a reasonable request to have such a person present as well as a chaperone.

11. If either you or the patient does not want the examination to go ahead without a chaperone present, or if either of you is uncomfortable with the choice of chaperone, you may offer to delay the examination to a later date when a suitable chaperone will be available, as long as the delay would not adversely affect the patient’s health.

12. If you don’t want to go ahead without a chaperone present but the patient has said no to having one, you must explain clearly why you want a chaperone present. Ultimately the patient’s clinical needs must take precedence. You may wish to consider referring the patient to a colleague who would be willing to examine them without a chaperone, as long as a delay would not adversely affect the patient’s health.

13. You should record any discussion about chaperones and the outcome in the patient’s medical record. If a chaperone is present, you should record that fact and make a note of their identity. If the patient does not want a chaperone, you should record that the offer was made and declined.”¹⁹

¹⁹ http://www.gmc-uk.org/guidance/ethical_guidance/21168.asp

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Finding

F28 The chaperone policy at the time Dr Bradbury was working at the trust did not fully comply with this guidance.

11.9 Following Dr Bradbury's exclusion from the hospital, the chaperone policy was revised, bringing in much tighter provisions:

- when an intimate examination is taking place, the chaperone must be a professional;
- no child, young person or vulnerable adult can be seen or examined without a chaperone being present; and
- any failure to comply with these requirements has to be justified.

11.10 The policy then spells out that:

- if it is ever necessary to see or examine a child or young person without a chaperone, consent must be obtained from the parent and the young person and the reasons recorded in the notes;
- any proposed intimate procedure has to be explained to both the parent/carer and the child before it is carried out; and
- children and young adults being prepared for transition may be seen without their parent/carer at their request, but should be examined in the presence of a chaperone.

Finding

F29 The new policy is undoubtedly more stringent than the older policies, in that it specifies that a professional chaperone is needed for intimate examinations and that any intimate procedure must be explained to the parent/carer as well as to the patient. It also reflects the principles of the GMC guidance quoted above.

11.11 Nevertheless, it has a number of weaknesses and ambiguities.
11.12 The ‘key message’ that a child should not be seen without a chaperone is weakened by the provisions for patients who are being prepared for transition to adult services. Dr Bradbury saw some of his patients on their own in apparent accordance with the transition policy, but then carried out intimate examinations, in breach of the policy, without colleagues being aware.

11.13 Also, on the face of it, the policy would require a chaperone to be present every time a health professional sees a child, even when that child is an inpatient, and even if, for instance, the professional is changing a baby’s nappy. We had a discussion with Dr Ahluwalia about this:

“The issue of nappies I specifically raised myself because I had a very interesting discussion with our chairman and others around chaperoning policies around why aren’t we enforcing this all the time. I said ‘Does changing a nappy qualify for having a chaperone? On the children’s wards that would be a heck of a lot of chaperones!’... My understanding is that nappy changing isn’t an intimate examination. It’s a procedure, if you like. It is something that parents would ordinarily do themselves by and large, anyway. We have to be practical about it... One of my concerns about all this is that the whole of the profession is predicated on trust... I’m not here to defend it as some noble profession.... However, on the other hand I am very conscious that one practises medicine built on trust and particularly paediatric practice where there are already quite a lot of tensions in the room around how many people are in the room examining this child who may not know why they are being examined, and so we can’t have hordes of people causing unintended intimidation. However, we have tried to be practical with the policy. I would have thought nappy-changing is outwith that because it is not a medical procedure, it’s an act of daily care issue, really...

What we would expect, though, is the policy to be read and interpreted in conjunction with a general heightened alertness around, actually, ‘Why is [that doctor] in that cubicle? He has nothing to do with that patient.’”
Comment

Dr Ahluwalia’s common sense approach has much to commend it in terms of practicality. However, it does not accord with the policy, which sets out that, if a child is examined or seen without a chaperone, consent has to be obtained and the reason recorded in the notes. The implication is that consent has to be obtained on each occasion, as a blanket consent by a parent would undermine the whole purpose of the policy.

Findings

F30 The current chaperone policy, if strictly applied, appears to be unworkable in certain situations.

F31 It is likely that some staff, in some situations, will disregard the policy for practical and understandable reasons but it is undesirable to have a policy that staff find is sometimes unworkable.

Recommendation

R5 The chaperone policy should be reviewed again to take account of the varying treatment needs of inpatients in the absence of their families. The new policy should offer guidance on how to develop the thoughtfulness and heightened awareness mentioned by the trust’s medical director in Section 11.

11.14 The chaperone policy will be of limited value unless patients and their families or carers are aware of its provisions, understand what information they can expect to be given, and know what to do if they are not given this information. An impromptu and unexpected intimate examination would be seen to be in breach of the policy if the patient, parent or carer was not informed in advance, and a teenager who knew that private consultations were only for conversation would be less likely to accept an examination during such a meeting.
11.15 Providing this information need not necessarily create mistrust between staff and patients or their families: it is evidence of a respect for the dignity of the patient, and respect for the parents'/carers’ right to be kept informed.

Comment

The tightening of the policy, and the requirement to record the presence or otherwise of a chaperone are clearly improvements. However, neither is sufficient, either separately or together, to prevent completely the risk of abuse as both still rely on the professional in charge of the appointment or examination complying with the policy and accurately recording the information. The presence of family members at an appointment did not prevent abuse taking place behind the curtain in this case.

11.16 The transition policy remains unchanged, because it relates only to private conversations and not to private examinations.

Making appointments

11.17 Following the discovery of Dr Bradbury’s crimes, the trust revised the appointment letters sent out to families, adding the information that children would never be examined without a chaperone (a copy is attached at appendix H).

11.18 The trust explained that it wanted to ensure that parents knew what to expect in terms of chaperoning, but did not want to alarm them by emphasising the need for vigilance, since doing so might undermine the trust and confidence of children and their families in the commitment and goodwill of the staff at the PDU.

11.19 By coincidence, at about the time Dr Bradbury was excluded from the hospital, the trust started using a new electronic patient record system, EPIC. This has changed the way appointments are made and recorded. However, routine reporting on frequency of appointments for individual patients does not occur.
11.20 Dr Ahluwalia believes that as the trust becomes more familiar with EPIC’s potential, the system will be used to compare the performance of clinicians, and will be able to pick up those with unusual patterns of treatment, such as those who follow up patients for much longer than their colleagues.

*Comment*

*As doctors’ practices are compared to identify the most effective treatments, a side benefit may be the identification of unusual practice justifying further investigation.*

*Staff safeguarding training*

11.21 We were told that some staff now recognised that the safeguarding training needed some additions made to it. One of the consultants told us:

> “I think the focus of safeguarding training - in the e-learning packages we use either through the NHS e-learning for health or from the College of Paediatrics - is focused on identifying abuse in a child from a parent/carer or person known to them. But nowhere is there anything about watching your colleagues or questioning people... But it doesn’t ever get covered in safeguarding.”

*Recommendations*

**R6** The trust should include good practice on creating a safe environment into its safeguarding training at all levels.

**R7** The trust should suggest to NHS England, The Royal Colleges, other professional associations for healthcare workers, and the LSCBs that their guidance supports such training.
Audit of files

11.22 Because Dr Bradbury saw many of his victims more frequently than was necessary, we discussed with some interviewees the value of regular file audits as a potential deterrent to abusers.

11.23 One of the consultants told us:

“Many of the notes that he wrote in, I wouldn’t bat an eyelid if I looked at [them]... but if we were auditing a set of notes the only thing we might have seen is - they’re coming a bit often - but he didn’t even write in the notes all the time, so when we were going through in detail we found children [who] had an appointment on the system were documented as having arrived and left but there was nothing written in the notes. So you might look and think they’re four months apart, when in fact they had been seen monthly and sometimes he’d write ‘wanted to chat about difficulties at school’, which was part of his cover... Any audit would not be a notes audit but a whole process audit, how many patients would you look at, we could hone down on a pattern and find some of the children but without knowing where would we start?

“And it’s only when you know that you’re looking for something and you start finding out what the diagnosis, who they’ve seen, who did they see last time, what times of the day did they come, what times of the week? It’s that degree of audit you would need to do.”

11.24 Clearly the sort of audit described would be an intensive piece of work and only likely to be undertaken when a concern or suspicion had been raised.

Recommendation

R8 The possibility of using EPIC, the trust’s electronic case management system, to identify unusual patterns of treatment by individuals that require further investigation should be kept under regular review by the trust.
Clinic appointments

11.25 We spoke to several interviewees about the arrangement of clinic appointments, the recording of those appointments and the changes made since Dr Bradbury was excluded.

11.26 One of them suggested that, in addition to the regular pre- and post-clinic meetings, a weekly meeting could take place to review all other patients who had been to clinic that week, but who had for one reason or another not been included in the regular pre- and post-clinic meetings. She suggested that the clinic clerk could:

“...produce a list of other patients. Because if we had done that I suppose we would have said ‘So why were they coming? That patient has been off treatment six years - why are they coming?’ and you would then remember, ‘Didn’t they come a month ago?’ But because the patients that tend to come up, most of them were coming up for a specific issue. We’ve never thought of doing this before. We never felt we needed to.”

11.27 She also told us that, whenever possible, she saw her patients during routine clinics:

“If they’ve got exams I’d say: ‘Well okay, don’t come in a month, come in five weeks. And you could come on a Monday or Tuesday, or you could come on a Thursday or Friday - see which end of the week is best’. But there will still be the odd patient that comes through. So say, like yesterday I saw a child who was also under the liver team. They had an appointment with the liver team and then they would come up and be seen by me rather than having to come twice. They live at the other end of the county. Or, they need an ultrasound scan and the only slot we can get unless we’re going to wait another month, is at the end of the afternoon. So there will still be the odd patient like that, but there would be very specific things...

Q: How would that be recorded now? Would it simply get recorded on the booking system as an out-of-normal clinic?
A: What I’ve done with those is, I’ve put them into the clinic but I’ve said they’re going to be late. So we still discuss them on a Tuesday morning but I know that I’m going to be seeing them much later in the day, just because it fits in with the other appointment they’ve got. And I think increasingly we’re moving follow-up patients into the afternoon because the clinics in the morning are too big. So we have a similar pre- and post-clinic meeting in the afternoon.

Q: If you haven’t discussed that with your colleagues, is there a mechanism by which all of you would sit down and agree that’s what you’re all going to do in future?

A: We discuss how we work at consultant meeting... We have agreed that patients get seen in clinic, but we all know that there will be an occasional patient - but they’re logged in the clinic list so we know they’re coming.

Q: So they’re all logged in the clinic list and so they’re all going to be seen?

A: Either in a clinic time, but maybe - and I think that is the first patient I’ve seen outside a standard clinic time for 9 or 10 weeks. So it’s just an occasional one.”

Finding

F32 Patients and their families value the flexibility of being seen outside clinic hours from time to time.

F33 Patients seen in clinics are subject to discussion by the clinic team, which provides an important level of oversight of their overall care.

Recommendation

R9 The trust should ensure that all patients seen on the PDU are discussed by a clinic team before or after each appointment, whether or not their appointment is during clinic hours.
12. Learning from elsewhere

12.1 We have spoken to a consultant at Birmingham Children’s Hospital to compare the practice there with that at the PDU. We also spoke to a nurse who works in the general paediatric outpatients’ department at CUH, to ask whether any practices there were different from those on the PDU, and, if so, why.

Birmingham Children’s Hospital

12.2 The consultant at Birmingham explained that there the paediatric outpatient and day treatment unit is, like the PDU, a stand-alone unit. This is necessary to minimise the risk of patients with weakened immune systems catching any infection. We visited the unit which also had a teenager’s room similar to the one at Cambridge.

12.3 He confirmed that, as with the PDU, some patients have routine appointments with a doctor, others drop in for ad hoc reviews, and others may be coming in for treatment administered by a nurse. The unit is busy, with a constant flow of patients and families going in and out of the unit.

12.4 We asked him whether there was any routine monitoring of the frequency of appointments of particular patients, or of the patients of particular consultants. He thought there would not be:

“There are no processes that I think that would flag, you’d have to be seeing someone so frequently that it was impacting on your work activity, so it was showing that you were doing more than others... I don’t see an easy way that there would be a red flag raised from that happening... The other thing that confounds the matter here, and I think in Cambridge as well, is what’s called ‘shared care’, where patients may have some of their treatment in the main centre and some in surrounding hospitals. I think if you were a member of staff, a nurse for example, working in the department, some people being seen more frequently than others, you wouldn’t necessarily clock that...”
12.5 All patients, even those who turn up on the day, should be entered into the system to show that they had been seen. The consultant conceded that very occasionally someone’s appointment might not be listed, and gave this example:

“If someone grabbed you in the corridor and said ‘I need a prescription’ and you say ‘Right okay, come on’ and just give it to them; it’s quicker than joining the queue if five people are there.

Q. If Mrs Smith rings up and says ‘I’m really worried about Fred, he’s been sick this morning, can I talk to you?’, would you say ‘Come in tomorrow morning to the clinic’, or would you say ‘Pop in and see me this afternoon because I’m here until five o’clock?’

A. Either.

Q. If she popped in to see you at five o’clock, would there be any record other than the note you made on the patient’s file?

A. Possibly not.

Q: When Mrs Smith comes in, would the receptionist put them in the diary, having come in?

A: At five o’clock they might not, they might have gone… But if you have someone who has rung up and said, ‘I need to see you to discuss this’, and they are not coming in as an emergency, say I knew I was going to be in the clinic until six o’clock and someone turns up at half past five, yes, it is possible that they could come in and not be logged.”

Comment

The need to provide a flexible and responsive service increases the likelihood that not all appointments will be recorded.
12.6 Patients move to adult services between the ages of 16 and 18, depending on their treatment needs, and there is a transitional service within adult services for children diagnosed between 16 and 18.

12.7 The consultant told us that once the children are in the transitional service they are usually seen on their own for conversations, and this is something that is also offered to children in the paediatric service from about the age of 12, although many continue to have their parents with them.

12.8 He explained his practice in relation to intimate examinations:

“Part of my physical examination would be to examine them lying down on a couch, behind a curtain, where I would listen to their chest, palpate their abdomen, and then examine the external genitalia. If it was a young child, certainly under eight, nine, I would want to have a parent in with me to reassure and comfort them.

Q. Behind the curtain?

A. Yes. If it was an older child who was becoming embarrassed, there are some boys who don’t want their mums to look at their bits, my practice would have been to just examine them myself with mum on the other side of the curtain. If it was a teenage boy, again, I wouldn’t usually do it with someone else there, although occasionally there are trainees there who will come in. Some boys are very embarrassed, understandably, by this, so an alternative is that you explain what you want them to do and get them to [do the examination themselves]. That’s fine if you are looking at development, but if you are worried about a recurrence of disease, then you need to physically get your hands on. So, I didn’t used to have chaperones, I think now I would, if I was going to examine the external genitalia, other than if I had got permission from the parent and the patient, then stepped behind the curtain with the parent in the room, and a teenager, I would bring in a chaperone...

... boys can have the option of being examined by a male doctor if they wish and girls by a female doctor if they wish, in those clinics we almost always have a mix,
so another thing that happens relatively frequently is that I’ll be called in by a female colleague to assess a young man’s testicles.”

12.9 We asked what would happen if a teenage boy asked to see the doctor on his own for a private conversation and then it turned out that an examination needed to take place:

Q. “Would you then call in the parent or carer to sit on the desk side of the curtain, or would you just carry on and do it?

A. No, I’d probably carry on and do it, but normally in those circumstances the parent would know that there was going to be a consultation.

Q. Also know that there was going to be the examination?

A. Well, it would depend on how it came out. I suppose an example, recently, a young man came to see me in clinic, completely unrelated to his tumour, ‘I have this problem, I need to discuss it…’ His mum knew that this was going to be discussed, I said ‘Well, I’d better examine you then’. I saw him and examined him, his mother was on the other side of the curtain, but if he had sent her out of the room I wouldn’t have called her back in, I would have examined him.

Q. How old was he?

A. Seventeen, I think.

Q. If he had been 14 would you have done the same?

A. It would depend on the maturity….I’d be far more likely to call someone in to chaperone me now than I would have been before, in the circumstances, and there are some circumstances where I positively do it. If it was a young woman, if I had to examine any young woman, who was 12 or beyond, where I had to listen to her chest, and had to undress her to do it, I would always have a chaperone, there would be no question that I would attempt that without.

Q. Would that chaperone be a parent, or a colleague?
A. I would usually prefer that it was a nurse, but there are circumstances where a parent would be obviously appropriate, again, it depends on what’s happening, and exactly what you’re needing to examine.”

Comment

This description suggests that the chaperone and transition practice at the PDU when Dr Bradbury was working there was in line with standard practice in at least one other paediatric oncology day unit.

Design of consulting rooms

12.10 We noted that the doors of the consulting rooms in the PDU had transparent glass panels, so that someone outside the room could see if the room was occupied without having to disturb anyone who might be in it. The panels were at adult head height, and so someone would have to be close to the door to see into the room to know if there was a chaperone while the curtain was drawn.

12.11 We asked staff at the trust if they thought the chaperone policy might be easier to monitor if there was a vertical glass panel the full height of the door, so that a passer-by could see into it fairly easily. The staff to whom we spoke were not convinced that this was a good idea, as they felt that it would reduce the privacy of patients or families who might be having a difficult conversation with the doctor.

12.12 The consulting rooms at Birmingham have tall, vertical, glass door panels, and the layout in the room was that the doctor’s chair faced the door and the patient and family chairs faced away from it. The consultant explained:

“The parents won’t be looking at the door, as the doctor you have the opportunity to do that so it means that people can signal you something’s happening. The other thing to say is that when you’re having a difficult conversation you should not be having that on your own, if it’s at all possible to avoid, it’s usually with a
nurse specialist of some sort as well, and there are two of you there supporting the family through that conversation.”

Comment

The Birmingham arrangement suggests that the staff on the PDU may be unnecessarily concerned at the privacy implications of having vertical glass panels in consulting room doors.

Recommendation

R10 The safeguarding leads and non-executive director with safeguarding responsibility should carry out an assessment of the value of having consulting room doors with vertical glass panels.

General paediatric outpatients

12.13 The nurse from the general paediatric outpatients department at the trust, Clinic 6, told us that the outpatient department ran clinics for a number of different specialities, all of which use the trust’s transition policy.

12.14 The PDU is quite deliberately kept physically separate from the other paediatric outpatient clinics, as the immune systems of the children and young people attending the PDU will very often be damaged by the treatment they are receiving, and therefore they must not be unnecessarily exposed to the risk of infection.

12.15 The nurse told us that, as far as she was aware, no child was ever seen in Clinic 6 on his or her own, unless it was in accordance with the transition policy.
Royal College of Paediatrics and the General Medical Council

12.16 We know that there are many reports of this kind and serious case reviews carried out by LSCBs, and we explored the extent to which relevant lessons learned were extracted from these reports and reviews and disseminated to those professionals who would find it useful in their work.

12.17 We spoke to the chair of the Royal College of Paediatrics and Child Health Committee on Child Protection. He told us that his committee considers these reports and reviews and occasionally publishes information from them on its website and in its newsletter which goes to all members. His committee is planning to do this more systematically, in order to ensure that relevant information reaches all the members of the college.

12.18 We asked him if there were any improvements in safeguarding that he would like to see, and he told us that, although he believes it is up to trusts to decide what safeguarding training is right for their staff, he would like to see a national curriculum and some nationally agreed guidelines on the nature and length of training that should be provided at the various levels the law requires. He considered that national guidelines on chaperone policies would also be useful.

12.19 We also spoke to members of the standards and ethics team at the GMC. They told us that the GMC has an inquiries and review team which, among other things, looks at inquiries and reports to see if they reveal areas where the GMC should be providing or improving guidance to their members. They have always done this to a certain extent, but the inquiries and reviews team, set up in the wake of the Mid-Staffordshire reports, enables the GMC to deal with such issues in a more systematic way than previously.

12.20 They explained that before they issue guidance on professional standards for doctors they have an extensive process of consultation, which in itself raises awareness of the subject matter. When guidance has been published, they have a range of communication channels for raising awareness amongst the profession, employers and the wider public. As well as their regular newsletter, they may use the media to publicise significant issues covered in the guidance, and their own regional liaison service and other outreach teams to run themed sessions with doctors, patient groups, local employers and others.
12.21 They also told us that they are linked in with other regulatory bodies, including the Care Quality Commission, in ways that allow them to share information and identify and act on issues of concern.

Recommendations

R11 The trust should invite NHS England, the Royal Colleges and Local Children’s Safeguarding Boards to consult on creating a national curriculum and/or guidance on safeguarding training.

R12 The trust should invite NHS England to consult on creating guidance on the areas to be covered and principles to be reflected in chaperone policies.

R13 The trust should invite NHS England to review the efficacy of its systems for disseminating lessons learned from investigations that are relevant to safeguarding patients.

Lessons learned from other relevant investigations

12.22 We have looked at a number of reports written after the discovery of the sexual abuse of patients by healthcare professionals. In this section we set out relevant findings and recommendations of these reports, and measure the suitability and effectiveness of the systems and processes at the trust by reference to them.

12.23 We also look at any ways in which these reports suggest Dr Bradbury’s behaviour should have raised concerns in his colleagues.

Report of the Clifford Ayling Inquiry by Dame Anna Pauffley, 2004

12.24 Clifford Ayling was a GP and hospital doctor who was convicted in 1998 of sexually assaulting women and teenage girl patients over two decades. Some of his victims had made complaints about his conduct which had been ignored, and in other cases they were
persuaded to withdraw their complaints. The assaults were carried out under the guise of necessary medical examinations, and consisted of inappropriate touching or examinations of his victims’ breasts or gynaecological organs.

12.25 The findings and recommendations of the inquiry included the following:

“Sexualised behaviour

In the course of our Inquiry, we heard allegations of a number of disturbing instances where Ayling’s behaviour was overtly sexual and broke the boundaries of the trust and integrity patients have the right to expect from their doctor. We have learnt even more of the long history of continuing unease that his approach generated amongst those who worked with him on a regular basis or were treated by him. His approach was described as being overfamiliar to sensitive and intimate examinations which bordered on the unprofessional and was distressing to both recipient and observer. We have adopted the phrase ‘sexualised behaviour’ to describe this. In the course of our Inquiry, we have found little if any published guidance for employing or regulatory authorities in either recognising or responding to ‘sexualised behaviour’. We believe that there is an urgent need to address this and ensure that all NHS employers and contracting organisations recognise and respond to such behaviour as vigorously as they would to allegations of sexual harassment. A consistent theme of the evidence presented to us was the interpretation placed on what they were told by healthcare professionals who were in a position at the time to take action on allegations about Ayling’s abusive and unacceptable approach to his patients. We recognise the magnitude of the breakdown in belief in professional integrity that to do otherwise would have represented for many of Ayling’s colleagues working within the ethical framework of the same profession. In effect, they recast what they heard into explanations which they could find acceptable and in so doing, deceived themselves and failed their patients.”

12.26 The report recommended that the Department of Health set up an expert group to develop guidance and best practice for the NHS on this subject. The group should take advice from experience of dealing with “sexualised behaviour” elsewhere in the public sector such as educational services and from healthcare systems in other countries.
Comment

This work was subsequently undertaken by the Council for Healthcare Regulatory Excellence (CHRE\textsuperscript{20}.)

12.27 It also recommended that local policies within all NHS trusts for reporting staff concerns (whistleblowing) should specifically identify “sexualised behaviour” as appropriate for reporting.

Comment

The evidence of our investigation is that, prior to concerns being raised by the family of Child X in November 2013, no professional had observed any sexualised behaviour by Dr Bradbury. At least one mother had felt uncomfortable about his behaviour on one occasion (see 10.28), but she had not raised her concern with anyone because she was not sure how to do so, and was also not sure whether what he had done was wrong.

Finding

F34 Professionals did not ignore or rationalise evidence of sexualised behaviour as they did not witness it; neither was it reported to them.

12.28 In the report there is a discussion about chaperoning, and a recommendation that:

“no family member or friend of a patient should be expected to undertake any formal chaperoning role. The presence of a chaperone during a clinical examination and treatment must be the clearly expressed choice of a patient. Chaperoning should not be undertaken by other than trained staff: the use of

\textsuperscript{20} The Council for Healthcare Regulatory Excellence. Since December 2012 this has become the Professional Standards Authority for Health and Social Care. It oversees statutory bodies that regulate health professionals in the UK and social care in England.
untrained administrative staff as chaperones in a GP surgery, for example, is not acceptable. However, the patient must have the right to decline any chaperone offered if they so wish.”

Comment

Dr Ayling’s victims were women or girls aged 16 and over, and the chaperoning referred to was only considered necessary for sensitive or intimate examinations. Chaperoning for children has different purposes and requirements, so the recommendation that the presence of a chaperone must be the clearly expressed wish of the patient or that the patient must have the right to decline any chaperone offered will not apply in the case of younger patients.

Findings

F35 The trust’s chaperone policy for children and young people did not comply with this recommendation, in that family members were routinely expected to act as chaperones when intimate examinations were taking place and on occasion we know that Dr Bradbury abused his patients when parents were taking this role.

F36 The trust’s current policy complies with the recommendation of the Pauffley report that only trained staff should act as chaperones when an intimate examination is taking place.

12.29 The report also recommends that:

“Beyond these immediate and practical points, there is a need for each NHS trust to determine its chaperoning policy, make this explicit to patients and resource it accordingly. This must include accredited training for the role and an identified managerial lead with responsibility for the implementation of the policy.”
Finding

F37 We understand that the trust has not made its policy explicit to patients and their families and have recommended that they do so.

Recommendation

R14 If the trust does not have a trained, accredited managerial lead with responsibility for implementation of its chaperone policy, it should consider creating such a role.

12.30 In 2007 the government published Safeguarding Patients: The Government’s response to the recommendations of the Shipman Inquiry’s fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries. (Shipman was the GP who murdered about 250 of his patients over a 20 year period, and Neale was an obstetrician who was struck off the register in Canada for incompetent performance but nevertheless managed to retain his registration and obtain employment in the UK for several years afterwards. Kerr and Haslam are referred to below).

12.31 The report details the actions the government planned to take in response to the recommendations of the various reports. Its response to the above recommendations in the Paulffley report on comprehensive guidance on chaperoning for PCT’s and primary health care professionals, covering these and other points, was issued by the Clinical Governance Support Team in June 2005\(^1\). The basic principles are applicable to health professionals working in all settings, but the government will discuss with the health professions regulators and with NHS Employers whether specific guidance on chaperoning in secondary care settings would be helpful.

12.32 There is a further recommendation in the Paulffley report that: “reported breaches of the chaperoning policy should be formally investigated through each trust’s risk management and clinical governance arrangements and treated, if determined as deliberate, as a disciplinary matter.”

\(^1\) Guidance on the role and effective use of chaperones in primary and community care (National Clinical Governance Support Team).
12.33 The *Safeguarding Patients* report responded to this recommendation: “The government agrees and will ask CHRE to draw this recommendation to the attention of all healthcare organisations as part of the suite of guidance described at para 6.4 above.”

**Comment**

*The suite of guidance referred to in para 6.4 related to boundary transgressions and sexualised behaviour in the context of the sexual and emotional abuse of psychiatric patients who were above the age of consent.*

*We have not been able to find any national guidance on this point.*

**Finding**

**F38** The current chaperone policy for children appears to be so restrictive that breaches will be commonplace.

**Recommendation**

**R15** Once the chaperone policy is revised to ensure it is workable in all situations, the trust should consider how best to enforce it.

12.34 The paulffley report refers to the inadequacy of the communication with patients during the criminal investigation into Ayling’s conduct, and recommends that guidance be developed by the NHS, regulators and the CPS for handling the criminal investigation of the behaviour of healthcare professionals. It also recommends that:

“...part of the guidance we have suggested SHAs [strategic health authorities] and the Department of Health develop for the NHS should specifically address a patient’s communications strategy and the involvement of local victim support services.”
Comment

The memorandum of understanding referred to at paragraph 7.35 created the guidance on how the NHS, CPS and regulators deal with criminal investigations of the behaviour of healthcare professionals.

Finding

F39 The trust has complied with the recommendations regarding communication and the involvement of local victim support services: its communication strategy is described in section 7, and its provision for patients or families to contact the NSPCC, with its specialist child abuse expertise, is a satisfactory alternative to involving victim support services.

12.35 Other findings and recommendations in this report were not relevant to the Bradbury case as they related to very different circumstances.

Report of the Kerr/Haslam Inquiry 2005

12.36 William Kerr and Michael Haslam were consultant psychiatrists working during the 1970s and 1980s at the same psychiatric hospital in York. Both men were convicted of indecent assault; their victims were female patients. In the subsequent inquiry, many other women came forward to complain of having been assaulted, and the inquiry accepted their accounts.

12.37 The inquiry took place many years after the events complained of, despite the fact that many of the victims had complained to professionals about the conduct of these two doctors at the time. Except in a very few cases, their complaints were ignored or dismissed by professionals who did not believe them, and in some cases were suppressed by professionals who chose not to pursue them. It was also the case that some professionals who did seek to take action on the complaints had their concerns ignored or dismissed.
12.38 The report identified organisational, cultural and structural failings, as well as failings in professional practice and individual failings. Some of the report’s recommendations specifically related to mental health services and the users of those services, but some have a wider application, and we here set out those that are relevant to the events at Addenbrooke’s.

“Managers, and mental health and social care professionals, must be left in no doubt that the breach of professional boundaries with regard to their patients (service users) is unacceptable, and must always be treated as harmful. Every effort must be made to prevent all patient abuse.”

12.39 The report identified education of all staff, promoting the obligation to speak out and promoting knowledge and skills as ways of achieving the change of ethos recommended above.

Comment

There is no evidence that Dr Bradbury breached professional boundaries. His offences were criminal acts committed under the guise of medical treatment.

Finding

F40 Our enquiry into Dr Bradbury’s behaviour revealed that staff were aware of boundary issues and the need to prevent patient abuse.

12.40 Kerr/Haslam recommendation:

“Patients should have a clear and well-publicised point of contact if they wish to raise a concern or make a complaint about a mental health or social care professional. PALS and complaints staff should be actively linked into a clinical governance and information-sharing network with regular access to data on performance issues drawn from such things as claims, patient satisfaction surveys, audit and peer review. PALS and complaints staff should have direct access to a
line manager at board level and to senior medical staff and they should be appointed at middle management level.

“The roles of complaints officer and PALS officer should be distinct.”

Comment

PALS is available to patients and families at Addenbrooke’s.

12.41 Kerr/Haslam recommendation:

“One of the referees in any job application should be the consultant who conducts the applicant’s appraisal, their Clinical Director, or their Medical Director. When appointments to the NHS are considered, references should be obtained from the three most recent employers and those references should be properly checked.”

Comment

This occurred in Dr Bradbury’s case.

12.42 Kerr/Haslam recommendation:

“Policies should be developed that enable health workers to feel able to disclose feelings of sexual attraction at the earliest stage possible without the automatic risk of disciplinary proceedings. Colleagues must also feel able to discuss openly and report concerns about the development of attraction/overly familiar relationships with patients. These policies should include all grade levels, including consultant.”
This recommendation is made in the context of sexual contact between male doctors and their women patients that would not have been problematic if it had taken place between consenting adults in an equal relationship. The circumstances are very different, therefore, from those in the Bradbury case. Nonetheless, the recommendation that the risk of inappropriate sexual feelings is one that should be openly discussed is one that has relevance to this case. We refer to it further at the end of the next section.

12.43 Kerr/Haslam recommendation:

“Mental health services should provide routine information to patients attending appointments on what to expect from a consultation with a mental health professional. This should apply to consultations in all settings, including home visits.

“Where physical contact forms part of the consultation, or where there is a risk of loss of consciousness, there should be a national policy and implementation guidelines to safeguard patients and staff and support the maintenance of appropriate boundaries.”

Comment

We have already made a similar recommendation for paediatric patients at the trust.

12.44 Kerr/Haslam recommendation:

“The mental health trusts, together with the primary care trusts, should draw up and distribute patient information leaflets, so that patients referred by their general practitioners to the care of a consultant psychiatrist can better understand what to expect, and the circumstances - if any - in which the patient
can expect to receive any physical examination or treatment from the psychiatrist. This leaflet information should include the following topics:

- when the patient can expect a physical examination by the psychiatrist;
- a description of boundaries, and what is and what is not acceptable behaviour by the psychiatrist;
- what the patient is likely to expect in the course of talking therapies (for example, questions and enquiries which some may consider too intrusive and intimate);
- what, if anything, is expected of the patient;
- the availability of trained chaperones and, if installed, the use of virtual chaperones;
- the contact details of the person to whom they may turn in confidence to discuss any issue that may give them concern before, during and after treatment.”

Comment

We have made a similar recommendation for paediatric patients at the trust.

An independent investigation into the conduct of David Britten at the Peter Dally clinic

12.45 The report into the conduct of David Britten at the Peter Dally clinic was published in 2008.

12.46 David Britten was employed as a nurse in the eating disorders service at the Gordon Hospital in London from 1980. He transferred as clinic manager to the Peter Dally clinic, a specialist eating disorders service, when it opened in October 1996. In March 2002 he was dismissed on grounds of professional misconduct.

12.47 Some patients had complained about his conduct before he was dismissed, and many more did so afterwards.
12.48 The investigation found that Britten had had numerous abusive relationships with patients over many years, many of them simultaneously, without detection by his managers or colleagues. His grooming of these patients was characterised by:

- choosing vulnerable patients;
- making patients feel special;
- speaking about his personal history and problems;
- making his patients emotionally dependent on him;
- separating clients from their families;
- undermining patients’ trust in colleagues; and
- encouraging dependence after discharge.

12.49 Colleagues did not suspect the extent of David Britten’s abuse even though many were concerned about his practice. Colleagues who did challenge him were variously bullied, victimised, threatened with legal proceedings and often driven out of the service by him.

12.50 Britten was the manager of the unit and used his position to run the clinic almost totally independent of the trust. Many of his colleagues were deeply concerned about his conduct, but others appeared to collude with it, or were frightened of confronting him. He did not comply with the requirements of supervision, and carried on seeing patients for therapy while denying he was doing so. He saw patients one-to-one in his office, which did not have a viewing panel, and he routinely locked the door during these sessions. Other staff had such sessions in interview rooms with viewing panels. He was well known for overriding the decisions of clinicians without consulting them. His victims believed that they were in an exclusive and loving relationship with him.

12.51 He was not charged with any criminal offences, as the CPS considered that there was insufficient evidence to do so.

Comment

The circumstances in this case are very different from those in the Bradbury case, in that Dr Bradbury was engaged in criminal acts under the guise of treatment, rather
than in abusive relationships; his colleagues had no concerns about his conduct; and patients and families made no complaints about his conduct.

Finding

F41 The nine recommendations in the Britten report are very specific to the facts of the case, focusing on how to conduct internal investigations, how to manage patient/professional boundaries for vulnerable patients such as those with eating disorders; the effective handover of information, particularly that relating to patient safety, when services are reorganised; the evaluation of risk in eating disorder services; ensuring the effectiveness of clinical supervision; multi-agency cooperation in investigations and the possibility of regulators having the power to refer individuals to the POVA register.

12.52 None of the findings has relevance to the facts of the Bradbury case.

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22 POVA - Protection of Vulnerable Adults Scheme - At the heart of the POVA scheme is the POVA list of careworkers who have harmed vulnerable adults in their care. People on the list are banned from working in a care position with vulnerable adults.
13. Meeting with Dr Bradbury

13.1 When we interviewed Dr Bradbury in prison, we asked him to comment on some of his actions at the trust, and his comments have been included in our report where those actions are described.

13.2 In correspondence before our visit we informed Dr Bradbury that it would help us in writing the “lessons learned” part of our report if he could give us his views on what might prevent others committing crimes such as his, or what might have stopped any such person continuing once he had started. Dr Bradbury agreed to discuss this with us.

13.3 He explained to us that he did not want to seek to excuse his behavior. He knew that what he did was wrong, and he is very sorry for the harm that he did. He was willing to talk to us in the hope that this would reduce the risk of other children being subject to harm in future.

13.4 He agreed with our suggestion that a prior description of any intimate procedure, together with the reasons for it and prior consent of an adult would be a barrier to abuse, as would more information to patients and families about what to expect on appointments.

13.5 He told us that after he had been arrested the police had given him the number of a confidential telephone service that men and women who had sexually abused children, or who were worried that they might do so, could call for advice.

13.6 The purpose of the telephone service was to help callers understand the serious harm they were inflicting or planning on inflicting, with a view to trying to prevent future abuse.

13.7 Dr Bradbury had known nothing of this service until after his arrest. He felt that if the service, or others like it, were more widely known, people might contact the service for advice on how to turn away from offending, as some offenders may not understand the extent of the harm they are committing or planning.
13.8 He pointed out that if he had sought advice from anyone who knew him, even before his offending began, he would probably have lost his job, which meant that this was not an option he considered.

Comment

Dr Bradbury was quite right in his perception that he would probably have lost his job if it had been known that he was having inappropriate sexual thoughts about his patients. If he had admitted to a counsellor or other professional that he had sexually assaulted his patients he would have lost his job, his career and probably his liberty, as such abuse would inevitably have been reported.

13.9 We asked Donald Findlater from the Lucy Faithfull Foundation about the value of such telephone services in preventing the sexual abuse of children. He told us about a scheme that the foundation runs called “Stop It Now”, which is a child sexual abuse prevention campaign, supported by a confidential helpline. The helpline is targeted at three primary caller groups:

- adult offenders and potential offenders, to help them to realise that their behaviour is harmful and wrong and to seek help so that they do not cause such harm (the first time or subsequently);
- adults concerned about the sexual thoughts or behaviour of another adult they know (often a family member or friend) - helping them with advice, information and support to take action that will protect a child; and
- parents and carers of children and young people with worrying sexual behaviour - helping them to recognise worrying behaviour in children close to them and providing information, support and advice about steps they can take to help prevent harm and protect all the children involved.

13.10 The helpline has between two and four lines operating during the week and takes about 700 calls per week. Forty-five per cent of callers are offenders/potential offenders; 26 per cent are adults (mostly female) worried about the sexual behaviour of an adult, typically in the family, and typically male; six per cent are parents with concerns about their children. Currently about 2,000 calls per month are missed.
13.11 Callers to the helpline are told that their call is confidential, and they do not have to give identifying information. But, if they do, and also reveal information about a crime committed or a child at risk, the Lucy Faithfull Foundation will pass that information on to statutory agencies. Those arrested typically feel their illegal behaviour is known to police, so reveal to the helpline who they are. Callers can be offered a ‘call-back’ with a specialist practitioner, where their circumstances are more complex or where a sequence of calls is expected to be needed to take them through a process of change for themselves or someone they are supporting.

13.12 The helpline is considered sufficiently valuable to receive funding from the Ministry of Justice, the Home Office, the police and internet service providers.

13.13 We asked Dr Ahluwalia what information is given to doctors and medical students about where they can turn if they are in difficulty, for instance with drugs, alcohol or gambling, and whether doctors or students are given any advice on where to seek help if they have inappropriate sexual thoughts about a patient or patients.

13.14 He told us that junior doctors receive information during their training about the resources available to them if they get into difficulty:

“We have pointers to sources of help that you can have, including the BMA [British Medical Association], the Medical Defence Unions, your GP, counselling services, psychology services, and also the places like NCAS [National Clinical Assessment Service] and the GMC have a self-referral pathway.”

13.15 We suggested that there could be some value in proving information on Alcoholics Anonymous, Gambling Anonymous, Narcotics Anonymous and helplines such as that at the Lucy Faithfull Foundation, and Dr Ahluwalia agreed that this was worth considering, possibly across the NHS.

13.16 As mentioned earlier The CRHE was asked to develop guidance on boundary violations and sexualized behavior, as recommended by the Ayling and Kerr/Haslam reports. It did so, with guidance for doctors, medical students, patients, regulators and those responsible for the education and training of doctors and medical students.
January 2008 it produced a report *Learning about sexual boundaries between healthcare professionals and patients: a report on education and training*.

**Recommendation**

**R16** The trust should consider how best to inform doctors and medical students of the help available to them if they have inappropriate sexual thoughts about patients. It should also discuss with NHS England whether national guidance should be issued.

**13.17** One of our experts has suggested that psychometric testing at an early stage in students’ or doctors’ careers could help them to choose areas that develop their strengths rather than accentuate their weaknesses.
14. Conclusion

14.1 In considering what lessons can be learned to protect children in future, we are in some difficulty if we simply focus on Dr Bradbury, as his offences were specific to him and his circumstances, and lessons learned from him will not necessarily protect children from abuse from other health care workers in other settings and situations.

14.2 Some of the people we have interviewed are of the view that whatever processes are in place, an abuser will find a way round them. This view fits in with the commonly held perception that child sex abusers are driven to commit their offences by their perverse sexual preferences, and that they compulsively seek out opportunities to gratify their desire.

14.3 We spoke to Donald Findlater, director of research and development at the Lucy Faithfull Foundation. He is of the view that there are steps that can be taken to deter some abusers, many of whom are sufficiently in control of themselves to avoid situations where abuse is likely to lead to discovery and punishment. The steps can be broadly summarised as making it more difficult for a potential offender to commit offences and making it more likely that offences will be discovered.

14.4 This view is supported by Dr Bradbury’s claim that if one of his patients objected to a proposed (and supposed) intimate examination, he did not proceed. Whatever stories Dr Bradbury may have been telling himself about what he was doing, he knew that it was wrong and criminal, and he reduced the risk of being discovered by avoiding any challenge.

14.5 In principle it would be possible to prevent abuse of patients by ensuring that patients are never seen on their own in any circumstances, but such a solution is completely impracticable. Acute hospitals are characterised by the presence of sick or injured, and therefore vulnerable, people, many of whom need nursing care and other interventions involving physical contact, including intimate contact. A situation in which a nurse has to be chaperoned changing a baby’s nappy, or helping an accident victim use a bedpan, would not only be impossibly expensive but also very destructive of the trust that currently, and quite rightly, is at the core of the relationship between patients and those who treat and care for them professionally.
14.6 There has to be a balance between trusting professionals to behave professionally and having systems in place to prevent poor performance of any kind, whether incompetent, negligent or deliberate and criminal.

14.7 The situation in children’s services adds a layer of complication, as parents and carers of sick children will be constantly on the premises, including overnight, where professional oversight will sometimes be very limited.

14.8 The trust staff we interviewed explained the pressure that they work under, with ever increasing workloads. The growing workload is an indicator of success, with more children surviving for longer than ever before. The focus of the staff is to provide the best possible treatment for their patients, and they rely on families to provide the emotional and practical support that these dangerously ill children need. If resources have to be diverted to providing professional chaperones on C2 and the PDU, logic dictates that the same would have to apply in the other paediatric outpatient settings at CUH, and at similar settings elsewhere in the NHS.

14.9 As all but a tiny number of doctors can be entirely trusted with their patients, this means that in almost all cases this type of chaperoning will be unnecessary and as these resources will have to come from elsewhere in an already financially overstretched NHS, it is difficult to see how such diversion of resources could be justified to deal with the real, but very remote, possibility of an abusive doctor.

14.10 We have made recommendations on record-keeping, monitoring of the treatment of individual patients, safeguarding training, amending policy, improving security, supporting doctors in difficulty and sharing lessons learned across the NHS. All these recommendations have a particular application to the paediatric haematology and oncology service as a result of Dr Bradbury’s crimes, and many of them also have a wider application across the trust and in other trusts and the NHS generally.

14.11 If the trust and the NHS want to raise the safeguarding standard to cover all children in all situations and all settings, a culture change is needed, centring on the empowerment of patients, parents and carers.
14.12 Empowerment covers two quite different processes: the first is when one person empowers another to do something by giving them permission to do it and the second is when someone feels empowered within themselves to act.

14.13 In talking to staff during our investigation we found that staff involved patients and their families in treatment decisions and expected and were willing to answer questions by patients and their families: the staff empowered them to do so.

14.14 However the families gave vivid evidence of the extent to which it did not occur to them to question what the doctor was saying or doing, or, if it did occur to them, the difficulty they had in doing so.

14.15 We therefore consider that our recommendations on providing information, encouraging questioning and enabling discussion online between staff, patients and families to be recommendations most likely to improve safeguarding in any setting where they are adopted. The discussion is particularly important as it ensures that policies and practices remain under active consideration over time, and that new patients and their families can see how staff respond to queries or opinions put forward by existing patients and families.

14.16 Developing the best way to do this without damaging the trust between staff on the one hand and patients and their families on the other will require thought and care, but there are already examples of good practice that can be drawn upon.