STATES OF JERSEY

COMMITTEE OF INQUIRY INTO THE DEATH OF MRS. ELIZABETH ROURKE (P.76/2009): COMMENTS

Presented to the States on 16th June 2009
by the Minister for Health and Social Services

STATES GREFFE

2009 Price code: B P.76 Com.

COMMENTS

Background

Proposition P.76/2009 seeks to establish a Committee of Inquiry into the circumstances surrounding the death of Mrs. Elizabeth Rourke and to discontinue the independent investigation conducted by Verita. I do not support this proposition. It is unnecessary in that it will provide no more information or understanding. The family of Mrs. Elizabeth Rourke is satisfied with the investigative process, including the Verita independent review. It will allow everyone to discover the truth and to enable lessons to be learned.

Following the tragic death of Mrs. Elizabeth Rourke in October 2006, there was a lengthy criminal investigation conducted by the States of Jersey Police. This resulted in Dr. Moyano being charged with manslaughter. In the Royal Court trial that followed in January 2009 before Sir Richard Tucker Q.C., the Jury found Dr. Moyano not guilty. Following the completion of this trial, the former Minister for Health and Social Services, Senator Perchard, sought advice from the Chief Executive of the National Patient Safety Agency (NPSA) which is the U.K.'s leading authority in monitoring patient safety. He did so independently of the Health and Social Services Department. As a result of this advice, Senator Perchard commissioned Verita, an independent organisation, to undertake a thorough investigation of the incident.

Verita's report will be provided direct to the Minister without editing by, or involvement of, the Department. This is to be followed, upon completion, by the Inquest conducted by the Deputy Viscount.

Taken together, the criminal investigation, Court Hearing; the Verita investigation and report; as well as the independent Inquest, will establish a very clear picture of all of the matters surrounding this tragic case.

Contained within the proposition are allegations based upon factually incorrect information. This comment corrects the factual errors and provides the rationale for opposing the proposition.

(1) The actions of Senior Management with regard to this incident.
(2) The Verita Investigation.
(3) A Committee of Inquiry.

(1) The actions of Senior Management with regard to this incident.

(i) It is suggested in the proposition that the Consultant Anaesthetist who cared for the patient in the final hours of her life was appointed as the internal case manager for the Serious Untoward Incident (SUI) investigation. **This is incorrect.** The Consultant Anaesthetist who cared for the patient is **not** the same Consultant Anaesthetist who led the internal SUI investigation.

(ii) The proposition includes in the Appendix an e-mail exchange between managers which Senator Syvret believes: "*have every appearance of being a co-ordinated attempt to conceal the truth,"*

This e mail exchange does **not** relate to the internal SUI investigation or to the independent investigation by Verita. It relates to a separate process concerning potential acts and omissions of an employee of Health and Social Services. I can find no evidence of an attempt to conceal information from the former Minister or from any party, and the e-mail from the former Minister to a Consultant attached in **Appendix 1** would lend further weight to this view.

(2) The Verita Investigation

The terms of reference for the Verita investigation are attached in **Appendix 4**. They were developed after discussions with the Minister for Health and Social Services, the Health and Social Services legal adviser and the Medical Director and the Director of Nursing and Governance. They were shared with Mr. Rourke in draft form and accepted by the Health and Social Services Department. They cover many of the terms of reference proposed by Senator Syvret. Verita operate independently of Health and Social Services and will report directly to the Minister.

(i) Since my appointment, I have obtained independent references regarding Verita and am confident about their independence and integrity. Their reputation for conducting complex and high-profile investigations and reviews is evidenced by their involvement in reviewing the healthcare received by Baby P in the tragic events in London. They have also investigated the Board leadership and governance of Maidstone and Tunbridge Wells NHS Trust following the deaths of 90 patients from Clostridium difficile infection. This work was commissioned by the chairman of the NHS South East Coast – the responsible strategic health authority – after a recommendation by the Healthcare Commission and Verita's report has subsequently been shared across the NHS, with local organisations taking action in line with the findings and recommendations.

(ii) I am satisfied by the appropriateness and rigour of the current independent investigation and the fact that its terms of reference are in keeping with investigations into similar cases commissioned on the mainland.

(iii) I have met, independently of officers, with the investigators from Verita, as has a member of the deceased's family. We are both supportive of Verita's investigative process. We are frustrated by attempts to divert and delay the current process.

(iv) The terms of reference for the investigation are in accordance with Serious or Untoward Incident policy and focus on systems and patient safety. They do not preclude any separate action being taken by the Health and Social Services Department (see **Appendix 2** – SUI Policy 2005 excerpt).

(v) The current independent investigation is at an advanced stage. Two-thirds of the formal interviews with clinicians and managers have been completed, and Verita invites anyone who has anything to say relevant to the terms of reference to give evidence to the investigation, including Senator Syvret. A number of people have already taken up this opportunity.

(vi) This rigorous investigation is making good progress, is receiving high levels of co-operation from interviewees, and moreover it is supported by the family of the deceased. It will be completed by the end of September 2009. I will ask

Verita to send the first draft of the report to the Greffier of the States of Jersey to maintain independence. A copy will then be sent to the Deputy Viscount so that the Inquest can proceed. I intend to provide Mrs. Rourke's relatives with a full copy of the report and will also forward a copy to the Chair of the Health and Social Services Scrutiny Panel in confidence. Following this, I will release the recommendations of Verita's report into the public domain.

(3) A Committee of Inquiry

The Royal College of Obstetricians and Gynaecologists does not undertake investigations of this sort; however Verita have appointed Mr. Julian Woolfson, from the Royal College of Obstetricians and Gynaecologists, as their adviser. The Care Quality Commission (CQC) rarely investigates cases relating to a single patient unless there are implications for the NHS as a whole. The CQC would expect the responsible authority to commission the kind of investigation that is already underway (see **Appendix 3**).

Senator Syvret proposes that the Committee of Inquiry will cost no more than the one being undertaken by Verita.

> *"I do not know what the cost of this investigation will be. What can be said with confidence is that it will certainly be no more than H&SS propose to spend on their preferred firm".*

Whilst the search for truth does not have a price tag, I must correct Senator Syvret's statement. A conservative estimate for such an Inquiry could run into millions of pounds. Should this proposition be supported, then in reality the States of Jersey would have little choice other than to appoint a Queens' Counsel (Q.C.) or equivalent and junior counsel to conduct the investigation supported by a panel of 2 or 3 people. A Q.C.-led investigation typically takes between 18 months and 3 years to complete.

Putting aside the costs, the important issues are that a public inquiry would be unlikely to –

- reveal anything not already covered by the police investigation, the court case, Verita's independent investigation or the Inquest which will take place once the current investigation has been completed;

- meet the long-term aim of improving the quality and safety of health care for local people.

For these many reasons, I do not support this proposition. Although my thoughts remain with the family at this time, whose sorrow and anguish on their sudden loss is hard for anyone to contemplate, my primary concern must be patient safety.

APPENDIX 1

E-Mail exchange between Minister and certain H&SS Consultants

-----Original Message-----
From: Stuart Syvret
Sent: 05 February 2007 16:12
To: xxxx xxxxxx
Cc: xxxx xxxxxxx
Subject: xxxx xxx
Importance: High

Dear xxxx

I have just received your letter concerning XXXX and his continuing suspension. I will reply in detail soon, but in the interim you and your colleagues can rest assured that I am constantly kept informed as to the status of enquiries. I share your concerns and I certainly hope these proceedings can be resolved speedily. This view is shared by xxxx x and his team. We are all aware of the pressures that xxxx's absence are causing. I will again talk to xxxx about this to see if there is anything we can do to help with the workload. We certainly don't want excessive pressure on xxxx at this time.

I will send you a substantive response to your letter in the next couple of days. Sorry I cant reply immediately, but as you may have seen, I'm rather busy at the moment.

Regards

Stuart

APPENDIX 2

Excerpts from
The States of Jersey Department for
HEALTH and SOCIAL SERVICES
Management of Serious Untoward Incidents
August 2005

Policy statement

Serious untoward incidents are traumatic for all those involved, whether patients, clients and relatives, staff, contractors or members of the public. It is not the intention for Health and Social Services to seek out people to unfairly blame, but to understand their organisational causes so that changes can be implemented to improve the safety and quality of services.

For this reason disciplinary action will not be instigated against any member of staff involved in or reporting any type of incident ***except*** *where there is evidence of*

- *Deliberate, malicious or criminal intent*
- *Serious professional misconduct*
- *Failure to improve performance after counselling or training*

APPENDIX 3

E-Mail received 10/6/09 from Head of National Inspection and Assessment Care Quality Commission

I can confirm that I am familiar with Ed Marsden and the work of Verita over the last few years - during which time I was Head of Investigations for the Healthcare Commission (until the establishment of the Care Quality Commission on 1st April 2009). Whilst I have never had the need to commission Verita's services directly, I am familiar with their work and have always been extremely impressed with the professionalism of the organisation and the quality and timeliness of their reports.

I consider Ed to be extremely knowledgeable, reliable and constructive - and I could think of no better organisation to undertake this sort of work on your behalf**.**

I trust that this is helpful but please do not hesitate to call if there is anything you would like to discuss.

Regards,

Nigel

Nigel Ellis

Head of National Inspection and Assessment

Care Quality Commission

Finsbury Tower

103-105 Bunhill Row

London EC1Y 8TG

APPENDIX 4

Verita Investigation Terms of Reference

States of Jersey Health and Social Services

Independent investigation into the care, treatment and management of Mrs. Elizabeth Rourke

Commissioner

The Minister of Health and Social Services, States of Jersey, has commissioned this independent investigation as part of his general obligations to ensure the safety of health services and improve the quality of care for patients. The investigation has no disciplinary remit and will not consider the acts and omissions of individuals. Rather it will provide a narrative explanation of the incident and consider organisational systems and processes.

Terms of reference

The purpose of the independent investigation is given below.

- Examine the care, treatment and management of Mrs. Elizabeth Rourke from her related GP referral up until the start of the police investigation.

- Review the main actions taken by the health and social services department in response to the death of Mrs. Elizabeth Rourke including its own interim internal investigation. This will include establishing whether or not there are any significant omissions to the investigation and, if so, exploring these.

- Review progress made against the recommendations of the interim internal investigation.

- Identify any further actions that the Health and Social Services department should take to improve the safety and quality of health services.

- Provide a written report with recommendations to the Minister.

Approach

The investigation team will carry out its work by reviewing relevant documentation and, where the team considers it necessary, interviewing key staff in private to enable people to speak freely. The team will follow established good practice in the conduct of the work e.g. by offering interviewees the opportunity to be accompanied and to comment on the transcripts of their interview.

The team will take account of the views of Mr. Rourke and Mrs. Rourke's family in the conduct of their work.

Where appropriate the team will share information with those conducting other related investigations. They will report immediately any significant concerns to the Health and Social Services Minister.

Investigation team

The investigation will be carried out by Dr. Sally Adams, Derek Mechen and Ed Marsden supported by relevant expert advisers.

Timetable

The investigation team will aim to complete their work by September 2009.

Publication

The Minister will publish the outcome of the investigation and any recommendations that may arise.

Senator James Perchard
Minister of Health and Social Services
13th March 2009