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INVESTIGATIONS – REVIEWS – INQUIRIES

An independent investigation into the care, treatment and management of Mrs Elizabeth Rourke

A report for
the Minister for Health and Social Services, States of Jersey

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1. Introduction

1.1 This report provides an independent account of the circumstances leading to the death of Mrs Elizabeth Rourke in the day surgery unit at Jersey General Hospital on 17 October 2006. It reports on the incident and the court proceedings in January 2009 when Dr Dolores Moyano faced a charge of gross negligence manslaughter. It describes the internal investigation carried out by hospital management in 2007 and the progress in implementing changes and improvements to hospital systems and processes. It makes conclusions about the wider causes of Mrs Rourke's death and proposes recommendations.

1.2 Mrs Rourke died at 6.25pm on 17 October 2006. She had been admitted for routine gynaecological surgery – a hysteroscopy for the removal of a possible polyp - and was expected to go home that day. She was the ninth patient on the morning list. She was a public patient under the care of Mr John Day, consultant obstetrician and gynaecologist, at the time of her death.

1.3 Mrs Rourke was a staff nurse at Jersey General Hospital and worked on Beauport ward. She had been employed in the hospital since 2002.

1.4 Mrs Rourke died from complications of massive blood loss. This followed the perforation of her uterus and injury to her left common iliac vein during surgery.

1.5 The health and social services department (HSSD) informed States of Jersey police of Mrs Rourke's unexpected death on the evening of 17 October. Initially police investigated on behalf of the Deputy Viscount (coroner).

1.6 Mr Day was advised to stay away from work and was subsequently formally excluded on 23 October by Mr Mike Pollard, at that time chief officer of HSSD. Mr Day remains excluded at the time of writing.

1.7 The death became a criminal investigation on 23 October and eventually Dr Moyano became its focus. She carried out the surgical procedure on Mrs Rourke on 17 October 2006 just after Mr Day had left the operating theatre. Dr Moyano was charged with gross negligence manslaughter on 27 September 2007 and tried at the Royal Court on 5 January 2009. She was found not guilty on 27 January 2009.

1.8 Mrs Rourke's unexpected and untimely death was devastating to her husband who works as a staff nurse on Portelet ward at Jersey General Hospital. It has also had a profound impact on Mrs Rourke's family and her professional colleagues at the hospital. The hospital has a reputation for providing safe care and the death of a patient in such circumstances was shocking. The death was the first on the day surgery unit. The tragedy was compounded by the fact that the hospital's own investigation of Mrs Rourke's death was restricted by the criminal process.

1.9 After the criminal trial Senator Jim Perchard, then Minister for Health and Social Services, announced an independent investigation into Mrs Rourke's death. Its purpose was to give a full account of the incident, review the hospital's internal investigation and make further recommendations about how patient safety could be improved. The minister asked Verita to conduct the investigation. He also wrote to Mrs Rourke's husband Bob to explain the purpose of the work.

1.10 Verita is a consultancy specialising in the management and conduct of investigations, reviews and inquiries in public sector organisations. Ed Marsden, managing director of Verita, Derek Mechen, director of client work and Lucy Scott-Moncrieff, associate, carried out the investigation. Mr Julian Woolfson, consultant obstetrician and gynaecologist adviser at the Royal College of Obstetricians and Gynaecologists (RCOG) and Verita associate has provided expert medical advice. All have wide experience of public services and conducting investigations. Dr Sally Adams was part of the investigation team at the outset. She stood down for personal reasons unconnected with the investigation.

1.11 We have had the benefit of the experience of Terry Hanafin CBE, until recently the chief operating officer for NHS London, who has acted as an adviser. Dr Jean-Pierre van Besouw, consultant cardiothoracic anaesthetist, St George's Hospital London, was nominated by the Royal College of Anaesthetists to provide expert advice. Mr Will Butcher, consultant vascular surgeon at the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and visiting consultant to Jersey General Hospital provided us with an opinion about matters concerning vascular surgery. Mr Butcher has left Bournemouth to take up a post abroad.

2. Terms of reference

Commissioner

2.1 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.

2.2 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.

2.3 The full terms of reference for the investigation appear at appendix A at the back of the report.

2.4 We provided a two-page private letter to the director of nursing and governance in May 2009 outlining progress with the investigation and identifying a small number of issues for the Minister and the management team to consider. We sent a copy of the letter to Tom Gales, our liaison officer from the Chief Minister's department, on 24 June.

2.5 Deputy Anne Pryke, who was elected Minister for Health and Social Services in late April 2009, reconfirmed the nature of the investigation in a meeting with us that month.

2.6 On 29 May 2009, Senator Stuart Syvret tabled a proposition in the States Assembly calling for the investigation to be stopped and a committee of inquiry set up in its place. States members debated this proposition in mid-June and agreed that the investigation team should make a presentation to them. Three members of the team appeared before States members on 24 June 2009 to give a presentation and answer questions. Members debated and voted on the matter on 30 June and 1 July and agreed by 35 votes to 15 that the investigation should continue.

2.7 After the presentation and the debate the minister wrote to us on 2 July and clarified and expanded on aspects of the terms of reference and her expectations about publication and the implementation of any recommendations. She invited us to produce an addendum to our report. The minister's letter is at appendix B.

2.8 In conducting the investigation we did not and do not challenge the verdict of the Royal Court.

3. Executive summary and recommendations

The incident

3.1 Elizabeth Rourke died on the evening of 17 October 2006 as a result of a medical accident after a routine hysteroscopy in the day surgery unit at Jersey General Hospital. She worked at the hospital as a staff nurse on Beauport ward and had been referred by her GP to Mr John Day, consultant obstetrician and gynaecologist.

3.2 Dr Dolores Moyano, a locum, was assisting Mr Day with his day surgery list. In trying to remove what she believed to be a polyp, she perforated Mrs Rourke's uterus and her left common iliac vein causing massive blood loss.

3.3 The medical and nursing staff found it impossible despite their best efforts to repair the vein and save Mrs Rourke's life.

Scope of the investigation

3.4 We built up a detailed picture of what happened on 17 October. We examined Dr Moyano's recruitment and employment along with some of her actions and opinions. She declined our invitation to talk to us.

3.5 We had access to a statement she made after Mrs Rourke's death, the transcripts of her interviews with the police, the contents of her personal file held in the HR department, the hospital records of the patients on whom she operated, her work rotas and the assertions she made through her advocate at her trial, where she did not give oral evidence. Some of this information is contradictory. These contradictions are laid out in this report and may ultimately be resolved by the General Medical Council which is to hold a hearing into her fitness to practice.

3.6 Our terms of reference go beyond consideration of Dr Moyano's activities. We found long-standing organisational weaknesses, contributory factors and failed organisational barriers that may have contributed to Mrs Rourke's death and made for an unsafe patient environment in the hospital on that day.

The hospital

3.7 Jersey General Hospital has 270 beds and more than 2,000 staff. It is the only hospital on the island. It is popular with patients and provides acute care to 91,000 residents and to visitors. It carries out about 11,000 surgical operations a year. It cannot rely on having specialist services close at hand, unlike a district general hospital on the mainland.

3.8 About 40 per cent of Jersey's population has private healthcare insurance. Consultants are encouraged to carry out private practice so long as public patients do not have to wait longer than three months for care and treatment. The hospital's facilities are routinely used for private care and operating lists are often a combination of public and private patients with the split usually 70:30.

3.9 No elective vascular surgery (arterial surgery) is carried out on the island and all 'fit' patients who present with emergency conditions, for example aortic aneurysm, are transferred by air ambulance to Bournemouth. The hospital in Jersey has dealt successfully with vascular emergencies in the past, including one involving a young patient a year or so before the incident involving Mrs Rourke.

The obstetrics and gynaecology department

3.10 The obstetrics and gynaecology department provides a full obstetrics and gynaecology service. The department's range of services is excellent for a small general hospital serving an adult female population of about 35,000.

3.11 The health and social services department employed three full-time consultant obstetricians and gynaecologists in 2006: Mr John Day, Mr Neil MacLachlan, and Dr Fiona Nelson. All three consultants carried a general obstetrics and gynaecology workload and also managed a sizeable private workload. Many of those we interviewed volunteered their views on the three consultants. The common view was that each consultant was clinically able and committed but that they worked as individuals

rather than as a team. The evidence suggests that the junior and middle-grade doctors worked together harmoniously.

3.12 The department was heavily reliant on locums in 2006, using a total of 643 locum days, nearly half of them at consultant level.

Dr Dolores Moyano

3.13 Dr Moyano qualified as an obstetrician and gynaecologist in Spain and worked there as a consultant, specialising in fetal medicine but also carrying out all the tasks of an on-call obstetrician and gynaecologist.

3.14 She obtained registrar posts in England in prestigious units, working in fetal medicine. Her referees from these units thought well of her, although they could not comment on her general obstetrics and gynaecology skills. The reference forms were not detailed or robust enough to ensure that useful information would be provided about Dr Moyano's suitability for the locum post for which she applied.

3.15 Surgery involves high risks and even expert surgeons can make fatal errors. The fact that Dr Moyano made such a mistake does not prove that she did not have the necessary expertise to carry out the procedure.

3.16 Dr Moyano worked at Jersey General Hospital at various times as both a locum registrar and a locum consultant. She was recruited by HSSD to act as Mr MacLachlan's locum to cover his on-calls in August and early September 2006 while he was on light duties after sick leave. She had also agreed to provide locum cover to Dr Nelson in October and to Mr MacLachlan in October/November and in December. In October 2006, including 17 October, she was locum for Dr Elfara, a registrar at the hospital.

Mr John Day

3.17 During Dr Moyano's trial Mr Day was strongly criticised for leaving Dr Moyano to carry out the procedure and for his subsequent conduct on 17 October. We have examined these criticisms in detail, and, in the main, do not agree with them.

The factors that contributed to Mrs Rourke's death

3.18 It is not possible to determine whether Dr Moyano was suitable for the locum consultant posts she was offered by HSSD. If she was, then the damage to Mrs Rourke's iliac vein was an accident for which no one but Dr Moyano can be held responsible. The General Medical Council hearing should determine whether she was suitable and the nature of any responsibility.

3.19 On the other hand, if Dr Moyano should not have been employed or re-employed as a locum consultant, the factors that allowed her to work at the hospital also contributed to Mrs Rourke's death.

3.20 The fact that we have not been able to determine whether Dr Moyano was suitable for the posts she was given indicates that the hospital systems of risk assessment and risk management were inadequate.

3.21 We think the following factors may have contributed to Mrs Rourke's death and that they did contribute to an unsafe patient environment.

Latent factors or organisational pre-conditions

- Despite the dedication and skill of many of its staff, in 2006 the hospital had an underdeveloped culture of patient safety and governance. The evidence for this is, for example, the relative lack of policies and procedures, an unwillingness to report serious incidents and a blame-oriented environment.

- The ‘distant’ senior management team did not engage well with senior medical staff or provide sufficient leadership to the organisation.

- Managerial focus on the day-to-day operation of the hospital was under-developed and clarity about accountabilities, for example the identity of the manager to whom consultant medical staff reported, was lacking. The medical management structures were relatively unsophisticated. For example, appraisal and job planning for consultants had barely taken root by this point.

- There was a growing reliance on locum medical staff, many of whom were no longer the tried and tested individuals of previous years. This was part of a wider national problem about medical staffing. Most overseas doctors specialising in obstetrics and gynaecology who come to the UK want to gain membership of the Royal College of Obstetricians and Gynaecologists (RCOG), become consultants and settle. Opportunities to do so in Jersey were limited and this is likely to have deterred many doctors from applying for training posts. As our analysis shows, the obstetrics and gynaecology department was heavily dependent on locums.

- The hospital had no robust policy for recruiting locum medical staff, including expectations about what to look for in references and a clear division of responsibility between HR medical staffing officers and consultant medical staff about the appointment of locums. The reference form in use was inadequate.

- The lack of a written policy on the procedure for recruiting locum medical staff resulted in no requirement for formal appraisal on arrival, with documentation to go to human resources; no policy on who saw references and no policy on sharing CVs.

- The hospital had no robust process for induction and early appraisal of the capability of locum medical staff. This led to an assumption that suitability for one locum post implied suitability for all others at the same or more junior levels.

- The long-standing culture of the obstetrics and gynaecology department was of individual rather than team work. The strong impression is of senior practitioners

working in relative isolation. This did not allow for regular and timely communication between the three consultants.

- Gynaecology day surgery unit lists were overloaded. The management team appears not to have challenged this.

- Communication between individuals and departments was generally poor.

Contributory factors to the incident on 17 October

- The poorly constructed reference form resulting in an ambiguous response from referees about whether they thought Dr Moyano was unsuitable for the post of locum obstetrics and gynaecology consultant or simply did not know whether she was suitable.

- Failure of a consultant in the department to review the references of Dr Moyano after she was appointed and in the context of her induction.

- No proper appraisal of Dr Moyano on her arrival in post.

- HR contracting Dr Moyano to fill other vacancies in the obstetrics and gynaecology department without checking this with the obstetrician and gynaecology consultants. Dr Moyano appears to have been appointed in August 2006 to cover for Dr Nelson simply because she was available. By September she was established as the locum of choice.

- Dr Moyano's language difficulties. Analysis of the reported incidents points to her having problems communicating with colleagues and patients.

- Late publication of the obstetrics and gynaecology middle-grade duty rota leading to last-minute changes to the deployment of middle-grade staff. A misunderstanding between Mr Day, Dr Williams (a staff grade in the department)

and Dr Moyano about the need for Dr Moyano to be in theatre and the nature of her role.

- As a result of annual leave, no consistent anaesthetic cover for the morning list, possibly affecting the atmosphere and working environment in the theatre.

- Having no diagnostic hysteroscope on the theatre tray.

- Dr Moyano deciding to continue with a clinical procedure if she had doubts about her ability (her experience in hysteroscopic resection is unclear from the evidence).

- Dr Moyano failing to tell Mr Day that she had seen bowel and that electricity had been used in the procedure.

Barriers that failed (before and after the event)

- Organisation of the theatre instrument tray so that a resectoscope was available to Dr Moyano without those who prepared it knowing whether she could use it.

- The interim serious untoward investigation – designed to help the hospital learn and improve – has not been acted on with sufficient vigour. A number of factors appear to have played a part in this:

    - the report itself appears to have been the subject of internal discussion and amendment.

    - the obstetrics and gynaecology department and possibly others did not appear to know about the amended version of the report until 2009.

    - the chief officer and deputy chief officer have not been able to oversee its implementation (Mr Pollard because he did not get involved for fear of a

conflict and Mr Jouault because of his secondment during the crucial period of 2008).

- the management team has been distracted by the continuing exclusion of Mr Day.

- no single person being given responsibility for overseeing the implementation of the recommendations.

Conclusion

Our investigation has shown that Jersey General Hospital is a much-loved and appreciated part of island life where many skilful, hard-working and dedicated people work. Some of the problems we found result from internal weaknesses. Others have their roots in the hospital's particular circumstances of being isolated both geographically and organisationally. Concerted efforts by staff at all levels and all backgrounds will be necessary to ensure that the hospital maintains its position in the affections of the people of Jersey and to restore the hospital as an enjoyable and stimulating place to work and a safe environment for patients.

Recommendations

3.22 The following recommendations are developed from our findings and conclusions in this report and from our addendum. They relate not only to Mrs Rourke's care, treatment and management but also – as our terms of reference asked us to do – to further actions HSSD should take to improve the safety and quality of health services. Some of the recommendations may have already been acted on but we include them for completeness.

3.23 We make recommendations under eight headings:

- The management of the hospital
- Maintaining and enhancing a patient safety culture
- Tackling staffing
- The operation of the obstetrics and gynaecology department
- The use of locums
- Day surgery unit and theatres
- Information
- Managing external relationships.

3.24 Recommendations we consider to be urgent are marked as such in ***bold italics***.

The management of the hospital

- The chief officer should appoint a hospital director to manage the hospital day to day. This person would act as the focus for all hospital matters. There should be clear separation of responsibilities between the chief officer (strategic) and the hospital director (operational). ***Urgent*** **(R14 on page 193)**

- The chief officer should appoint a new medical director in advance of the current medical director's retirement so as to ensure a smooth transition. **(R15 on page 194)**

- The new medical director should review the roles, responsibilities and authority of clinical directors and leads with a view to strengthening their part in running the hospital. These should be set out in job descriptions and reflected in individual job plans. **(R16 on page 196)**

- The chief officer in conjunction with the committee chair should develop written terms of reference for the medical staff committee to support its role as a key part of the hospital infrastructure. **(R19 on page 203)**

Maintaining and enhancing a patient safety culture

- Directorate management teams should ensure that staffing rotas are published at least seven days in advance so that any problems can be resolved before the rota starts. ***Urgent*** **(R1 on page 51)**

- HR and the senior management team should ensure that all new staff – permanent and locum – receive a personalised induction and training so that they can fulfil their responsibilities from the first day of their employment. Their training should be updated as appropriate. ***Urgent*** **(R7 on page 104)**

- The chair of the SUI panel should put in place a robust system for ensuring that recommendations arising from investigations (where accepted) are implemented. The outcome of changes should be reported to the panel and made available to hospital staff. **(R13 on page 187)**

- The chief officer and the consultant body should continue to encourage openness about matters to do with patient safety. They should challenge any tendency for self-censorship. This will allow professionals to acknowledge their own limitations and raise concerns about the practice of colleagues. Staff who report reasonable concerns should be safeguarded and appreciated for contributing to improved patient safety. This is the sign of a strong organisation. **(R20 on page 205)**

- The chief officer should ensure that organisational arrangements are in place to support good corporate and clinical governance. This includes developing and implementing policies and procedures to cover significant risks, ensuring that incidents are reported, investigated (where necessary) and the changes and improvements implemented. ***Urgent*** **(R25 on page 208)**

- The commissioners should investigate what the staff in the obstetrics and gynaecology department knew or believed up to 17 October 2006 about Dr Moyano's skills and abilities. ***Urgent*** **(R11 on page 158)**

Tackling staffing

- The chief officer should confirm the appointments of a fourth consultant to the obstetrics and gynaecology department and a sixth middle-grade doctor. ***Urgent*** **(R22 on page 207)**

- The senior management team should implement the outcomes of the staffing review so as to ensure safe levels. ***Urgent*** **(R28 on page 11 of addendum)**

- Simultaneously, the chief officer should commission a review of the terms, conditions - including residency rules – and prospects offered to those who come to work in HSSD and consider their impact on the staffing of the hospital and on its ability to attract and retain good-quality staff. ***Urgent*** **(R29 on page 12 of addendum)**

The operation of the obstetrics and gynaecology department

- The chief officer should bring in independent professional mediation to help the obstetrics and gynaecology department to support and develop the service in the aftermath of this incident. **(R21 on page 205)**

- The department should review and adopt policies and protocols to help with day-to-day management. These should take account of the Royal College of Obstetricians and Gynaecologists (RCOG) guidance on Standards for Gynaecology,

Diagnostic and Operative Hysteroscopy, Hysteroscopy Procedures, Obtaining Informed Consent, and Medical Staffing. **(R23 on page 208)**

- The clinical lead should use the Royal College of Obstetricians and Gynaecologists (RCOG) dashboard annually to monitor the 'health' of the department. **(R24 on page 208)**

- The three consultants should hold regular minuted meetings and include permanent middle-grade and junior staff. Nursing staff should also join these meetings. The three consultants should also attend departmental meetings. ***Urgent*** **(R26 on page 208)**

The use of locums

- The chief officer and the medical staff committee should ensure that locums have a detailed job description, receive a proper induction and orientation (permanent staff should be responsible for this). This should include establishing and making colleagues aware of any clinical limitations of a locum. Locums should receive an early, written appraisal from a senior member of the permanent medical staff. **(R6 on page 104)**

- The chief officer in conjunction with the medical staff committee should ensure that policies for the recruitment of locum medical staff are fit for purpose and properly implemented. Recruitment – including reference request forms - documents should be redesigned to ensure that they capture detailed information about an applicant. **(R17 on page 200)**

- The chief officer and senior management team should minimise the use of locums by tackling the underlying medical staffing problems. Figures for locum usage should be reported to the chief officer monthly. ***Urgent*** **(R18 on page 201)**

Day surgery unit and theatres

- The directorate manager and clinical director should ensure that the theatre team remains unchanged during the course of an operating list. This may require separate public and private lists or that the consultant anaesthetist is present for the entire list (see paragraph 7.35 and appendix D). **(R2 on page 57)**

- Consultant surgeons should check the records of the patients on their operating lists before the operating order is finalised to ensure that each list is balanced, safe and in the right order. ***Urgent*** **(R3 on page 69)**

- The theatre management group should ensure through regular audit that instrument trays remain standardised and contain all appropriate equipment. **(R4 on page 73)**

- The theatre management group should continue to develop and disseminate guidelines on the management of major bleeding with a view to establishing a simple, agreed approach. **(R5 on page 90)**

- The theatre management group should continue to develop the use of the World Health Organisation (WHO) pre-operative/surgical safety checklist and ensure that it is used in all theatres. **(R27 on page 211)**

Information

- The chief officer and information governance lead should ensure that patient records are clearly numbered under a single system and that all records are filed safely and in correct sequence *by hospital number,* not by name. Any records on a particular patient held by another medical organisation, for example a private consultant or another hospital, should be filed in the original patient record folder. **(R8 on page 128)**

- The chief officer and information governance lead should ensure that no original patient records are removed from hospital premises under any circumstances. Where a request for records is made, for example by another hospital, a private consultant or in the course of litigation or similar review (and with the patient's consent), the records should be photocopied and only the copies sent. **(R9 on page 128)**

- All staff should ensure that records – including patient records and departmental rotas – are accurate and comprehensible and include last-minute amendments and changes. **(R10 on page 128)**

Managing external relationships

- The chief officer should begin discussions with the States of Jersey Police and the Deputy Viscount about developing a local protocol setting out working relations in the event of a patient safety incident. This should be supported by guidelines for hospital staff and senior investigating officers. The 2006 protocol between the National Health Service, Association of Chief Police Officers and Health and Safety Executive, along with the associated guidelines, would provide a helpful starting point. ***Urgent*** **(R12 on page 167)**

- The chief officer should set out in a published action plan a response to this report and account publicly for the actions taken. A status report for each recommendation should be produced six months after publication. This should include evidence of what has been done.

DETAILS OF THE INVESTIGATION

4. Approach, structure and those involved

Approach to the investigation

4.1 The investigation was undertaken in private. It comprised 66 formal interviews, other discussions and an examination of all available relevant documentation including the transcript of the court case, the witness statements from the criminal investigation and the jury bundle. Initially our interviews were conducted on HSSD premises. After a debate in the States in June we relocated to Morier House where all formal interviews were conducted from then on. Two witnesses were interviewed elsewhere at their request – one in St Helier and another in London. Three of us were shown around the hospital by Gary Kynman, head of nursing for surgery. Mr Woolfson spent a day visiting the obstetrics and gynaecology department to meet staff and see facilities. He also reviewed patient records on HSSD premises. We visited the hospital to discuss and collect documents and to make informal enquiries of individuals with information relevant to the investigation. Two of us visited the day surgery unit and observed the World Health Organisation (WHO) pre-operative/surgical safety checklist being used in theatre.

4.2 We met Mr Rourke, Mrs Rourke's husband, at the outset of the investigation and saw him again during the course of the work and kept him up to date with progress by email. We offered to see Mrs Rourke's family, who live in England. After consultation with Mr Rourke, they declined this offer.

4.3 We conducted interviews with every individual who had been identified as relevant and who agreed to participate. This included members of the hospital management team, senior and junior clinical staff including former employees. We extended our invitation to interview to all other HSSD staff who had information relevant to our terms of reference. We also met various States members and offered to meet others. We spoke to Stephen Upsdell, medical director of health services, Isle of Man, where the healthcare issues being faced are not dissimilar to those on Jersey.

4.4 We offered interviewees the opportunity to comment on the factual accuracy of interview transcripts or to add to them and if appropriate to comment on relevant extracts of this report while it was in draft. Amendments have been made where we accept the validity of these comments.

4.5 Early on in our work we wrote to Dr Moyano about the investigation and invited her to interview. We attached our terms of reference to the invitation letter. She forwarded our invitation to her legal advisers who advised her not to speak to us because the General Medical Council (GMC) had not decided whether they would hold a fitness to practice hearing about her conduct. On advice, she also declined to respond to our written questions.

4.6 We kept in contact with Dr Moyano's advisers during the investigation – both by telephone and email – and made further enquiries about progress with the GMC investigation in the hope that we could talk to her. In the later stages of our work the GMC confirmed that they would hold a fitness to practice hearing, after which we made a further and final written offer of an interview. This was declined. Dr Moyano's legal advisers also wrote to say she would not be willing to provide written comments about extracts of our report when it was in draft form. However, we have had access to a statement she made after Mrs Rourke's death, the transcripts of her interviews with the police, the contents of her personal file held in the HR department of HSSD, the hospital records of the patients on whom she operated, her work rotas and assertions she made through her advocate at her trial, where she did not give oral evidence.

4.7 In line with good practice, we believe we have made all reasonable efforts to engage Dr Moyano in our investigation. She has made an apparently informed decision not to participate. The absence of her direct testimony should be borne in mind when reading this report.

4.8 We held informal discussions with Detective Chief Inspector Chris Beechey and Detective Sergeant Sam Smith from Jersey Police. We also met Mr Timothy Le Cocq QC, then HM Solicitor-General, now HM Attorney-General, to discuss access to the legal advice provided to HSSD about the conduct of the internal investigation.

4.9 We requested a large amount of documentation relating to the care, treatment and management of Mrs Rourke and the operation of the hospital. This included information from States of Jersey Police and legal representatives. Appendix C sets out what has been made available to us. We believe we have received all the documents we requested where they existed or their nearest equivalent, other than advice which was withheld under legal privilege.

4.10 We have looked at all the written statements made in response to the interim serious untoward incident investigation and the criminal investigation and we have read the transcripts of the court evidence.

4.11 We have looked at documentary evidence other than statements – including internal and external letters, emails and records of meetings and conversations, phone logs, theatre records, duty rotas, diary entries, medical notes and incident reports.

4.12 We started from the position that the documentary records were likely to be accurate (although this is not always the case) as far as they went, but that they were written for a particular purpose and one should not read other meaning into them without good reason.

4.13 We assumed that everyone tried their best to tell the truth as they recalled it. However, memories fade over time, so we tried to corroborate information by comparing different recollections and documents.

4.14 We assumed that if there were discrepancies between different statements from the same person, that person's memory was more likely (but not necessarily) to be accurate in the earlier version.

4.15 When considering more detailed later statements made in response to specific questions, we bore in mind that on the one hand a witness may not have mentioned a matter in an early statement because it did not seem significant or relevant, and on the other that those who gave evidence at Dr Moyano's trial, or followed it in the media, were likely to have been influenced by what they heard, experienced or read,

and that this may have affected their memory. Where we found significant and irreconcilable inconsistency, we set this out.

4.16 We also assumed that where a person gave a number of substantially similar accounts, that person's memory was probably more reliable than that of someone whose accounts differed.

4.17 We made findings, comments and recommendations based on our interviews and the information available to us to the best of our knowledge and belief. The evidence provided to us came over time. Some important documentary evidence was not received until near the end of our investigation. We started drafting our report as soon as we had obtained and absorbed enough information to do so, but this first draft was in outline only, and was constantly amended to take account of fresh information and greater detail on specific matters. We constantly discussed among ourselves the emerging evidence, testing and challenging each other's views and suggestions. The final report is the agreed and considered opinion of us all. We have strictly limited our findings and recommendations to our terms of reference and have not, for instance, considered whether any individual may have breached his or her employment contact with HSSD, nor have we attempted to determine whether any professional has breached the regulations of his or her profession. Where we criticise individual actions we do so in the context of risk to patient safety.

Structure of this report

4.18 The report is divided into three. Part one provides a factual description of the incident and the matters that flowed from it. Part two sets out some background information about the hospital from 2006. Part three explains why we think the incident happened and sets out the issues that contributed to it.

4.19 We provide a brief summary at the end of some sections where we think it helps the reader.

4.20 Our findings from interviews and documents are set out in ordinary text. Our comments and opinions are in ***bold italics***.

Part one

4.21 Section 5 describes the obstetrics and gynaecology service in 2006.

4.22 Section 6 describes the police investigation and Dr Moyano's trial in January 2009.

4.23 Section 7 provides a detailed examination of the care and treatment of Mrs Rourke, from her first GP appointment until her death in the early evening of 17 October 2006.

4.24 Section 8 describes the recruitment and employment of Dr Moyano.

4.25 Section 9 comments on some of the allegations made about Mr Day and Dr Moyano during Dr Moyano's trial in January 2009.

4.26 Section 10 describes the conduct and findings of the interim serious untoward incident investigation and progress implementing recommendations.

Part two

4.27 Section 11 sets out the factual background and context to Jersey General Hospital including, where relevant, in 2006, the management of the hospital.

4.28 Section 12 provides background information about the surgical directorate.

4.29 Section 13 sets out the history and day-to-day working of the day surgery unit.

Part three

4.30 Section 14 describes causes of the incident. These range from underlying factors, contributory factors and organisational controls that failed.

People who feature in the report include:

Elizabeth Rourke

Elizabeth Rourke had wanted to be a nurse since she was a child. She worked originally as a dressmaker, but when her own children grew up, she set out to fulfil her dream. In 1997 she enrolled on a course in Salisbury where she met Bob Rourke, who was to become her second husband. A few years later they trained together at Bournemouth University and moved to Jersey soon after.

Elizabeth joined Beauport ward as a staff nurse in October 2002 and soon became a popular member of staff. She loved her job. Former colleagues speak of her with affection and she received letters and presents from the many patients she befriended during their stay in hospital.

Her children, grandchildren, mother, siblings and other members of the close-knit family often visited her in Jersey.

She died on 17 October 2006 and her ashes were buried in Salisbury, where a bench and a commemorative stone provide a place where family and friends can go to remember her.

Dr Khalid Ahmed started working at the hospital in 2003 as a staff grade obstetrician and gynaecologist, and still does.

Mr James Allardice started working at the hospital in 1995 as a consultant general surgeon and still does. He has a special interest in colo-rectal/laparoscopic/breast surgery.

Dr Lawal Bappa started working at the hospital in 1999 and continued to do so until taking up a consultant post on the mainland in 2009.

Angela Body started working at the hospital in 1979 as a staff nurse. She moved into management in 1977 and has been directorate manager for surgery since August 2006.

Sarah Boyes-Varley started working at the hospital in 1993 as an anaesthetic nurse, and still does.

Mr John Day started working at the hospital in 1981 as its first consultant obstetrician and gynaecologist and set up the department. He has a special interest in gynaecology and gynae-oncology and pioneered laparoscopic gynaecological oncology surgery.

Dr Irina Dnes worked at the hospital as a senior house officer in obstetrics and gynaecology from February 2006 to February 2007.

Mr Douglas Dumbrill qualified as a consultant obstetrician and gynaecologist in South Africa and worked as a consultant there for five years before training in Jersey and the UK to obtain local qualifications. He worked as a locum staff grade and as a locum consultant in the hospital in 2006. He has since returned to South Africa.

Judith Gindill has been the lead nurse for day surgery and endoscopy since 2007. She is in charge of the day surgery unit and the lead nurse for endoscopy.

Jackie Harley has worked for health and social services in Jersey for 14 years. She is responsible for nurse workforce planning and has experience in conducting serious untoward incident investigations.

Julie de la Haye was the manager of the day surgery unit in October 2006, and had been for six years.

Dr Chelliah Ilangovan started working at the hospital as a staff grade anaesthetist in 1989, and still does.

Mr Nicholas Ingram started working at the hospital in 1988 as a consultant general surgeon and still does. He specialises in urology and acts as the link consultant with the vascular service in Bournemouth.

Richard Jouault started working in the hospital as a paediatric speech therapist in 1995 then worked as an adult therapist and team leader before moving into management. He is the deputy chief officer and director of corporate planning and performance management. Since September 2009 he has been the acting chief officer.

Gary Kynman started working at the hospital as a charge nurse in 1996, was intensive care manager from 2001 to 2007 and is now head of nursing for the surgical directorate.

Dr Richard Lane started working at the hospital in 1994 as a consultant anaesthetist. He worked part-time as an anaesthetist and part time as medical director from 2002 and has been full time medical director since the beginning of 2008.

James Le Feuvre is currently employed as the new directions project director and is a member of the corporate management team. He held the post of director of the general acute service between 1998 and 2004.

Karina Leed started working at the hospital as medical staffing assistant in the human resources department in January 2006 and was promoted to medical staffing officer in 2007 before leaving the HSSD in 2008. She returned to a medical staffing post in October 2009.

Mr Neil MacLachlan started working at the hospital in 1991 as a consultant obstetrician and gynaecologist and still does. He specialises in obstetrics and ultrasound and is acting clinical lead for the obstetrics and gynaecology department.

Lis Martins started working as clinical risk manager at the hospital in June 2006 and left in the summer of 2009. Among other things, she coordinated serious untoward incident investigations.

Suzanne Mottram started working at the hospital in 1984 as an operating theatre nurse. She is now a senior sister in theatres.

Dr Dolores Moyano worked at the hospital as a locum consultant obstetrician and gynaecologist from 14 August to 22 September and from 5 to 8 October 2006 and worked as a locum staff-grade obstetrician and gynaecologist from 2 to 17 October 2006.

Rose Naylor started at the hospital in July 2005 as head of governance and acting head of nursing and has been director of nursing and governance since June 2006.

Dr Fiona Nelson started working at the hospital as a consultant obstetrician and gynaecologist in 2004 and still does. She has a special interest in ultrasound and psycho-sexual counselling.

Mike Pollard was the chief officer of the health and social services department between May 2004 and September 2009, when he resigned.

Dr Graham Prince started working at the hospital in 1989 as a consultant anaesthetist, and still does. He has a special commitment to intensive care.

Dr Liezl Sullivan worked as a locum/temporary junior doctor in the obstetrics and gynaecology department of the hospital from the end of September 2006 until July 2007, before taking up a post as a general practitioner in Jersey.

Elaine Torrance started working at the hospital as head of midwifery in 2005, and still does.

Dr Gbolahan Williams started working at the hospital as a staff grade obstetrician and gynaecologist in August 2006 and still does.

Dr Malachy Wilson is a GP in St Helier and was Mrs Rourke's GP.

Part one

The first part of our report describes the obstetrics and gynaecology department in 2006. It sets out the outcome of the criminal case against Dr Moyano. It describes the care, treatment and management of Elizabeth Rourke before and on 17 October 2006. It explains the background to Dr Moyano's recruitment and employment. It comments on the allegations made against Mr Day and Dr Moyano during the criminal trial. These were widely reported at the time and, on the basis of what we have been told, are believed by many people on the island. It concludes with a section on the hospital's interim investigation of Mrs Rourke's death.

5. Obstetrics and gynaecology

Description of the service in 2006

5.1 In this section we explain the context in which the events of August to October 2006 took place.

5.2 The obstetrics and gynaecology department provided a full obstetrics and gynaecology service to the island. The service was however more generalist than in parts of the mainland, where there was greater sub-specialisation.

5.3 The obstetric caseload was mixed, covering both low- and high-risk patients on account of Jersey's geographic location. The low-risk antenatal care was shared between general practitioners and the hospital midwives while the hospital consultants held weekly antenatal clinics for the higher-risk cases.

5.4 Obstetric services included:

- antenatal care for low risk patients provided by the hospital's midwives
- antenatal care for high risk patients provided by the hospital's consultants
- antenatal scanning
- a designated operating theatre on the labour ward with 24-hour anaesthetic cover
- a well-equipped labour suite complete with intra-partum monitoring and blood gas analysis
- a tele-medicine link with the department of fetal medicine and cardiology at Guys & St Thomas' Hospital, London.

5.5 The gynaecology department provided all aspects of gynaecological investigation and treatment, although complex gynaecology cancer cases were referred to the Royal Marsden Hospital, London.

5.6 Gynaecological services included:

- outpatient ultrasound scanning
- 10 inpatient beds
- operating facilities in the day surgery unit and main theatre, each with a range of laparoscopic equipment
- a colposcopy unit
- an assisted reproductive unit
- a satellite assisted reproductive service for egg recovery and embryo transfer arranged between the hospital and Bourn Hall in Cambridge
- chemotherapy and radiotherapy clinics provided by visiting specialists from the UK
- uro-dynamic assessments and uro-therapy physiotherapy.

Comment

For a small general hospital serving an adult female population of about 35,000, the department's range of services was excellent.

Clinical activity

5.7 In the year to October 2006 there were:

- 4366 gynaecological outpatient appointments; with 1382 new patients
- 57 gynaecological oncology outpatient appointments; with two new patients
- 964 colposcopy appointments; with 368 new patients
- 568 infertility appointments; with 164 new patients
- 1501 gynaecological procedures; 646 of which were carried out in the day surgery unit.

The birth rate on the island had generally been rising since 2001 with the department managing about 1000 births each year.

Comment

The number and range of appointments suggest that the hospital was (and remains) a popular place for treatment, not only for those whose treatment was paid for through taxes, but also for those whose treatment was paid for through health insurance and who could presumably have gone elsewhere.

This view is reinforced by the results of the 2007 Picker Survey of Maternity Services in which 94 per cent of Jersey respondents gave a Good to Excellent rating compared to 86 per cent in England. See paragraph 11.7 for more information.

Staffing

5.8 The health and social services department employed three full-time consultant obstetricians and gynaecologists in 2006: Mr Day, who was appointed in 1981, led gynaecology, oncology and laparoscopic surgery; Neil MacLachlan, who started in January 1991, led the assisted reproduction service; Dr Fiona Nelson, who started in January 2004, led the termination of pregnancy service and psycho-sexual counselling. All three consultants carried a general obstetrics and gynaecology workload and worked to a one-in-three on-call rota. All three consultants also managed a sizeable private workload.

Comment

This level of on-call duty for consultants was commonplace in the UK.

5.9 Mr Day was the clinical lead in the department until his exclusion on 23 October 2006. We have evidence that he took his role seriously – he was responsible for ensuring that the services of an unsatisfactory locum consultant were dispensed with in July 2006 and in the same month he worked with the head of midwifery to provide a training programme for a junior doctor whose practice was giving cause for concern.

5.10 As well as these three consultants, the department was highly dependent on the middle and junior grades to undertake clinical workloads in both obstetrics and gynaecology. There were three middle-grade doctors and seven junior doctors – two specialist registrars, four senior house officers and one F2 grade. These doctors worked to a one-in-five on-call rota.

5.11 The middle and junior grade posts had been assessed by the postgraduate dean for Wessex and were recognised by the Royal College of Obstetricians and Gynaecologists (RCOG) for training purposes.

The weekly rota

5.12 Dr Lawal Bappa was responsible for compiling and managing the medical staffing rota for the middle and junior grades in the department and he was allowed a half-day each week to deal with the administration involved in this. The prevailing rule was that the doctors would cover for each other for periods of absence shorter than one week.

5.13 For further information about the medical infrastructure, see section 11.

Nursing staff

5.14 The senior management team minutes of September 2006 record that the hospital had difficulties in recruiting nursing staff although we do not know the precise number of vacancies in obstetrics and gynaecology.

5.15 The labour suite and labour ward had an establishment of eight Band 6 senior sisters and 34 whole time equivalent midwifery and nursing staff. In addition, there were a small number of nursery nurses and nursing auxiliaries. The maternity and neonatal department annual governance report for 2005/2006 states that the staff had to work flexible shift patterns due to recruitment difficulties and high sickness absence rates. Rose Naylor told us that maternity went through a staffing review called Birth Rate Plus in 2006 and that staffing was subsequently increased in 2007.

5.16 There were just over 17 whole-time equivalent members of staff on Rayner, the gynaecology ward – two ward sisters, 11 staff nurses, three health care assistants and a ward clerk. This staffing complement allowed for two trained and one untrained member of staff to be on the 10-bed ward most mornings – with three trained staff on duty on Wednesdays when there were two theatre lists.

Locums

5.17 HSSD had no locum policy in 2006. However, the general rule in the obstetrics and gynaecology department at that time – for consultants, staff grades and specialist registrars - was to provide internal cover for short periods (under five days) of annual leave and study leave - and to cover longer periods of absence (five days or more) with locums.

5.18 A full-time senior house officer (SHO) was employed for part of the year to cover annual leave by the other junior doctors.

Mr MacLachlan's absence

5.19 The staffing of the department was greatly affected by Mr MacLachlan's absence between April and August 2006. A member of his family was suddenly diagnosed with a life-threatening illness, which resulted in his being given compassionate leave. This was followed by his own sickness absence. He returned part-time on 24 July and full-time in the department on 4 September.

5.20 A locum was arranged to cover his work for three months at the beginning of his absence but did not stay long because he was offered a permanent job elsewhere. Throughout the summer Mr MacLachlan's duties were subsequently covered, but only to a limited extent, by a series of locums.

Comment

Mr MacLachlan's absence put a considerable strain on his consultant colleagues, who had to cover his on-call duties when there was no locum to do so and regularly had to spend time selecting suitable locums. They also had to ensure that the public and private patients Mrwould routinely have seen were still seen in his absence. Several interviewees told us that the department willingly rallied around to ensure that service as normal was provided, but it is clear to us that Mr Day and Dr Nelson had a lot of extra work over the summer of 2006, which must have been difficult to manage. One consequence of this was that they delayed their own holidays until they knew that Mr MacLachlan would be back at work, with the result that periods between the beginning of August and 17 October when all three consultants were at work at the same time were brief.

5.21 From our analysis of locum usage in 2006 that is based on raw data provided by the HR department we estimate that the obstetrics and gynaecology department used a total of 643 locum days - 22 per cent of the total used in the hospital. Nearly half of the locum days were at consultant level. Twenty-one different locums were used – 11 just once. Sixty-nine per cent of the locum days were to cover periods of annual leave and 14 per cent to cover sickness absence.

Comment

The department was using a disproportionately high number of locum days and the number of locums passing through must have placed a large extra burden on permanent staff – especially Mr Day and Dr Nelson.

Bearing in mind the overall activity levels and the range of services to cover, the whole department and the medical staff in particular were working under significant pressure.

Team working and culture

5.22 It is difficult to get a full picture of the way the department worked in 2006 but the evidence indicates no regular structured meetings of the medical staff in the department and few policies and protocols.

5.23 Also that the three consultants worked more as individuals than as a team. According to Mr Day:

> "*The consultants operate (d) in a collegiate but relatively independent manner, holding departmental meetings probably every 3 months.*"

5.24 Many of those we interviewed volunteered their views on the three consultants. The commonly held view was that each consultant was clinically able and committed.

5.25 The evidence also suggests that the junior and middle-grade doctors worked together harmoniously.

Comment

We consider that the difficulties over the summer of 2006 had an adverse effect on the already limited communication between the consultants in the department. All three consultants were clearly committed to providing a high-quality service to their patients and had different views about how the department could achieve these objectives. This led to some tensions between them.

Patient safety

5.26 Obstetrics and gynaecology had no risk management system.

5.27 Two patient safety incidents in the department were recorded for 2006 – both obstetric cases. One was a drug error; the other concerned hepatitis B.

5.28 Various audit activities were being undertaken in the department:

- Obstetric outcomes were audited using the Protos maternity system while the obstetric ultrasound department were using the fetal medicine package – PIA fetal database.
- Fetal abnormalities were recorded and the unit participated with the Wessex antenatal detection register (WANDA).
- Obstetric outcomes were monitored and the department participated in the Confidential Enquiry into Stillbirths and Deaths in Infancy.

5.29 A multi-disciplinary gynaecology cancer audit was undertaken every six months. This recorded the numbers of new cancer cases by site, along with numbers referred to the Royal Marsden Hospital.

Summary

The picture in 2006 is of a busy understaffed department popular with patients but whose policies, procedures and working relationships were underdeveloped. This was compounded by the long-term absence of one of the consultants and an increasing reliance on locum medical staff to cover the workload.

6. The police investigation and Dr Moyano's trial

6.1 As is more fully described in section 10, the start of the police investigation in October 2006 severely curtailed the hospital's own investigation into Mrs Rourke's death and resulted in no one really knowing what happened or why. Most of the information published or disseminated has been in the context of the criminal investigation and trial. The purpose of a criminal trial is to determine whether the defendant is guilty as charged, which is quite different from the purpose of our investigation, as set out in our terms of reference. Nonetheless, there is clearly an overlap and we think it would be helpful to say something about the trial and how we have dealt with it in our investigation.

6.2 HSSD informed the police of Mrs Rourke's death on 17 October. The police attended the hospital that day on behalf of the Deputy Viscount, who has a duty to investigate any sudden death. Following a discussion with the Attorney General on 23 October the police decided to start a criminal investigation. Twenty-eight witnesses gave statements to the police. Mr Day and Dr Moyano were interviewed under caution in March 2007. Dr Moyano was later charged with gross negligence manslaughter.

6.3 Dr Moyano's trial started over two years after Mrs Rourke's death, on 5 January 2009, and ended on 27 January. The court sat for 12 days and heard from 21 witnesses. Most of them worked at the hospital but two police officers gave evidence, as did six medical experts in the fields of obstetrics and gynaecology, vascular surgery, pathology and gynaecological pathology.

6.4 The commissioner Sir Richard Tucker said in his summing up that the issues for the jury were:

> *"Bearing in mind again the circumstances in which the defendant found herself, first was she competent to carry out the therapeutic aspect of the hysteroscopy? If she was not, and knew she was not, was she grossly negligent in embarking on the procedure?*

Second, was the defendant grossly negligent in the manner in which she performed the procedure and in perforating the common iliac vein?

In deciding this question, one of the issues will be for you to consider whether, when she damaged the vein, she was using diathermy, though the prosecution case is that, whether she was or she was not, she was criminally negligent.

The third matter you will have to consider is: was there negligence in the remedial treatment of Mrs. Rourke? If so, it does not exclude the responsibility of the defendant unless the negligent treatment was so independent of her act, and in itself so potent in causing death, that you regard the contribution made by the defendant as insignificant."

6.5 The prosecution's case was that the answer to all these questions was *"yes*", and that therefore Dr Moyano was guilty as charged.

6.6 Dr Moyano did not deny having a duty of care for Mrs Rourke and did not deny damaging her iliac vein. Her defence was in two parts. First, that she had made an error of judgement which led to Mrs Rourke's death, but that this did not amount to negligence, let alone gross negligence. She asserted, through her advocate, that Mr Day had instructed her to resect the polyp and that she had made the decision to carry out the surgery in good faith, in the genuine and justified belief that she was competent to proceed and in the sincerely held belief that she was acting in Mrs Rourke's best interests. An expert for the defence said her error in using the surgical equipment was the error of a trainee and not unusual in the circumstances. It did not amount to negligence and certainly did not amount to gross negligence justifying a finding of manslaughter. Second, her defence was that she had not caused Mrs Rourke's death and that it was Mr Day's actions when he returned to the operating theatre to try to repair the damage she had done which caused Mrs Rourke to die.

6.7 The jury were unable to reach a unanimous verdict after nearly four hours of deliberation. Under Jersey law, ten votes in favour of a verdict of guilty are enough to convict and any fewer results in a verdict of not guilty. Each jury member gave the commissioner their individual decision and he announced the verdict of not guilty.

Comment

In providing a full account of the events of 17 October 2006 we have had to cover some ground that was covered in Dr Moyano's trial. We have done so to comply with our terms of reference.

6.8 We make no findings based on the expert evidence provided at the trial because it all related to the question of Dr Moyano's guilt on the charge of gross negligence manslaughter, with which we are not concerned. Furthermore, some of it was based on incomplete or inaccurate information, the experts disagreed on several important issues and it was not comprehensive. However, we have read the transcript of the evidence and the written reports of the experts and have borne their views in mind when instructing our external medical experts and when reaching some of our conclusions.

6.9 We are aware that severe criticism of Mr Day's actions in relation to Mrs Rourke's treatment was made during the trial and that this criticism received wide publicity. We address this in section 9, for the reasons set out at the beginning of that section.

7. Elizabeth Rourke's care, treatment and management

GP referral

7.1 On 21 March 2006 Mrs Rourke went to her general practitioner, Dr Malachy Wilson, complaining of a number of symptoms that could have indicated that she was starting to go through menopause but which could also have been symptoms of other conditions. In view of her earlier gynaecological history, Dr Wilson suggested a number of investigations, including a scan of her uterus, to see if this showed any abnormalities that might be the cause of her symptoms.

7.2 The scan was carried out on 3 April and the report, sent to Dr Wilson, found no obvious problems but identified the possibility of some changes that might explain Mrs Rourke's symptoms.

7.3 On 18 April Mrs Rourke met Dr Wilson to discuss the scan and other investigations, which had not identified abnormalities. She told him that one of her symptoms had gone but they agreed that she should see a gynaecologist at the hospital because her other symptoms had not cleared up.

7.4 On 21 April Dr Wilson wrote to Mr Day, asking if he would see Mrs Rourke, who he described as *"This 48-year-old staff nurse who works on Beauport Ward"*. He gave brief details of her medical history, described her symptoms and concluded:

> *"I wonder if she needs a hysteroscopy to look at the possible cyst and possible fibroid. She is otherwise fit and healthy."*

Comment

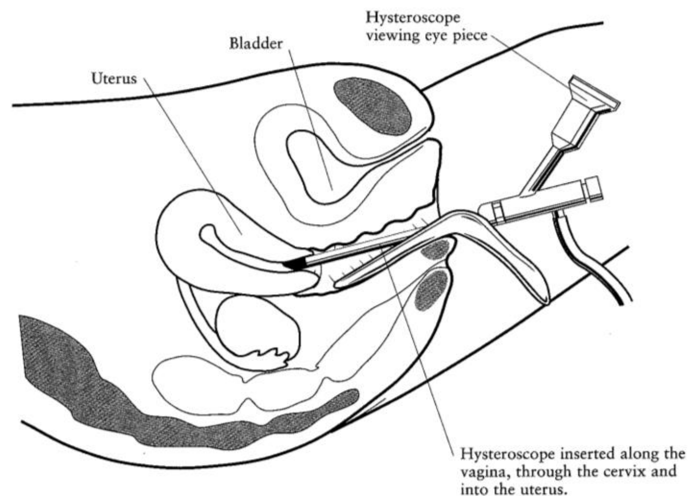
This was an entirely proper action for Dr Wilson to take: he could have offered Mrs Rourke treatment to try to help with her symptoms but seeking an expert opinion was appropriate because it might help decide what treatment to offer.

Outpatient appointment

7.5 Mrs Rourke was offered an appointment at Mr Day's gynaecology outpatient clinic on 26 July 2006. Mr Day was away on study leave on that day, so she was seen by Mr Douglas Dumbrill, a locum staff-grade doctor who was well known at the hospital because he had trained there.

7.6 Mr Dumbrill suggested to Mrs Rourke that she should have a hysteroscopy and that she consider having a Mirena coil fitted. His handwritten medical note reads:

> *"…needs hysteroscopy to assess endometrium +/- Mirena."*[1]



7.7 After her outpatient appointment, Mrs Rourke was provisionally booked onto Mr Day's day surgery list for 17 October and given an appointment with the pre-admission nurse on 10 October.

[1] Hysteroscopy is a procedure whereby a fibre-optic camera and a light source are introduced into the uterus via the cervix, with the picture from the camera being transmitted back to a screen which allows the doctor/operator to identify any abnormalities. Sometimes these abnormalities are insignificant and no action is needed; sometimes the abnormalities need to be dealt with through a more extensive operation on a later occasion, and sometimes a problem will be identified that can be dealt with there and then. The Mirena coil is an inter-uterine device mainly used for contraception, but can also be used to correct irregular periods. In Jersey, hysteroscopy requires either an inpatient admission or admission as a day patient. A decision on which is most appropriate, is made during a pre-admission appointment with an experienced nurse.

Pre-admission appointment

7.8 On 10 October the pre-admission nurse, Wendy Pycraft, who has since retired, saw Mrs Rourke. Ms Pycraft told police she could not remember details of that meeting but the form she filled out indicated that Mrs Rourke was a suitable patient for day surgery, so her place on the list for 17 October was confirmed. She was advised to attend at the day surgery unit (DSU) at 8.00am that day.

17 October 2006 – 8.00am to 9.00am

7.9 Mrs Rourke arrived at 8.00am with her husband Bob. He said:

> "*At approximately 08.00 hrs on Tuesday 17th October 2006, I took my wife, Elizabeth, to the Day Surgery at the General Hospital where she was due to have a hysteroscopy which had been arranged the week earlier. I went with Elizabeth to the Day Surgery Ward and she sat by her bed and I left her there.*"

7.10 Mrs Rourke was ninth on the list, so was shown to bay nine. She was admitted by a staff nurse, Marita Haley, who recognised her as a member of staff. Ms Haley told us she was surprised that Mr Day did not come through to talk to Mrs Rourke, because in her experience he would always come through to talk to patients who worked at the hospital. She mentioned to other staff on the ward that Mrs Rourke was a member of staff, but assumed that the message did not reach Mr Day because he did not come onto the ward to speak to her.

7.11 Mr Day arrived shortly after 8.00am and went to his office where he was working on a schedule of clinical activity for a recently arrived staff grade doctor, Dr Gbolahan Williams.

7.12 Dr Moyano, who was the registrar/staff grade on call from 8.30am, arrived early and went to the labour ward at a few minutes past 8.00am. She went to the labour ward because she had patients to see but she was also on call for any gynaecology problems.

7.13 Dr Williams, who was on the rota to assist Mr Day with his day surgery list, also arrived. He had found himself in a difficult position; he was studying law with the Open University and was due to sit an exam in the Midlands on 18 October. He needed to leave Jersey on 17 October to arrive in time. He had gone through the procedure to obtain study leave, including getting Mr MacLachlan's written authorisation, and had made arrangements that included flying to the UK on the morning of 17 October. The junior doctors' rota for each week was finalised and issued the previous Friday and Dr Williams recalled that it was not until the morning of Monday 16 October that he saw he was booked to help Mr Day with his morning list on 17 October. Dr Williams recalled that he spoke to Dr Nelson, who said he would not be able to leave until later in the day if he could not find cover for his duties and that this might be difficult as two other registrars/staff grades were also away.

7.14 Dr Williams already knew that Mr Day did not mind dealing with his day surgery list without the help of a registrar or middle-grade doctor, but because he did not wish to appear inconsiderate or offhand, he decided to get to the hospital early to *"consent"* the patients on the list.

7.15 *"Consenting"* consists of a doctor discussing with the patient the details of the proposed operation or procedure, explaining its purpose, the risks of carrying out or not carrying out the procedure, the possible complications and their likelihood. Having obtained the patient's consent, the doctor fills in a form confirming that the discussion that has taken place, and the patient signs it, thus confirming informed consent to the procedures detailed on the form. The doctor doing the consenting should be experienced in carrying out the procedure being discussed, even if s/he is not undertaking the operation.

Comment

There was clearly a breakdown in communication about Dr Williams' unavailability that was not noticed until the rota had begun. This led to a last-minute attempt to solve the problem. In turn, the solution created confusion about Dr Moyano's role in theatre that morning.

Recommendation

R1 Directorate management teams should ensure that staffing rotas are published at least seven days in advance so that any problems can be resolved before the rota starts. ***Urgent***

7.16 Once he had consented the patients, Dr Williams intended to ask Dr Moyano, who he knew was the on-call registrar, to cover for him during Mr Day's list. If Dr Moyano had not been free, for instance if she had been dealing with an emergency on the labour ward, he intended simply to ask Mr Day to let him leave after the first patient, expecting that Mr Day would have no objection. When we discussed this with Mr Day he said: *"…I would not really be aware of Dr Williams. I would normally do that list myself…I, as a rule, do that list just with an SHO".*

7.17 Dr Williams explained to us that the junior doctors frequently covered for each other, and as far as he was aware he was behaving normally in seeking to get cover from Dr Moyano in this way.

7.18 Other witnesses have confirmed that this was normal practice and that the junior and middle-grade doctors always seemed willing to help out in this way. They explained to us that in a busy hospital, dealing with emergencies as well as routine work, planned patterns of work are often disrupted and the staff at the Jersey General Hospital (not just the doctors) are flexible in responding to these disruptions and willingly accommodate the changes to ensure that patients receive a good service and that extra work is shared out reasonably fairly.

7.19 Dr Williams arrived on the day surgery unit at about 8.00am and saw Mrs Rourke at about 8.30am. He was accompanied by Dr Liezl Sullivan, a senior house officer (SHO), who was listed to assist in the day surgery unit that morning.

7.20 Mrs Rourke told Dr Williams she did not wish to have a Mirena coil fitted, so he simply obtained her consent to a hysteroscopy and to dilatation and curettage (D&C).

7.21 It is generally thought best that the person obtaining consent is a doctor who will be present during the procedure, even if s/he is not carrying it out. It was good practice to go through the consent procedure with the patients first thing in the morning and at that time Dr Williams was the only person present with the experience to do so: Mr Day was not on the ward and Dr Sullivan, the SHO, did not have the operating experience. We asked Mr Day why he had not been on the ward at 8.00am to consent the patients on his list. He said:

> "*Normally this is a list, which again I have said in my statement, that I would do with the SHO. It is quite a nice time for me to be with the SHO: they see the patients, they clerk the patients, they often consent the patients. If there is any query, I will see the patients on the ward, I wouldn't normally, but I would then see every patient in the anaesthetic room to go through the consent, to make sure that the symptoms they have are the same symptoms that the notes say they have and then to make sure that we agree exactly what we are doing. I would do that for every patient whenever I was doing an operation. I would try to instil in all doctors who work with me to do the same thing. I always see the patient in the anaesthetic room.*"

Comment

It is good practice to provide information about the nature, benefits and risks of any proposed operation at every stage and there is evidence that the hospital complied with this practice and that this would have been done during the outpatients' appointment and also at the pre-admission appointment. However, the written and signed consent of the patient is usually obtained close to the time of the procedure.

Dr Williams is an experienced doctor who had carried out the procedures intended for Mrs Rourke so he was an appropriate person to obtain her consent.

7.22 After being consented, Mrs Rourke waited on the ward while the other patients were dealt with.

17 October 2006 – 9.00am to 9.23am

7.23 Once Dr Williams had finished obtaining the consent of the public patients, he telephoned Dr Moyano a few minutes after 9.00am, telling her that she needed to attend the day surgery unit because he had to leave at 10.00am. Dr Moyano said in her police interview that by this time she was on Rayner, the gynaecology ward, seeing the patients that she had assisted with in the main theatre with the previous day. Dr Moyano was shown the way to the day surgery unit because she had been there only once before. Dr Williams briefed her, telling her that he had consented all the public patients and that Mr Day would undertake the whole list. While Dr Williams was briefing her on each of the public patients, Dr Moyano made notes on her copy of the surgery list. Dr Williams mentioned that Mrs Rourke did not wish to have a Mirena coil fitted.

7.24 Private patients, whose costs are usually paid through health insurance, pay the hospital for all aspects of their care and treatment other than the medical aspect, for which the consultant is paid directly. Only consultants are entitled to carry out private work at the hospital. It follows that Mr Day had to consent his private patients that morning and consultant anaesthetists had to be available for the private patients as the anaesthetist on duty for the list, Dr Chelliah Ilangovan, was a middle-grade doctor. Mr Day's regular anaesthetist for his Tuesday morning list was Dr Gari Purcell-Jones, a consultant, and if he had not been on leave, there would have been a single consultant anaesthetist throughout the list, with a middle grade assisting.

7.25 The first patient on the list was a private patient and Dr Graham Prince, consultant anaesthetist, had already agreed to be the anaesthetist during this procedure. Identifying consultant anaesthetists for private patients is a matter for the anaesthetists' secretaries: Dr Lane was the on-call anaesthetist that day, but as he had a meeting at 9.00am, Dr Prince had agreed to deal with the first private patient for him. Dr Prince was due to leave by 9.30am for a teaching commitment, and thought that Mr Day was aware of this and would be ready to start his operating list promptly at 9.00am. Dr Lane would deal with the later two private patients, and Dr Ilangovan would deal with the public patients.

7.26 It seems that Mr Day did not know that Dr Prince needed to get away promptly: he had been dealing with paperwork in his office, and had wanted to photocopy some documents. When he reached the photocopier he realised he did not remember the pass code so he waited until 9.00am when the secretarial staff would be able to help. He did not therefore arrive at the day surgery unit until shortly after 9.00am, having been bleeped at 9.06am. He had rung the day surgery unit when he was bleeped, but received no answer. When he arrived at the unit he found that the battery of the cordless phone in theatre was flat. Mr Day does not remember precisely when he arrived but told us that as the first patient would not be taken to the anaesthetic room until he was ready to start the operation, an approximate arrival time can be calculated by finding out when this happened. The computer record shows that the first patient was taken to the anaesthetic room at 9.23am.

7.27 Mr Day told us that on arrival on the ward in his ordinary clothes he consented his three private patients, then: "*It is the first time we are back into those theatres. I go to a temporary changing room, having been shown it when I come on the ward, and I can't get in, so the only time in my life I have to go back to the main theatre changing rooms to change*". The day surgery unit had been closed for refurbishment for the previous few weeks and a number of areas had been rearranged. There was a temporary changing room, and when Mr Day went there to change he found that the door was jammed, so he was not able to get in and had to go to the main theatre changing room. He estimated that the consenting and changing took about 15 minutes, which puts his time of arrival on the day surgery unit between 5 and 10 past 9.00am.

7.28 When he returned to the day surgery unit he was aware that Dr Prince was "*steaming*" because of the late start. Mr Day told us he thought this was a bit unreasonable and that Dr Prince should not have had to leave by 9.30am if he had agreed to do the first operation of the day.

7.29 A number of witnesses told us that Mr Day had a reputation for lateness, which was annoying for those who had to wait for him. We asked Mr Day about this. He said:

> "*If you look at the main theatre...I am on the dot, starting at nine-I am there at about ten to nine, into theatre and I am waiting for the patient to come in. This day case theatre has a less clear start, and ...sometimes you have the energy to drive the start 'come on, let's get going' and sometimes that theatre is quite difficult to drive. The main theatre is excellent.*"

7.30 An analysis of the timekeeping of all three consultants is given in section 9, and this shows that the start times of Mr Day's day surgery unit lists were no later than those of Mr MacLachlan and were not much later than those of Dr Nelson.

7.31 Dr Williams recalled speaking to Mr Day before the first operation and telling him that the consent of all the public patients had been obtained, and that he, Dr Williams, would leave at 10.00am but that Dr Moyano would stay to assist. Mr Day recalls that Dr Williams had said something along these lines and later, while he was operating, he realised that there had been a conversation about Dr Williams' possible unavailability at the consultants meeting on 12 October, the previous Thursday. He understood that Dr Moyano wanted to work with him that morning:

> *"I would mention that as a rule I would normally do this list by myself, consultant led with the SHO (who that day was Dr Sullivan). I had no problem with the arrangement. However, Dr Moyano attended and I understood that she wanted to join me in theatre and operate. Dr Moyano had been working in the Department as mainly a locum consultant and also a locum registrar. I was aware that Dr Moyano was trying to gain a prominent consultant post in the UK and so for me to refuse her offer to assist would have been the height of professional rudeness and unacceptable and it did not cross my mind to do this."*

7.32 Some day surgery procedures take longer and are more complicated than others. Simpler procedures can take only a few minutes. A morning surgery list usually contains both. For the list as a whole to be dealt with safely and smoothly, the way patients are prepared before their procedure and cared for after it and the way the operating theatre is prepared for each patient is important.

7.33 Mrs Rourke was the last of nine patients on Mr Day's list that morning. This was a exceptionally long list. During the previous two years there had only been five other lists of nine patients, two for Mr MacLachlan in July and October 2005 and three for Mr Day in March, June and August 2006. He told us he had asked that he should not have such long lists, but to no avail.

Comment

There were a number of organisation problems that morning:

- ***Changes to regular anaesthetic cover, resulting in three anaesthetists working on the list instead of one***
- ***A breakdown in communication between Mr Day and the day surgery unit because the theatre phone was not working***
- ***A breakdown in communication regarding Dr Williams' availability that morning***
- ***The blocked changing room door***
- ***A big operating list***
- ***An unfamiliar, reconfigured, operating theatre***
- ***A breakdown in communication between Mr Day and Dr Prince, so that Mr Day was not aware in advance that Dr Prince needed to start on time.***

We do not consider that these factors directly contributed to Mrs Rourke's death but that they provide evidence of poor organisation of theatre processes on that day, which, as a matter of patient safety, should be designed to minimise muddle, mistakes and breakdowns in communication.

The morning list

7.34 Records show that the first patient went into the operating theatre at 9.26am, and the eighth patient came out at 12.30pm. Most of the patients were in theatre for between 15 and 20 minutes but one was in for eight minutes, another for 45.

7.35 Three anaesthetists were working on the list that morning – staff grade Dr Ilangovan and consultants Dr Prince and Dr Lane, who dealt with the private patients. Mr Day told us:

> *"I feel even if you just had the one anaesthetist…it has a rhythm to it, which we didn't have on that day. It was quite a big list that was, nine cases…If you have two people and they alternate, that is fine, but when they are coming and going it is not ideal."*

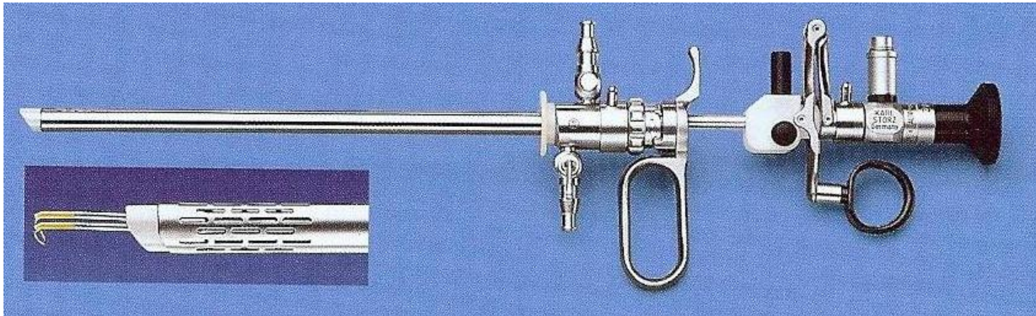
Recommendation

R2 The directorate manager and clinical director should ensure that the theatre team remains unchanged during the course of an operating list. This may require separate public and private lists or that the consultant anaesthetist is present for the entire list (see paragraph 7.35 and appendix D).

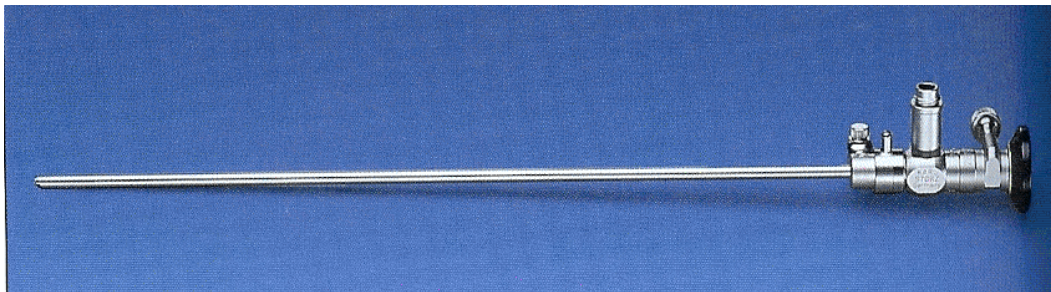
7.36 Mr Day undertook most of the procedures himself but invited Dr Moyano to conduct a number of them. Her contract of employment did not allow her to help with private patients but she was involved to a greater or lesser extent with four of the five public patients preceding Mrs Rourke.

7.37 On 17 October all the patients, including Mrs Rourke, had a diagnostic procedure: six patients had a hysteroscopy, one had a laparoscopy, one had a hysteroscopy and a laparoscopy and one had a colposcopy.

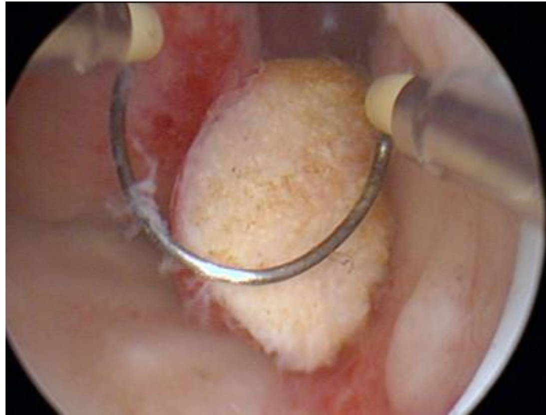
7.38 The main piece of equipment for a hysteroscopy is a hysteroscope – an instrument with a fibre optic camera and a light on the end that allows the interior of the uterus to be illuminated and examined on a monitor. There are two sorts of hysteroscope - a diagnostic hysteroscope, which is limited to examining the interior of the uterus and a therapeutic hystero-resectoscope (usually called a resectoscope), which can examine the uterus and also, if necessary, remove tissue from it. The procedure for removing tissue in this way is called diathermy. It is carried out by passing electricity through a small loop of wire at the tip of the resectoscope which becomes extremely hot and can then cut through tissue – like a hot knife cutting through butter. This is obviously an extremely dangerous procedure if undertaken by someone without the necessary skills: a mistake is liable to cause serious damage.



Hystero-resectoscope

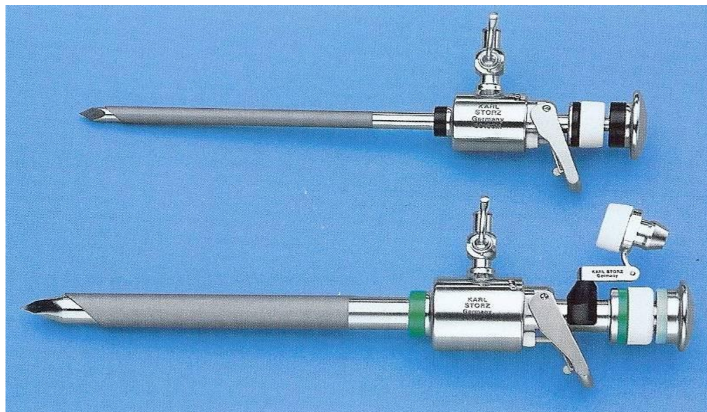


Diagnostic hysteroscope



Removing a polyp using a hystero-resectoscope

7.39 Laparoscopy is a procedure in which a sharp bladed instrument called a trocar is used to puncture the abdomen. In the centre of the trocar is a hollow tube called a cannula and once the cannula has been introduced into the abdomen through the hole created by the trocar, a laparoscope, consisting of a camera and light on the end of a rod, is passed into the abdomen through the cannula.



Laparoscopy trocar

7.40 Laparoscopy requires much greater skill than hysteroscopy, not least because it involves blind insertion into the body. Once inserted into the abdominal cavity the laparoscope can be used diagnostically, to look at the organs, or therapeutically.

7.41 Hysteroscopy and laparoscopy are similar in that they are primarily diagnostic procedures, as is colposcopy where the cervix is examined using a special microscope.

There are other diagnostic methods, such as ultrasound, CT scanning and MRI, each of which provides different information.

7.42 If one of the methods of diagnosis finds a problem, treatment is required. Any surgery then needed is described as a therapeutic procedure or operation. Hysteroscopy can be used therapeutically, as can laparoscopy, which uses specially designed scissors and diathermy probes to cut tissues or stop bleeding. Other therapeutic instruments such as forceps and curettes are used blind.

7.43 Apart from Mrs Rourke, only three patients had a *therapeutic* procedure; one had a coil removed, one had a polyp removed from the uterus by use of a resectoscope and one had some abnormal cells removed from her cervix by loop excision (using a loop of wire with an electric current (diathermy), similar to the procedure with a resectoscope).

Dr Moyano's involvement in the morning surgery

7.44 The second patient on the list had a hysteroscopy and a laparoscopy. Dr Moyano undertook the laparoscopy under Mr Day's supervision. He considered that she carried out this procedure with great skill and appeared to be entirely familiar with it:

> *"I have to say I watched very carefully from below after performing the hysteroscopy. Dr. Moyano performed the laparoscopy with a most sound technique. She tested the system and then the Verres needle with and without gas prior to passing the needle into the abdomen. There was a problem at first with the gas flowing through the needle but this was remedied by Sister Mottram attaching the feeder pipe directly to the insufflator. Dr. Moyano placed the Verres needle first time. I queried whether it was in far enough but she firmly said that it was (and she was right as the gas subsequently flowed freely into the abdomen. She then did the two tests expected without prompting. Firstly, she aspirated with a syringe to see that there was no question of any blood involved in the placing of the needle and, similarly, nothing suggested bowel or bladder contents. I should add that I had emptied*

the bladder at the end of the hysteroscopy as being part of the laparoscopy routine. Dr. Moyano then did a drop test where a small amount of normal saline is placed in the top of the Verres needle and then it descends into the needle itself under gravity, again demonstrating that there was free flow of fluid down the needle into the peritoneal cavity. She demonstrated this particularly accurately and well and having done that was able to connect the gas allowing the abdomen to distend. She confirmed the distension of the abdomen by percussing the abdomen and watching it uniformingly extend (percussion gives a tympanic sound as opposed to a dull dead sound if gas is not going into the abdomen). This went well and having put in over 2 litres she passed the trocar and cannula into the abdominal cavity. She removed the cannula and then passed the telescope. She was able to demonstrate at the laparoscopy the uterus and pelvic organs and with me lifting the uterus forward from below by pushing on a sound[2] backwards from below, she identified properly the subtle changes of early endometriosis with some red spots which she described and I concurred with her opinion. She also looked at the liver, she looked at the 360 degree view to make sure there were no adhesions (which is part of my routine laparoscopy) and again this was satisfactory. The procedure ended and the appropriate sutures placed in the abdomen.

I was very impressed with her safe and sound technique. I am always critical of laparoscopy surgery (especially when done by others). I did not notice or see any problems with Dr. Moyano's technique. Dr. Moyano passed the trocar and cannula and telescope all without incident, then demonstrated the possible cause of the pain with the finding of early endometriosis.

In fact I was actually impressed ... that she was sufficiently robust in her judgement to challenge my query about the depth of needle entry."

[2] A sound is an instrument for measuring the length of the uterus.

7.45 Dr Moyano also assisted with the fourth, seventh and eighth patients. In her statement of 8 November she says that Mr Day dealt with the fourth patient on his own but Mr Day clearly recalls that she carried out the procedure:

> "*This was a hysteroscopy and biopsy performed by Dr Moyano...I specifically watched Dr Moyano's technique and found it satisfactory...her dilatation of the cervix went well. We both thought it was quite tight in this post-menopausal lady and so I encouraged her to place a second Vulsellum on the cervix as sometimes the cervix will tear if you don't, which Dr Moyano did. In the event there was a small tear in the cervix…which was sutured by Dr Moyano…and is not unusual. Dr Moyano took the biopsy and ended the case and dictated a letter to the GP.*"

The patient's notes show that Dr Moyano participated in this procedure.

7.46 Dr Moyano's recollection, in her statement of 8 November 2006 was that the seventh patient simply had a hysteroscopy and the eighth patient had a hysteroscopy during which a polyp was removed. Mr Day's recollection in his statement of 20 December 2006, in his interview with police and with us, was that the seventh patient had the polypectomy and the eighth patient simply had a diagnostic hysteroscopy. When Mr Woolfson examined the patients' notes for 17 October he confirmed that Mr Day's recollection was correct.

Comment

Where Dr Moyano's account differed from that of Mr Day and we were able to obtain corroboration from records and documents, Mr Day's account was shown to be more accurate. Other examples of this appear in section 9.

7.47 Dr Moyano prepared the seventh patient and carried out the hysteroscopy while Mr Day was out of the room. During the procedure she discovered a large polyp and asked that Mr Day be called back. He returned and resected the polyp using diathermy. He told us:

"I knew this lady had a polyp, because there was a big polyp on the scan and it obviously needed resecting. Now that would not have been, unless I knew a lot about her practice, her job to resect it…I wouldn't ever leave something like that for someone else to do."

Comment

***Mr Day is making the point that he knew from the earlier scan that this polyp was so large that it would best be dealt with using the resectoscope and that this was a specialised task that he would not have delegated to Dr Moyano because he did not have information about her skills in carrying out this procedure*.**

7.48 Dr Moyano's reasons for calling Mr Day back are set out in section nine.

7.49 The seventh patient left the operating theatre at 12.00pm and the eighth came in at 12.10pm. During the ten minutes between patients Mr Day called his secretary at his private rooms and asked her to cancel his pre-clinic appointments and then called her back to check that they had been cancelled. He said in his statement:

"*Given that I would not be able to start my list of private consultations at my rooms at the Hotel de France, I took the opportunity to telephone my private secretary, Wendy, and asked her to tell the patients that I would not be able to attend and invite them to make further appointments. Usually these can be made for later the same day. I attach a copy of my diary for Tuesday 17 October 2006 which shows the cancelled appointments together with a note made by Wendy of my call. The asterisks next to patient's names denote that an alternative appointment was made.*"

He told us:

"…that is again about the coxing and boxing. You make plans and then you change plans, and because we are so close between our rooms and the hospital,

we were doing that. I don't know whether you have interviewed other consultants from other specialisms but you are having to do that all the time."

7.50 The eighth patient was a member of staff. We asked Mr Day if he knew this and he said that he did not because the notes had not made this clear and no one had alerted him.

7.51 Dr Moyano prepared the eighth patient for hysteroscopy, again while Mr Day was out of the room. As he came back in, he could see that she was having some difficulty in dilating the uterus, so he helped her. We asked him:

"Did it bother you that Dr Moyano was having difficulties?
A. No, just being cautious, I thought, 'No, it's fine'.

Q... so you wouldn't have thought, 'She doesn't seem to know what she is doing'?
A. This is somebody, again, who is doing multiple ERPCs in her obstetric list. You know, evacuations. No, I wouldn't analyse it."

7.52 Evacuation of retained products of conception (ERPC) is carried out under general anaesthetic following some births and some miscarriages. The cervix is dilated and the retained matter is removed using gentle suction or forceps. In both cases dilators are needed to allow the introduction of the therapeutic instrument. Dr Moyano confirmed in her police interview that her obstetric work had given her experience at using dilators to gain access to the uterus.

7.53 Details of Dr Moyano's expertise are set out in section nine.

7.54 There is often more than one doctor in the operating theatre capable of carrying out a procedure. All the consultants in the department told us it was not uncommon for a consultant to leave a junior colleague to carry out a procedure in his or her absence.

7.55 If the junior doctor is in training and the consultant has responsibility for that training, the junior must be given opportunities to carry out procedures within his or her competency so as to gain experience. An inexperienced doctor is closely supervised, with the consultant watching every move, but as the junior doctor gains in skill and experience, the consultant deliberately moves further away, until they are out of the room or even out of the theatre suite so as to show confidence in the junior doctor. Staff grades and associate specialists who are in possession of their certificate of completion of training (CCT) can practice independently providing that they have also been approved by a senior consultant. They too should be given regular unsupervised opportunities to undertake the whole range of procedures within their competence, as well as supervised opportunities to expand their range. All doctors we spoke to told us that junior and middle-grade doctors must not be allowed to operate in the absence of the consultant until the consultant is absolutely satisfied that they have the necessary skills and experience.

7.56 The lead surgeon sometimes leaves the operating theatre mid-operation, for example if the operation is long and he or she needs a short break. The patient remains in theatre, monitored by the rest of the team, and the surgeon returns and resumes the operation. This happens only in long operations when the patient is stable.

7.57 None of those in the theatre who we interviewed thought there was anything untoward in Mr Day's leaving the operating theatre during the procedures on the seventh and eighth patients.

Comment

There was nothing inappropriate or unusual in Mr Day's leaving the operating theatre during his list, leaving another doctor to carry out procedures. He had observed Dr Moyano's hysteroscopic and laparoscopic skills and was entitled to believe that she could carry out these procedures unsupervised. It is acceptable and normal practice in the UK and most hospitals to leave theatre provided that

the consultant is confident in the ability of the surgeon taking over the procedure to complete the operation.

Elizabeth Rourke's operation

7.58 The anaesthetic nurse, Sarah Boyes-Varley, took Mrs Rourke to the anaesthetic room at 12.14pm. She chatted with Mrs Rourke to put her at ease while she prepared her for anaesthesia. She discovered during the conversation that Mrs Rourke was a nurse at the hospital.

7.59 Mr Day came out to speak to Mrs Rourke, as he had done before each patient was taken into theatre. He read her notes for the first time and discovered that she was a nurse. He told us that when he discovered this he was annoyed that she had not been put earlier on the list. We asked him why he did not stay to do her procedure. He said:

> "*…because I already had the plan for Dr Moyano to do it and it seemed to be accepted and she seemed pleased to do it. So you don't need to change that sort of plan, I don't think, for a minor procedure such as a hysteroscopy.*"

7.60 We asked him if he would have taken the case back if his experienced staff-grade colleague Dr Lawal Bappa had been working with him that day and he told us that he would not have done so once it had been agreed that Dr Bappa would do the operation because:

> "*Dr Bappa is an excellent surgeon and an excellent doctor*."

7.61 Mr Day told us that if he had known that Mrs Rourke was a nurse before the list was finalised he would have ensured that she was placed near the beginning of the list, as a matter of courtesy.

7.62 The general rule is that the order of the list is altered only if absolutely necessary. When the surgical team are dealing with people they do not know well, or at all, and where the patient is anaesthetised before going into the operating theatre, it is crucial that there is no confusion about which patient is having which procedure. Changing the list order is an obvious way for such confusion to arise. Sometimes this is necessary, for instance if there is a particular instrument that is needed in two operations listed consecutively. It must be sterilised before it can be reused, so the second patient is put back. There is a set procedure to try to ensure that such changes do not result in muddle. Dr Lane told us:

> *"But there is a rule, really, that once you have your published list with names, order etc, and operation on it, you should not vary it.*
> *Q. So you might vary the order, but not the –*
> *A. Well, you should not even vary the order. Once it is stuck up on the theatre wall, you go by that. Or, you take the list down, you recognise it electronically and you reprint the list, and what we do here is now we have different colours. So the list is printed in black and white. If it changes once, you change it to yellow, with black typing and if it is changed twice, you change it to red. But some hospitals would not allow a list to be changed at the last minute like that."*

Comment

Mr Day did not see Mrs Rourke in outpatients and so did not see the letter identifying her as a member of staff.

He is not at fault for not having checked the notes after Mr Dumbrill's decision to make arrangements for a hysteroscopy; he knew Mr Dumbrill well, knew he had qualified in South Africa and worked there as a consultant for five years before coming to the UK and Jersey to obtain local qualifications. He had worked at the hospital in a substantive post as well as in locum ones and was a welcome regular locum.

It seems to be common practice at the hospital for the operating surgeon not to see surgery notes before the day of the operation, although in many cases the surgeon will have seen the patient at an outpatient clinic. If Mr Day was acting in accordance with local custom and practice, we believe it would be disproportionate to criticise him for not having read the notes the day before the list.

We consider that Mr Day should have reviewed the notes of all patients on the morning of the 17 October before starting his list, in accordance with best practice. If he had done so, he would have been aware that Mrs Rourke was a member of staff and might have decided to undertake her procedure himself.

7.63 We put this to Mr Day, who accepted the criticism but explained:

> *"…almost all of the patients would have been seen by me previously in clinic. Further, by the very nature of the unit, the procedures carried out in the day surgery unit are not so complex that there is insufficient time to consider the notes adequately during the course of the list."*

Comment

Our review of the day surgery lists of a number of consultants shows that it was commonplace for more junior doctors to carry out some of the procedures at the end of the list and we accept that Mr Day believed that Dr Moyano wanted to carry out the procedures and was competent to do so because she had worked as a consultant obstetrician and gynaecologist both in Spain and in Jersey. Mr Day confirmed to us that he was careful to observe professional courtesies with colleagues in the hospital. In allowing Dr Moyano to carry out procedures on his list he was showing her a professional courtesy. In allowing Dr Moyano to operate on Mrs Rourke once she had been identified as a member of staff he was showing them both professional courtesy by treating Dr Moyano as his professional equal and by ensuring that Mrs Rourke's operation was being carried out by an experienced consultant.

Recommendation

R3 Consultant surgeons should check the records of the patients on their operating lists before the operating order is finalised to ensure that each list is balanced, safe and in the right order. *Urgent*

7.64 We asked Mr Day why he had left Dr Moyano to operate when he had so little experience of working with her. He said:

> *"If we have a registrar, and we don't know them, we have to be the good shepherd … but an independent practitioner employed and labelled, to all intents and purposes, as a consultant, is outside that shepherding process I would suggest.*
>
> *…if you had heard that there were… various doubts and concerns … regarded to the fact that she was a consultant.*
> *I would say, 'Why are we employing her as a consultant?'*
>
> *…I would need another interview with her and say, 'You can't work as a consultant, it's as simple as that'. You can't supervise a consultant. If you have somebody who is on call for the whole night doing obstetrics and gynaecology, whether it is hysteroscopy, laparoscopy or caesarian section, which I would suggest is more dangerous… and I would have thought if there is a dysfunction like that, they are not employed at all."*

Comment

We have looked into the conduct of the list that day and find no medical reason why Mr Day should have stayed on in the operating theatre. We are aware of the 2004 guidance from the Royal College of Obstetricians and Gynecologists,* Minimum standards in respect of elective work performed during a consultant's absence. *It relates to work being delegated to specialist registrars or to staff grade doctors. It is not clear to us that this guidance covers the situation on 17

October, as it is not clear to us that Dr Moyano could properly be described as a specialist registrar or a staff grade at the time. We expect that the GMC will clarify this.

7.65 We asked Mr Day why he left the hospital before the end of his list. He said:

> *"A. Because I always do. Well, these are minor cases, and over the years one has been pleased for junior staff to do these cases. If they want me to stay; I am about three or four minutes away if they want me and I come back –*
>
> *Q. Okay, so to you it is no different to being in your office in the hospital?*
> *A. No. It is a practice that I have done … In our operating list, we are coming and going for minor cases. For major cases you never go. For difficult cases you never go, and you will always stay there. But for hysteroscopy – again, go back to the night duty – we have hysteroscopy, laparoscopy, caesarean sections, which sound simple but are very - but we are not there for them."*

7.66 Mr Day said in his statement of 20 December 2006 that he left the hospital for his private rooms, intending to have a sandwich and deal with departmental paperwork and correspondence before starting his afternoon clinic, explaining that his private rooms were quieter than his office at the hospital.

Comment

We arranged for the distance to be timed and established that in the middle of a weekday the journey by car was more likely to take eight to ten minutes. We do not consider this significant because we are aware that consultants on call at home can be much further away.

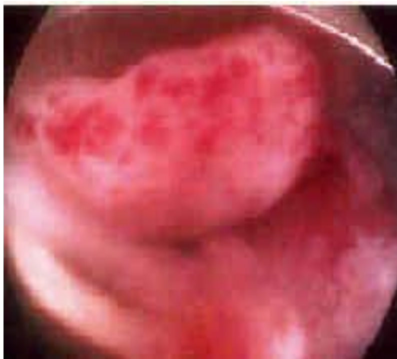
We do not comment on whether Mr Day was contractually entitled to leave the hospital before the end of his operating list as such issues are not within our terms of reference. Nor have we enquired into whether this was a practice common to other consultants as this, too, was not within our terms of reference.

7.67 We have been given other evidence that the hysteroscopy Dr Moyano was being left to undertake was simple and one that all on-call registrars and staff grades would carry out unsupervised at night, when the on-call consultants were at home. Her CV supports this and also shows that she was carrying out these procedures as a junior consultant in Barcelona in 2002-03 and as a senior consultant in 2004-05.

7.68 Further information about Dr Moyano's position on this point is in section 9.

7.69 At 12.33pm Mrs Rourke was wheeled into the operating theatre and Dr Moyano started the hysteroscopy, as she had done for the fourth, seventh and eighth patients. Mr Day left the theatre after Mrs Rourke had been brought in.

7.70 The procedures for which Mrs Rourke had given consent were hysteroscopy and D&C. Each procedure has a set of surgical instruments to cover it and any situations likely to arise from it. For instance, the tray of instruments prepared when a woman has a hysteroscopy always includes polyp forceps, the standard instrument for removing polyps before hysteroscopy and diathermy were developed in the 1990s.



Endometrial polyp

Polyp forceps

7.71 In some hospitals it is the custom or policy for the trays of surgical instruments to be standard for the procedure, regardless of the preferences of the surgeon. This is now the policy at the Jersey General Hospital but in October 2006 the trays were customised according to the preferences of the operating surgeon.

7.72 Mr Day is a skilled and experienced gynaecological surgeon and he preferred to use a resectoscope for diagnostic purposes, even where it was not clear that any diathermy would be required. He told us that when he was learning the skills of hysteroscopy, resectoscopes were more satisfactory than hysteroscopes because the light on them was more powerful and so more useful for diagnostic purposes. He had learnt his skills in this way and had continued to use resectoscopes for diagnostic purposes, even though hysteroscopes were now more effective than they used to be. He also said that when a hysteroscopy was bound to be followed by some sort of therapeutic procedure, a resectoscope might be less invasive than the use of a hysteroscope for diagnosis followed by another instrument for the procedure. For example, the dilators for dilatation and curettage go up to nine or 10mm, which is larger than a resectoscope, so a hysteroscopy plus D&C is more intrusive than taking a specimen with a resectoscope.

7.73 It is not possible to use the resectoscope with diathermy without having decided to do so. Pressing a foot pedal activates the electric current through the loop, but the electric current is available to be activated only when the electricity supply is plugged into the resectoscope by the surgeon or another scrubbed member of the team on the surgeon's instructions. This happens only once the need for diathermy has been identified, that is after the diagnostic hysteroscopy.

7.74 The instrument tray had been prepared in accordance with Mr Day's preferences and it was known that he did not use a hysteroscope, so there was not one on the tray, only a resectoscope. Unless she called for another instrument, Dr Moyano was therefore obliged to use the resectoscope to carry out Mrs Rourke's diagnostic hysteroscopy as she had done with patients 4, 7 and 8.

Comment

Mr Day may be justified in his use of the resectoscope: other surgeons have a different practice, and the composition of the instrument tray should have allowed for this.

Recommendation

R4 The theatre management group should ensure through regular audit that instrument trays remain standardised and contain all appropriate equipment.

7.75 Dr Moyano dilated Mrs Rourke's cervix and introduced the resectoscope without problems, commenting that dilatation was easy because Mrs Rourke had had three children.

Comment

This observation shows that Dr Moyano had prepared properly for the operation by looking at Mrs Rourke's records and relevant medical history.

7.76 Dr Moyano thought she saw the image of a polyp on the screen during the hysteroscopy. She at once asked Dr Sullivan, the senior house officer who was also in theatre that day, to contact Mr Day for instructions. She understood that this was the correct approach because there had been no mention of dealing with a polyp when Mrs Rourke's procedure had been discussed earlier and professional etiquette therefore required her to contact the patient's consultant before carrying on.

7.77 It was not until this point that Dr Moyano became aware that Mr Day had left the hospital.

Comment

This was a reasonable action for Dr Moyano to take. She believed that Mr Day was nearby, as he had been on the previous two occasions and she was therefore simply following the procedure that she had taken with patient 7.

7.78 Having established that Mr Day had left the hospital, Dr Moyano asked Dr Sullivan to telephone him. At 12.49pm the switchboard reached him on his mobile. Dr Moyano was not able to speak to him directly because she was still sitting in front of

Mrs Rourke, holding the resectoscope which was still in the uterus. Dr Sullivan therefore acted as the intermediary between Mr Day and Dr Moyano during the conversation.

7.79 Dr Moyano and Mr Day have different memories of the conversation (see section 9) but in neither account does he say that she should remove the polyp using diathermy.

7.80 In her statement of 11 October Dr Moyano said:

> *"I considered how best to proceed. Although unhappy at being left alone to undertake the procedure, I knew that I had done such procedures before and considered myself competent to perform it, subject to first assessing the nature and complexity of the particular polyp. I looked at the patient and thought: she is anaesthetised, there is a polyp and she has a history of intermenstrual bleeding. I thought that if, on further examination, the polyp was of a complex nature, (a sessile polyp – a relatively flat polyp) I would not seek to remove it and would instead halt the procedure. Further, I considered that if it were difficult to remove the whole polyp I might at least take a sample under visualisation so that it could be sent for testing. If it were benign, that would be the end of it. If I did nothing she would have to go through the whole procedure again. I considered that I should, in the interests of the patient, proceed to try and remove the polyp or a sample of it."*

Comment

One of the experts called for the defence during the court case described Dr Moyano as a trainee for the purposes of hysteroscopy and resection. We do not consider the way Dr Moyano explained her thinking about the procedure to be that of a trainee, either for the purposes of hysteroscopy or of resection and it is clear from her statement and police interview that Dr Moyano did not see herself in that light.

7.81 Further information about Dr Moyano's position at this moment appears in section nine.

7.82 In the days before hysteroscopy and diathermy, polyps were removed using polyp forceps or even a curette. The surgeon using these instruments works blind so the possibility remains that the instrument will not remove the polyp completely or at all on the first occasion, so a number of attempts may be needed. On the other hand, it is a low-tech and low-risk procedure with which any obstetrics and gynaecology doctor at registrar level and above, whether in England or in Spain, would be familiar. It is the procedure they were trained to carry out before they ever used a resectoscope.

7.83 We asked Mr Day how he thought Dr Moyano would remove the supposed polyp and he said he would have expected her to use forceps, as any polyp must have been small or it would have shown up on the earlier scan.

7.84 The following exchange took place in Dr Moyano's police interview:

> *"Q: How familiar are you with removing this type of polyp either by forceps or by curette?*
> *A:I did this kind of polyp before...other kinds of polyps are more complex. A pathology typical of women who are on Tamoxifen. In the hospital where I trained we had seen particularly this type of pathology in mammary oncology where a lot of women had more complex types of polyps as a result of taking this drug. I intervened in several procedures of this kind.*
> *Q: What is the benefit of using diathermy for removing a polyp? Why would you as opposed to using the other two options?*
> *A: The main advantage is speed so you save time, and time is of the essence because time can be a negative factor. Also the precision for cutting; it produces a clean cut because this polyp such as this was pedunculated polyp could have been removed with forceps too.*
> *Q: … Why did you choose the diathermy option over forceps?*

A: I did not decide on the instrumentation. This was the instrument that was already there assembled. I had seen during the day that this was the instrument that had been used and previously already seen that at this hospital that's what they were using. This is the most advanced technique. I haven't seen them using forceps before.

Q: Were forceps available to you if you'd wanted to use forceps?

A: I don't know.

Q: OK. Did you consider using forceps to remove this polyp?

A: I didn't think so at the time no.

Q: In your opinion what are the significant risks of using diathermy over forceps?

A: The perforation whilst using the diathermy, the danger with this is all the nearby structures can be affected.

Q: Are there any other obvious or significant known risks?

A: Not really because all the risks are due to the fluid and air because the electricity used for these cases is a very low voltage so there is no other risk."

Comment

Dr Moyano had worked as a specialist registrar in obstetrics and gynaecology between 1998 and 2002 and had provided consultant on-call emergency cover in gynaecology as late as 2005. We believe that she would not have lost the skill to do this basic procedure by October 2006. It is also the case that exactly the same forceps are commonly used for ERPC (evacuation of the retained products of conception), a procedure that any obstetrics and gynaecology on-call registrar or consultant would expect to carry out routinely and which Dr Moyano had carried out in Jersey.

Dr Moyano made clear in her statement of 8 November 2006 that she felt under pressure to complete the procedure, otherwise Mrs Rourke would have had to return on another occasion. This sense of pressure is not borne out in the answers in her police interview in March 2007, where she seems much more positive in her approach, as set out in section nine. As stated above, she did not think to use forceps but it is not clear why not. It is our impression from Dr Moyano's

explanation to the police that she decided to use diathermy because she thought it best.

7.85 Dr Moyano's advocate said during her trial that in resecting the polyp she acted on instruction from Mr Day but this is not supported by her statement or her police interview.

7.86 We asked Mr Day if he would have acted differently if he had been in the hospital when Dr Sullivan contacted him to tell him that Dr Moyano had found a polyp. He said that he would not have because his impression was that Dr Moyano was only calling him out of courtesy: "*this was a consultant doctor*".

7.87 Further information about this is set out in section nine.

7.88 The point when Dr Moyano realised that the uterus had been perforated was after she had used diathermy in her attempt to resect the polyp. As soon as she realised it, she used the light and camera to see if there was evidence of bleeding in the abdominal cavity. She saw none, so she removed the resectoscope and, in her statement of 8 November 2006, she says she then asked Dr Sullivan to telephone Mr Day again to report a false passage and perforation of the uterus.[3]

7.89 Once again, recollections of the conversation that took place differ. They are set out in detail in section nine. It is clear that Dr Sullivan understood Dr Moyano to be reporting a false passage and passed this on to Mr Day, who advised accordingly. It is also clear that there was a conversation about the use of electricity but not clear when because the phone records do not accord with the recollections of any of the three doctors. However, both Dr Moyano and Mr Day recalled that Mr Day asked whether electricity had been used and Dr Moyano said it had not. Dr Moyano said in her police interview that she thought Mr Day was asking whether diathermy had been

[3] A false passage describes accidentally making a canal or tunnel in the wall of the cervix with an instrument such as a hysteroscope, while on the way to the uterus, but generally not going all the way through into the peritoneal cavity. A perforation describes making a hole right through the wall of an organ, in this case the uterus.

involved in the perforation of the uterus, because she thought Dr Sullivan had already told him that the uterus had been perforated.

7.90 Mr Day told us that he was asking generally if diathermy had been in use during the procedure. We asked him what he would have done if she had said to him that she had just perforated the uterus with a resectoscope and seen the bowel, but haven't used electricity. He said:

> *"If she had perforated it, I would have come back whatever, because you have this difficult decision what sort of injury is it? How did you perforate it? Are we going to do a laparoscopy, or are we going straight to a laparotomy? It is a really difficult decision what is the right thing to do and obviously you look at the patient, the patient's general condition: are they collapsed? Ask the sister, what has happened. This is a very experienced theatre sister; you would get some picture."*

7.91 Dr Sullivan said she had told Mr Day that there had been a false passage only because that was what she had heard from Dr Moyano.

7.92 The records show that the perforation caused no immediate apparent ill effects. Mrs Rourke's blood pressure was within the normal range and she was taken to the recovery room in the normal way.

7.93 Some consultants, on realising that the uterus has been perforated by a large diameter instrument, routinely carry out a laparoscopy at once while the patient is still unconscious, to see if there is bleeding in the abdomen.

Comment

There was a serious breakdown in communication: Dr Sullivan did not tell Mr Day that there had been a perforation as she had not heard Dr Moyano say that there had. There is no evidence that Dr Moyano tried to let Mr Day know that she had

seen the bowel, which she should have done. There was a further breakdown in communication between Mr Day and Dr Moyano about the use of diathermy.

We consider that Dr Moyano should have carried out a laparoscopy while Mrs Rourke was still in theatre because she knew there had been a perforation and that it had been caused by a wide-diameter instrument. There is no evidence that she discussed this with Mr Day (which would have alerted him to the perforation) nor is there evidence in her statement or police interview that she thought about carrying out a laparoscopy.

7.94 We do not know, and now cannot know, how the damage to the iliac vein occurred. One theory, put forward by the prosecution at Dr Moyano's trial, is that the uterus was perforated and the iliac vein damaged as a result of a single thrust of the resectoscope with the diathermy element live. Another possibility, put forward by the defence, was that Dr Moyano had inadvertently thinned the wall of the uterus with diathermy, in her attempts to remove the polyp she believed to be there and had then perforated the uterus and damaged the vein with a thrust of the resectoscope through this thinned wall, but without the diathermy element being live. A third possibility is that the perforation was caused at the beginning by the sound (measuring instrument) or during the initial introduction of the resectoscope and that the later use of diathermy had nothing to do with the perforation or damage to the vein. An expert at the trial suggested this was unlikely because the liquid used to inflate the uterus would have leaked into the peritoneal cavity and this had not happened.

7.95 The reason for this lack of clarity is that the scientific evidence is inconclusive. Diathermy leaves a charred residue known as diathermy artefact. It is distinctive, and we can be sure that where it is found, diathermy has been used. In Mrs Rourke's case, there is no evidence of diathermy artefact other than on the inside of her uterus. There was no diathermy artefact on the vein at the post-mortem examination and Mr MacLachlan confirmed to us that he saw no diathermy artefact on the uterus when he carried out the laparotomy. However, if the damage had been caused by diathermy, the artefact would almost certainly have been swept away by the ensuing blood loss or

during the rescue operation. It is therefore not possible to say whether or not the damage to the vein was caused by diathermy.

7.96 Furthermore, it is not even possible to tell whether diathermy was wholly the cause of the perforation of the uterus, because the specimens taken after Mrs Rourke's death did not show the full length of the perforation. If they had, we would know if there had been diathermy along the full length and would have been able to assume that the diathermy had also caused the damage to the iliac vein. No specimen was taken of the full length of the perforation so it is impossible to know, one way or the other, whether the live element ever reached beyond the uterus.

7.97 The fact that Mrs Rourke's blood pressure did not drop appreciably until after she left the operating theatre does not help in fixing the time of the accident; the body compensates for blood loss until it is no longer able to do so, at which point the pressure falls. There is no set period during which this compensation will be effective.

Comment

Based on his previous clinical outcomes, it seems likely that there would have been no accident if Mr Day had carried out the procedure, either with or without diathermy. However, the evidence suggests that Mr Day's presence in the day surgery unit or elsewhere in the hospital would not necessarily have prevented the accident once it had been agreed that Dr Moyano would carry out the procedure. If Mr Day had still been in the day surgery unit, it seems likely that he would have returned to the theatre if Dr Moyano had asked him to do so on finding a polyp, because this had happened with patient 7. However, Dr Moyano did not ask him to return.

7.98 Dr Moyano recollected that after leaving the operating theatre she telephoned Mr Day again because she was not happy with his advice. He does not remember receiving this call and the hospital phone log shows does not show any calls to his mobile or consulting rooms at that time.

7.99 Staff nurse Tanya Hanson was Mrs Rourke's recovery nurse. A few minutes after Mrs Rourke came out of the recovery room, Ms Hanson noticed that she looked unwell and called Dr Moyano and Dr Sullivan to check her. Her blood pressure was too low to measure.

7.100 A series of actions was promptly taken; Dr Regina Thomsen, a junior anaesthetist, immediately prepared Mrs Rourke to go back into theatre. Mr MacLachlan, the on-call consultant gynaecologist, and Dr Lane, the on-call consultant anaesthetist and specialist registrar Dr Khalid Ahmed were bleeped. Mr Day was contacted and came straight back.

Comment

The staff acted promptly and professionally as soon as Mrs Rourke showed signs of injury. In particular Tania Hanson quickly noticed that Mrs Rourke looked unwell and Dr Thomsen showed great skill and presence of mind in responding to the emergency.

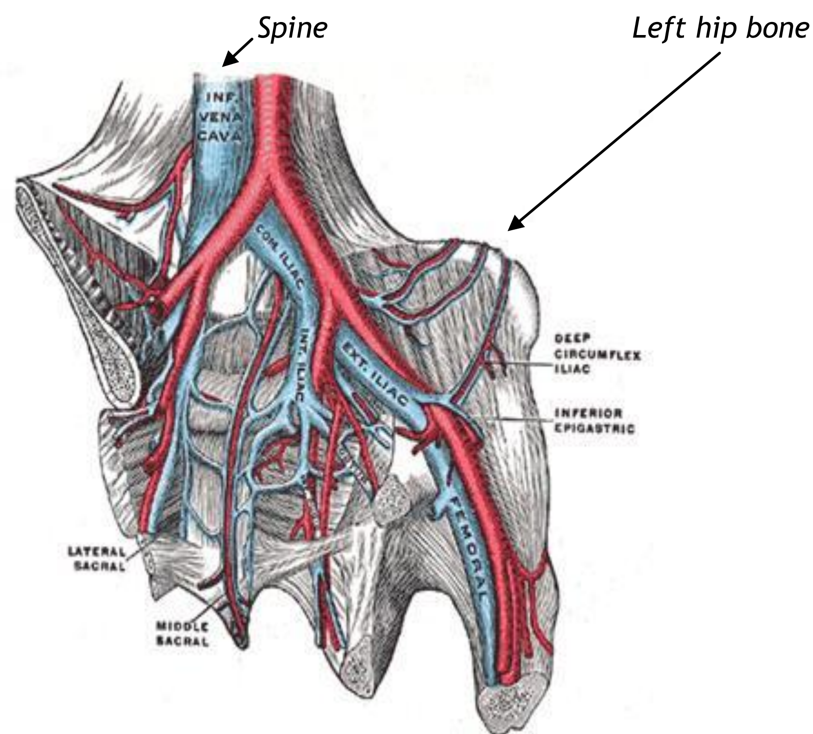
7.101 A detailed account of the afternoon's events in set out in the chronology at appendix E. A briefer description of the main events of the afternoon follows.

Comment

The events of the afternoon were complex, urgent and fast-moving, with up to 30 people working together to find a solution. Our task in piecing together the events was greatly assisted by the quick-witted realisation of Julie de la Haye and Judith Gindill that a record of events should be made and by the careful and diligent manner in which theatre assistant Brian Andrade made such a record, in difficult circumstances.

The rescue operation

7.102 At 1.25pm, Mr MacLachlan arrived in the recovery room, examined Mrs Rourke and confirmed that it would be necessary to undertake an emergency laparotomy (an operation to open the abdomen). Mrs Rourke was taken to the anaesthetic room where a general anaesthetic was given and she was taken to the operating theatre. Mr MacLachlan started the laparotomy at 1.35pm assisted by Dr Ahmed. Mr Day arrived sometime between 1.45pm and 1.50pm and took over as main surgeon with Mr MacLachlan assisting.



7.103 Mr Day tried to suture the hole in the iliac vein but was unsuccessful because it was so fragile. At 2.15pm, he asked that a general surgical consultant be called. It was established from the switchboard that James Allardice was the on-call surgeon but Mr Day asked that another surgeon, Nicholas Ingram, be called instead. We asked Mr Day why he had done this and he said that he had seen Mr Ingram a little earlier, so knew he was on the premises and would be able to come quickly. Furthermore, Mr Ingram was known to have a special interest in vascular surgery, so was the natural first choice in this situation.

7.104 Mr Ingram arrived about ten minutes later, when Mr Day was controlling the bleeding with direct pressure with his hand. Mr Ingram took over by trying to control the bleeding by suturing the vein and Mr Day left the theatre to seek advice from the vascular service in Bournemouth. He spoke to the duty surgeon, Mr Lasantha Wijesinghe who provided advice that was relayed to Mr Ingram. At the same time, a vascular surgeon on Guernsey was contacted and stood by to fly to Jersey.

7.105 Just after 3.30pm Mr Ingram contacted Mr Allardice, who arrived in theatre at 3.50pm. Mr Allardice was able to gain better control of the bleeding than the other surgeons, although it was impossible to obtain complete control because there was still bleeding from the back of the vein.

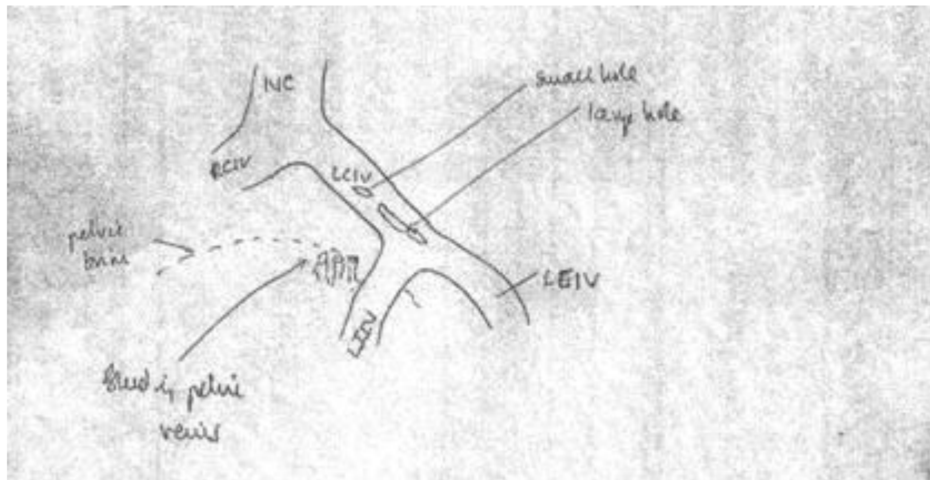


Diagram showing the position of the perforation in the common iliac vein, made by Mr Allardice immediately following Mrs Rourke's operation

7.106 It was decided collectively that because some control had been obtained, the best course of action was to pack Mrs Rourke's abdomen with swabs, which would provide pressure to stop the bleeding, and fly her to Bournemouth for treatment by a specialist vascular surgeon. Mr Gary Kynman, manager of the intensive care unit, was involved in making the arrangements. He went to the theatre to help prepare Mrs Rourke for transfer, and was therefore in theatre when she suffered a cardiac arrest at 5.40pm.

7.107 Attempts to resuscitate Mrs Rourke continued for 45 minutes until it was clear that there was no possibility of success, and she was pronounced dead at 6.25pm. Mr Day and Ms Angela Body told Mr Rourke that his wife had died and a priest was called. During this time, the operating theatre was cleaned up and a sheet was brought in to shroud Mrs Rourke. Mr Rourke, accompanied by a priest, went into the operating theatre to see his wife.

Comment

We consider that the hospital staff made every effort to keep Mr Rourke informed of developments and to be sensitive to his needs that afternoon and evening.

7.108 In investigating Mrs Rourke's care and treatment, we have looked at the attempts to save her life as well as at earlier events.

7.109 It was suggested during Dr Moyano's trial that Mrs Rourke would have had a 90 per cent chance of survival if the rescue operation had been carried out competently. Mr Day in particular was criticised for his actions. We deal in detail with these criticisms in section nine.

7.110 We decided to get our own expert to comment on the actions of the surgeons involved in the operation and instructed William Butcher, consultant vascular surgeon at the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. We chose him because he is familiar with the range of work carried out on Jersey and with the skill to be expected of surgeons working on the island. Furthermore, by the time we instructed him he had resigned from his post in Bournemouth and was in his last few months working in England. We were therefore satisfied that he would have no conflict of interest in giving us an opinion on the events of that day, with which he was not involved. We asked him to comment on the actions of the surgeons during the rescue operation. He commented on Mr Day's actions as follows:

> *"Faced with a large vein bleeding in the pelvis he did what I believe most surgeons would do. We already know that this was a lethal injury. We also*

have the benefit of knowing that there is particular difficulty associated with managing bleeding from the common iliac vein. It is not in my view unreasonable that Mr Day would have perhaps through lack of experience been unaware of this fact and attempted to repair the vein. Or indeed even knowing the severity of this type of injury may still have felt that he had no alternative other than to attempt repair. It is possible that a few timely and well placed sutures may have solved the problem right at the outset. In the event this did not happen, and when he failed he called for help. In reality had he called any vascular surgeon before attempting repair most, I believe would have told him that this was a very dangerous situation, and that if a vascular surgeon was available they should be called rather than attempting repair himself. I believe at this point I could easily have justified a decision to press on the vein for several hours waiting for a vascular surgeon from elsewhere to come rather than repair it himself. This view I think is shared by Professor Bell[4]. The difficulty is that when faced with a choice between standing and waiting for several hours or attempting repair I suspect the majority of surgeons would attempt a repair in the hopes of a simple and prompt solution to a difficult and vexing problem."

Mr Butcher referred to an article "Iatrogenic operative injuries of abdominal and pelvic veins: *Journal of Vascular Surgery 2004, 31, 931-36*" and said:

"This is an extremely responsible report from the world renowned Mayo clinic. It details the nature of 44 accidental abdominal venous injuries sustained during surgery over a 17 year period. None were laparoscopic. However, massive bleeding, difficulty with repair and a high complication rate were recorded. The mortality was 28 per cent. This occurred in one of the best centres in the world with a large vascular unit immediately available. In his discussion the author offers the following:

"It is natural that surgeons attempt to repair their injuries. However, excessive delay in obtaining vascular surgery assistance often leads to more blood loss.

[4] An expert at the trial.

Although we were not able to objectively assess how much blood loss the referring surgeon struggled with before calling for a vascular surgeon, our impression is that most of the blood loss occurred before vascular surgeons were involved."

Also:

"We found that a common mistake in attempting to obtain vascular control is the forceful use of clamps around the vein, resulting in additional injuries."

7.111 In relation to Mr MacLachlan's actions, Mr Butcher said:

"Mr MacLachlan was on call for Obstetrics and Gynaecology on the 17th October. When he became aware of a problem in the day surgery unit, it seems he responded promptly. When he arrived in the recovery area, faced with a hypotensive patient almost certainly due to bleeding and I believe fully aware of the complication that had occurred during hysteroscopy he made an appropriate decision to explore the patient.

This decision needs to be examined a little further. That Mrs Rourke's collapse in recovery was caused by bleeding from the Common iliac vein is now self evident. However, before the laparotomy was undertaken, this was not known. Suggestions were made during the trial that information may have been withheld by Dr Moyano. In his statement Mr MacLachlan states that he was aware that a uterine perforation had been made. After the fact (when his statement was written) this was self-evident. It is a reasonable question, at this time, to ask whether he actually knew that or simply assumed that he had known because of the findings at laparotomy. If Dr Moyano had not told Mr MacLachlan anything at all, Mr MacLachlan would still have been faced with a patient in recovery who was profoundly and suddenly haemodynamically unstable following an operation. The recovery unit would very likely have had a copy of the theatre list, and therefore Mr MacLachlan would have known something about the surgery which Mrs Rourke had undergone. In a previously

fit patient who has recently had a surgical intervention it is a logical and sensible deduction that the hypotension was a result of bleeding caused by surgical misadventure. In the absence of per-vaginal bleeding the assumption that there was intra-abdominal bleeding was present is logical and correct. Thus even with no information from Dr Moyano it would not have taken long for him to reach the conclusion he did.

A question that can be raised at this stage is, that having assumed that he was about to perform an emergency laparotomy on a patient with almost certain evidence of heavy intra-abdominal bleeding, did he feel competent to tackle this on his own? In retrospect it may have been more sensible to have called for general surgical support at that time, before the laparotomy commenced. This notwithstanding, however, he made a good decision to return the patient to the operating theatre and I believe most surgeons in his position would have assumed the responsibility for controlling the haemorrhage personally. Most surgeons I believe would have taken the view that they would open the abdomen and then if unable to control the bleeding would at that stage call for help. In the event help arrived very promptly in the form of Mr Day.

This confidence in one's own ability to resolve problems is common among surgeons of all types. The process of accepting responsibility for the operative care of a patient is not one that easily allows lack of confidence. Inevitably this confidence maybe misplaced at times. Realistically though it is a trait expressed by most surgeons and, in fact, one of the things that makes them good at their job. How individuals, directorates, hospitals and health services manage this confidence is a debate that needs to be had. Decision algorithms can be introduced which may help to direct practice and thus prevent surgeons from making decisions based on inappropriate levels of confidence. This is a process that is even more relevant in isolated institutions where skilled help may be very far away. The truth is though that if you restrict surgeons practice there will be other far reaching implications.

Shortly after beginning the laparotomy he reports a 4 unit blood volume in the abdominal cavity. These measurements are difficult to make and thus all I think we can really say is that there was a lot of blood. A volume that is unlikely to be commensurate with an injury that could be ignored, and therefore I am not surprised that an attempt was made to control the injury. Even if subsequent surgeons did not see this blood, Mr MacLachlan would have communicated the fact to them.

At this point Mr MacLachlan resigns to the position of assistant as Mr Day appears. If Mr MacLachlan is joined by a senior colleague, in whom he has confidence and who is, after all, the consultant responsible for the patient, it is entirely appropriate that he defers to him."

7.112 The actions of the general surgeons Mr Ingram and Mr Allardice drew this response from Mr Butcher:

"Both surgeons (at different times) are called to assist with bleeding in the pelvis. Mr Ingram apparently less experienced in vascular surgery is called first presumably because of his relationship with the vascular unit at Bournemouth where the majority of vascular cases on the island are referred. Mr Allardice, who was on call, is called later. Once again both feel confident to attempt control of the bleeding, which at this stage is heavy, and both fail to do so. Both report that the bleeding is at this stage controllable by finger or swab pressure.

Mr Ingram aware of the significant risk to Mrs Rourke also attempts to make a plan to get a more experienced surgeon from off the island. Either Mr Rice from Guernsey or Mr Wijesinghe from Bournemouth. Later another plan is formulated to move Mrs Rourke. Once some control had been achieved the patient's abdomen was packed and plans were made to try and transfer the patient. The transfer is then abandoned when she arrests. This series of actions are all reasonable. When confronted with a situation that was not

improving with current management the surgeons try and get help. When the situation seems stable the operation is terminated.

The death of the patient was almost certainly caused by massive haemorrhage with ensuing coagulopathy (failure of blood clotting), hypothermia (loss of body heat) and acidosis (drop in overall blood pH). Once these three things are present and severe a downward spiral in the patient's condition becomes inevitable and unrecoverable.

It is Professor Bell's view that if the surgeons had simply controlled the bleeding with direct pressure rather than persist with attempts to repair the vein, and had then called for expert help the outcome may have been different. This is obviously a very reasonable statement, and may be true. In reality, though, iatrogenic injury to the Common Iliac vein is a very high risk complication and survival even in the best hands in the world is not guaranteed. Temporary control of the bleeding allows the anaesthetic team time to catch up and restore the imbalances which have started to develop thus "getting the patients into the best position" for an experienced surgeon to come and attempt repair. My experience though and the report from the Mayo clinic suggests that, as a rule, non-vascular surgeons when faced with bleeding DO attempt to control the bleeding, at times to the detriment of the patient. Thus I can only conclude that what they did WAS reasonable."

Comment

Mr Butcher judged the decisions of the surgeons in context. He acknowledged that different decisions could have led to a different outcome but found that all the consultants that afternoon made reasonable decisions and acted as most of their fellow consultants would have. We accept Mr Butcher's opinion and therefore have no criticism of the individual actions of the surgeons during the attempted rescue.

It is relatively straightforward to plan for some routine situations, such as deciding which conditions need to be treated off the island. It is less easy to plan for the potentially lethal complications of routine surgery, but nevertheless, such plans need to be made. The events of the afternoon reveal the need for the hospital to have a contingency plan for dealing with major uncontrolled bleeding and we have made a recommendation to this effect.

Recommendation

R5 The theatre management group should continue to develop and disseminate guidelines on the management of major bleeding with a view to establishing a simple, agreed approach.

7.113 The majority of the vascular injuries looked at in the Mayo Clinic study were caused during open surgery and it follows that these injuries would have been recognised as soon as they occurred. In Mrs Rourke's case, the injury was caused between 12.35pm and 12.55pm. The laparotomy was at 1.35pm. Mrs Rourke had therefore been bleeding for at least 40 minutes and possibly for nearly an hour before rescue surgery began.

Comment

A laparoscopic or hysteroscopic injury may not be immediately apparent, so finding it and assessing its seriousness can take time. Continuing, uncontrolled loss of blood reduces the prospects of a good outcome and the fact that Mrs Rourke was bleeding for some time before her injury was located must have had this effect. We have already commented on Dr Moyano's failure to arrange for a laparoscopy once she saw bowel through the hysteroscope and it is reasonable to assume that if a laparoscopy had been carried out the delay in finding the source of the bleeding would have been shorter. The fact that Mrs Rourke's injury occurred in this way means that comparison against the Mayo clinic data is not totally appropriate because the diagnostic delay could have had an impact on the outcome. It might be more appropriate to consider her injury as compared to

someone suffering a stab wound in the street, where some delay before treatment would be bound to happen.

We asked Mr Butcher and Mr Ingram if they thought this was a fair analogy and they agreed it was.

Mr Butcher confirmed that prolonged delay before treatment undoubtedly reduces the prospects of survival.

7.114 We asked Dr Jean-Pierre van Besouw from the Royal College of Anaesthetists to review the anaesthetic management of the rescue operation. We told him that some of our interviewees had expressed concern about the conduct of one of the anaesthetists and that we wanted to know if there was evidence that anyone had acted unprofessionally or made decisions that harmed Mrs Rourke's prospects of survival. He was provided with all the medical records and the statements of the surgeons and anaesthetists in theatre during the rescue operation.

7.115 Dr van Besouw's report is at Appendix D. He concludes that the anaesthetic care Mrs Rourke received that afternoon was acceptable when compared to standard good practice. He felt it would have been helpful to have inserted a central line[5] earlier in the proceedings, to provide more information. He acknowledged a possible link between the packing of Mrs Rourke's abdomen and her subsequent cardiac arrest, but considered that once the cardiac arrest had taken place, removing the packs would have served no useful purpose. He also considered that packing the abdomen was the only option at the time.

Summary

Mrs Rourke died as a result of a medical accident when Dr Moyano, in attempting to resect what she believed to be a polyp, perforated Mrs Rourke's uterus and her left common iliac vein.

---

[5] A central venous catheter ("central line", "CVC", "central venous line" or "central venous access catheter") is a catheter placed into a large vein the neck such as the internal jugular vein, or the chest (the subclavian vein) or the groin (the femoral vein). It is used to administer medication or fluids, obtain blood for testing and to directly obtain cardiovascular measurements such as the central venous pressure.

Perforation of the uterus and of blood vessels are known complications of hysteroscopy. This was explained to Mrs Rourke before she gave her written consent to the operation. However, the site and size of this particular perforation of this particular vein meant that repair was in the end impossible.

Surgery involves high risks and as the Mayo clinic statistics Mr Butcher referred to show, even expert surgeons can make fatal errors. The fact that Dr Moyano made such a mistake does not prove that she did not have the necessary expertise to carry out the procedure. Whether she was competent to undertake the operation is for the GMC to decide.

The medical and other staff who tried to save Mrs Rourke's life on the afternoon of 17 October acted for the best at all times and in the way many others in a similar situation would have. There is evidence of prompt action, quick thinking and contact with off-island experts.

The hospital had no formal policy for dealing with a situation like this. Previous instances of serious damage to blood vessels during surgery had been dealt with successfully. See also paragraph 11.78 for progress.

8. The recruitment and employment of Dr Moyano

Recruitment

8.1 On 17 April 2006 Mr MacLachlan went on leave as a result of serious illness in his family, which affected his own health. He returned to work intermittently, but not to full duties until 5 September 2006.

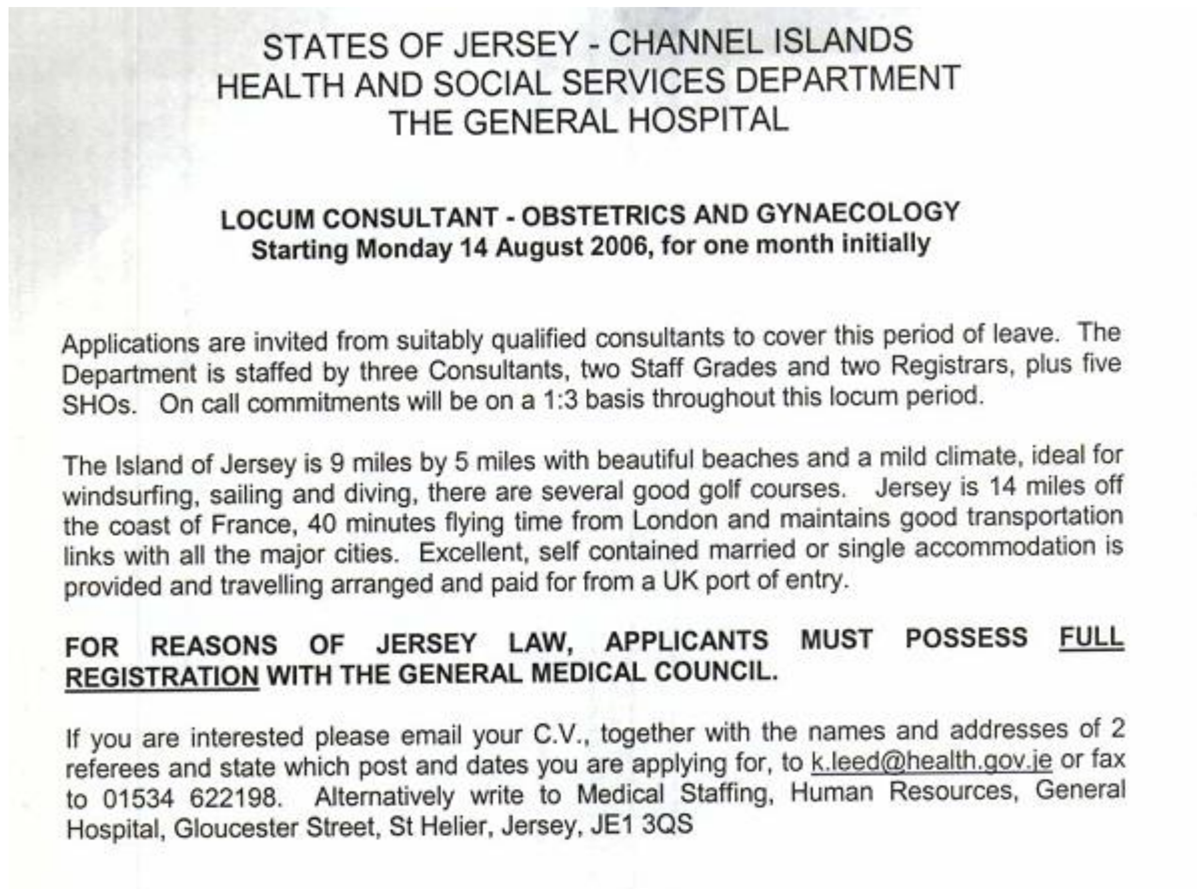
8.2 The occupational health service, Capita Health Solutions, decided in July that Mr MacLachlan was ready to return to work, but that his return should be phased over several weeks. He had leave booked from 31 July to 13 August and it was agreed that he would start on light duties on 24 July for a week and then gradually increase his workload when he returned from leave on 14 August until he was ready to return to full duties on 5 September. This meant he would have no on-call duties during July and August. An on-call consultant in the obstetrics and gynaecology department can expect to be woken during the night and this part of the job did not come within the definition of the light duties that Mr MacLachlan was undertaking before his return to full time work.

8.3 A number of locums were employed to cover Mr MacLachlan's absence, including one who had a contract from 10 to 28 July but who left the hospital on 20 July because Mr Day was not satisfied with his performance. It had long been arranged that Mr Mohamed Siddiq would cover Mr MacLachlan's leave in the first half of August, so the unexpected departure of his earlier locum meant that another locum had to be found at short notice and it was still necessary to find a locum to cover what would have been his on-call duties in the second half of August and the beginning of September.

8.4 A consultant who needs a locum is normally responsible for choosing someone to cover his or her work. However, Mr MacLachlan was not asked to involve himself in the process of finding his *"on-call"* locum before he went on leave, and the HR department asked Mr Day to help instead.

8.5 The process for appointing locums at the hospital at that time was that the HR department placed an advertisement in the British Medical Journal, inviting interested doctors to send in their CVs.

8.6 A standard advert was put on the British Medical Journal website on 1 August:



STATES OF JERSEY - CHANNEL ISLANDS
HEALTH AND SOCIAL SERVICES DEPARTMENT
THE GENERAL HOSPITAL

LOCUM CONSULTANT - OBSTETRICS AND GYNAECOLOGY
Starting Monday 14 August 2006, for one month initially

Applications are invited from suitably qualified consultants to cover this period of leave. The Department is staffed by three Consultants, two Staff Grades and two Registrars, plus five SHOs. On call commitments will be on a 1:3 basis throughout this locum period.

The Island of Jersey is 9 miles by 5 miles with beautiful beaches and a mild climate, ideal for windsurfing, sailing and diving, there are several good golf courses. Jersey is 14 miles off the coast of France, 40 minutes flying time from London and maintains good transportation links with all the major cities. Excellent, self contained married or single accommodation is provided and travelling arranged and paid for from a UK port of entry.

FOR REASONS OF JERSEY LAW, APPLICANTS MUST POSSESS FULL REGISTRATION WITH THE GENERAL MEDICAL COUNCIL.

If you are interested please email your C.V., together with the names and addresses of 2 referees and state which post and dates you are applying for, to k.leed@health.gov.je or fax to 01534 622198. Alternatively write to Medical Staffing, Human Resources, General Hospital, Gloucester Street, St Helier, Jersey, JE1 3QS

8.7 Recruitment policy required the HR department to make sure that applicants were qualified for the post (that is, had the relevant certificates and registration) and then to pass CVs to the consultant concerned, who would reject any that seemed unsuitable and rank the remainder in order of preference, so that the HR department would have someone else to fall back on if the first choice had changed his or her mind or had taken another position.

8.8 Dr Moyano sent in her application for the job, together with her CV (shown at appendix F), on 2 August 2009. On 7 August Karina Leed from HR showed Mr Day her

CV and that of another doctor. Dr Moyano was his first choice. As he said in his police interview on 1 March 2007, Dr Moyano's CV *"stood out like a shining light"*.

8.9 He told the police he did not look closely at the CV but saw that Dr Moyano was on the General Medical Council's specialist register as having completed her certificate of specialist training:

> *"I read a bit further, experience in her SpR training grade, busy hospital, 50 admissions a night into a unit in Barcelona which is a huge number of emergency admissions. Experience in hysteroscopy, laparoscopy, vaginal surgery in general terms, and then, on top of that, Mr Nikolaides, the professor from King's that I am sure you have heard of, very famous man."*

8.10 It was said at Dr Moyano's trial that she had not performed clinical gynaecological work since 2002. Mr Day told the police he had not read the CV completely and had not noticed this. In fact, Dr Moyano's CV shows that she continued to provide gynaecological cover on call and to treat emergency gynaecological cases until she worked as a senior consultant in 2005. This is borne out by what she said in her police interview.

8.11 Mr Day told Ms Leed that Dr Moyano was his first choice so she made contact with Dr Moyano to start the process of arranging her locum appointment.

8.12 Ms Leed took up references from Dr Sarah Bower and Ms Leonie Penna[6] on 8 August, sending a copy of the job advertisement and a standard reference form. Both referees replied the same day. The references are shown at appendix F.

8.13 Ms Penna ticked the 'excellent' or 'good' boxes for Dr Moyano's timekeeping, clinical ability, sickness record, relationship with colleagues/nursing staff and interpersonal skills. However, she ticked the 'poor' box for Dr Moyano's suitability for the post, saying *"I have not worked with her in this capacity"*. She was asked to

[6] Named as referees on the CV: Dr Bower was a consultant in fetal medicine at the Harris Birthright Research Centre for Fetal Medicine, and Ms Penna was a consultant in obstetrics and fetal medicine at King's College Hospital.

indicate practical procedures in which the applicant is competent and wrote *"General labour ward management. Extensive fetal medicine skills. She has not worked in gynaecology to any significant degree in this trust"*. She was asked to give a general opinion of Dr Moyano and wrote *"Dolores is an extremely good doctor. English is not her first language and she works hard to ensure she communicates effectively"*. Asked if she would recommend Dr Moyano for the post, she ticked the 'reservations' box, and commented *"I have not worked with her in a senior capacity and so cannot comment adequately on her skills although she has worked in Spain as a consultant"*. Asked if she would re-employ Dr Moyano she wrote *"Yes, at registrar level"*.

8.14 Dr Bower put "*yes*" in the 'excellent' box for each requirement on the form, and in the space for indicating Dr Moyano's competencies, referred to an attached reference. She also put an asterisk by the "*yes*" for 'suitability for the post applied for', with a footnote saying "**I cannot comment on general O and G skills"*. Where the form asked if she would recommend Dr Moyano for the post she said *"yes"*, and gave the same answer where it asked if she would re-employ her.

8.15 The attached reference by Dr Bower was dated 20 July 2006 and was general, rather than specific to this post. It was complimentary about Dr Moyano's scanning and diagnostic skills and described her as conversant with the management of fetal abnormalities. It also described her personal and professional qualities favourably, and ended:

> *"She has worked extremely hard and has been a valuable member of the department. I will miss working with Dolores and wish her every success in the future."*

8.16 Ms Leed noted that Dr Moyano had not undertaken gynaecological work with Ms Penna and that this had caused Ms Penna to express reservations about her ability to comment on Dr Moyano's suitability for the post. Ms Penna had expressed no criticism of Dr Moyano or her skills and had drawn attention to the fact that she had worked in Spain as a consultant, so Ms Leed identified this as an inadequate reference rather than as one exposing inadequacies in Dr Moyano's skills or experience. We showed Mr

MacLachlan this reference and he confirmed that he would have interpreted it the same way. Dr Bower's reference was seen as satisfactory, although her covering email said:

> *"My comments are limited as you will see from the reference that I only worked with Dolores in a fetal medicine capacity and cannot comment on her general Obstetrics and Gynaecology skills."*

Comment

In fact, Dr Bower's reference was as inadequate as Ms Penna's because Dr Bower made it clear in two places that she could not comment on Dr Moyano's general obstetrics and gynaecology skills. However, she filled out the form differently, so her comments, although clearly expressed, were not seen as reservations, and were apparently not meant to be. In both cases the referees' reservations about their ability to comment on Dr Moyano's suitability for the post were set in the context of their overall approval of her as a doctor and as a colleague.

8.17 Ms Leed decided that she needed to take up another reference because Ms Penna's was inadequate. However, she took no immediate steps because, as she told us, she was not sure that Dr Moyano was keen to take up the post. At this stage she did not discuss the references with Mr Day because she did not have a full set.

8.18 Mr Day recalled a telephone conversation with Dr Moyano in the middle of that week. He believed it was on Wednesday 9 August. He thought someone in HR put Dr Moyano through to him. We have not been provided with the hospital phone records of that week so we cannot trace when this call was made but as set out in detail in section 9, Ms Leed remembered Dr Moyano telling her on 11 August that she had already spoken to Mr Day earlier in the week, so we are satisfied that there was such a conversation on the 8, 9 or 10 August 2006.

8.19 Mr Day told the police, and us, that it was not a long or detailed conversation, but that he asked her if she was interested in the post, if she could do the obstetrics and gynaecology on-call rota, and whether she could do all the basic procedures, particularly caesarean sections, which he described to the police as a dangerous operation. They also had a short chat about the ultrasound work. He said Dr Moyano expressed no concern about any of this, but said that she could not commit immediately because she was also considering another post.

8.20 Dr Nelson remembers that at some point during this week Mr Day spoke to her about Dr Moyano, expressing pleasure that a locum had been found with ultrasound experience. Mr MacLachlan specialised in ultrasound, but none of the locums employed during his time off was able to take over this part of his work, so Dr Nelson had been under enormous pressure, trying to cover the ultrasound work that he would normally have done.

8.21 Ms Leed thought but could not be sure that Dr Moyano telephoned her later in the week or left a message to confirm that she wanted the job, as a result of which Ms Leed started to try to get another reference.

8.22 On Friday 11 August, presumably after hearing from Dr Moyano that she wanted the job, Ms Leed emailed her to ask her for details of another referee. Dr Moyano replied with the contact details of Lindsey Allan, professor in fetal cardiology at the Harris Birthright Research Centre, adding *"But, please, I need to know what kind of duties is supposed I should do it before"*. A request for a reference was emailed or faxed to Professor Allan, who responded the same day. She did not complete the reference form, but instead sent a letter to Ms Leed dated 11 August:

> "*I am happy to provide a reference for the above-named. She was with us in the Harris Birthright Unit between 2003-2005. She was an able student of my speciality, fetal cardiology, and was a diligent and capable member of staff. She quickly acquired competent skills and I was able to trust her to run the clinic when I was unable to be present. She was able to make sensible decisions in all cases, taking appropriate responsibility and asking for advice when she was*

aware that she needed it. She was a regular attender and I was not aware of her taking any sick leave. I am not aware of her being under investigation for any disciplinary matter relating to health, conduct or clinical performance. I am sure she will be competent in any locum work she applies for."

8.23 Ms Leed recalled discussing the references with Mr Day. She thought she might have shown them to him, but accepted she might only have spoken on the phone about them. Mr Day did not remember any conversation about them, and was sure he had never seen them before we showed them to him. His mobile phone records show that he spoke to someone in medical staffing at 12.01pm on Friday 11 August. We do not know if this was before or after Ms Penna's reference arrived because we have seen only the hard copy that arrived the following week. Mr Day's recollection was that he made this call to Ms Leed to alert her that he was leaving the hospital that afternoon and to ask if any progress had been made in recruiting Dr Moyano.

8.24 After this conversation Ms Leed contacted Dr Moyano to tell her that she had been appointed and Dr Moyano followed up on her earlier email comment and said that she needed to talk to Mr Day again. Consequently, Ms Leed left a message on Mr Day's mobile, asking him to phone Dr Moyano again.

8.25 Mr Day was going abroad on holiday on 11 August. He had his usual Friday morning clinic in his private rooms and then unexpectedly had to return to the hospital to operate on a patient who was bleeding after a sterilisation operation earlier in the week. He dealt with this case and then went directly to the airport.

8.26 He received Ms Leed's message when he landed in the UK en route to his holiday destination. His phone had been turned off so it is not clear when the message had been left, but as soon as he received it he phoned Dr Moyano as requested. His mobile phone records show that this call was at 6.35pm.

8.27 The conversation was clearly satisfactory because Dr Moyano sent an email to Ms Leed to say she would be coming. This arrived after Ms Leed had left work for the weekend, having circulated an email to the department saying that there would be no

locum cover for Mr MacLachlan on the following Monday. Dr Moyano's arrival at the hospital first thing on Monday 14 August was therefore unexpected and caused some embarrassment and confusion because no preparations had been made and she had had to make her own travel and accommodation arrangements over the weekend. However, the necessary paperwork was quickly completed and she was able to start her duties that day as originally planned. Ms Leed sent an email to a number of people at 9.04am on 14 August informing them that Dr Moyano would be working as *"a Locum Consultant in Obstetrics and Gynaecology covering Mr MacLachlan's sick leave"* until 4 September. Dr Nelson was the only consultant to receive this email, perhaps because Ms Leed knew that Mr Day was on leave and was not aware that Mr MacLachlan was returning to work that day after taking annual leave.

8.28 In his statement of 20 December 2006 Mr Day described the process for recruiting locums:

> *"In the ordinary course, the Hospital policy is not to bring people over for formal interviews but rather to assess candidates on the basis of their application form, their curriculum vitae ('CV') and their references. The HR Department will further consider their appropriateness by reference to immigration issues and GMC registration. If practicable, there will be a short telephone call between one of the Consultants in the Department and the locum to discuss the position further and to 'sound out' the locum.*
>
> *A decision is then made, usually in consultation with one or more of the Consultants in the Department and the candidate will be invited over to start work."*

It appears that this process was followed in Dr Moyano's case.

8.29 Ms Leed said in her interview that when she joined the HR department early in 2006 as a medical staffing assistant she had held a similar post previously. She said the staff in post were helpful in explaining what she needed to do but little was

written down and *"if I had come with no experience, I would have probably struggled as to what to do and maybe miss vital parts of the recruitment process"*.

Comment

The recruitment process was unsatisfactory. The referees were provided with too little information about the job and what it entailed, being sent only a standard form to complete, with the information that the applicant was seeking employment as a locum consultant in obstetrics and gynaecology. It would have been better to send a detailed job description so that the referee could see exactly what the applicant would be expected to do. Furthermore, the reference forms were inadequate in that the referee was asked to indicate the practical procedures in which the applicant was competent, without indicating the level of detail required. It would have been better if a request for a reference were accompanied by a list of all essential and desirable procedures the job entailed, so that the referee could confirm which ones the applicant had carried out while working with him or her.

Ms Leed thought she showed Mr Day the references, as would be her practice, but could not remember if she had. Mr Day was sure he had never seen the references until we showed them to him. It is clear that Ms Leed did not discuss the references until she had received all three, which was not until 11 August. Mr Day was in his private rooms in the morning of 11 August, then in the operating theatre, then on holiday, and we consider it more likely than not that he and Ms Leed did not meet, and that any conversation about the references was by phone. However, we also consider it more likely than not that Mr Day would not have changed his mind about Dr Moyano's suitability if he had read the references because the comments about her skills were highly favourable and the reservations about the referees' knowledge of her skills reflected the information in her CV.

8.30 It appears that Dr Moyano was not given a formal induction and no formal appraisal took place. Mr Day says in his statement of 20 December 2006:

> *"…it is only at that stage, once they have actually been employed that he or she would meet with one of the consultants in the Department who would then discuss any local working practices with them. This would also be the first opportunity for a senior member of the department to get a feel for the locum's own experiences and assess both their strengths and those areas in which they have less current experience."*

8.31 Mr Day told us he phoned the hospital several times during the first week of his holiday to speak to Dr Moyano and to make sure she had settled in properly. His mobile phone records show that he made a number of short calls on Monday 14 and Wednesday 16 August and received a four-minute call from the hospital at 6.40pm on 16 August. He said in his statement of 20 December 2006:

> "*I did have a conversation with Dr Moyano during her first week as a Locum, on my mobile telephone on the Tuesday or Wednesday whilst I was holidaying in Finland. I telephoned her. It was an informal conversation in which I asked her whether she had arrived safely and settled in. She informed me that it had all been fine and that she had had a good chat with a colleague in the department, though I do not recall who. I told her I would no doubt see her on my return at some stage and bid her goodbye.*"

8.32 Dr Moyano had a detailed conversation with Mr MacLachlan, and it seems likely that this was the conversation Dr Moyano mentioned when she spoke to Mr Day on the phone. Mr MacLachlan cannot remember the date but during the trial in January 2009 Dr Moyano's advocate, asserted in his cross-examination of Professor Forbes that the conversation took place on 14 August 2006.

Comment

Dr Moyano would have good reason to remember her first day at the hospital, so we consider that this conversation did take place on 14 August 2006.

8.33 Mr MacLachlan recalled:

> *"She showed me her CV and we had a good discussion because she is a good expert on fetal medicine, very obstetric, which I have always been interested in, so she was very interesting to work with. I discussed with her what was her plan, where she was going and she was very charming and said she had decided that she wanted to improve her skills in general obstetrics and gynaecology, because at the Harris Birthright she had been very specialised as a fetal medicine person. Even though she had a European CCT, she felt that the most sensible thing for her to do would be to work in English units to build up her experience before she applied for consultant jobs, and was pretty open about that. It surprised me that people did not know about that."*

8.34 Mr MacLachlan told us that at this point he did not know that Dr Moyano was a consultant, that she was his locum or that she had just started at the hospital. It is clear that he did not consider this conversation with Dr Moyano to be any kind of formal appraisal or induction:

> *"…when you met her and you were finding out about her, for all you knew she had been there for weeks, is that what you are saying?*
> *Yes, I didn't know when she started."*

Comment

The lack of a formal and documented appraisal and induction procedure and the fact that Mr Day went on leave just before Mr MacLachlan returned from leave meant that no one was aware that Dr Moyano had not been formally appraised. If

she had been, we would have contemporaneous written evidence about her own estimation of her experience and abilities.

Mr MacLachlan did not realise that Dr Moyano was new to the hospital or that his discussion with her was the nearest thing to a formal appraisal she received.

Recommendations

R6 The chief officer and the medical staff committee should ensure that locums have a detailed job description, receive a proper induction and orientation (permanent staff should be responsible for this). This should include establishing and making colleagues aware of any clinical limitations of a locum. Locums should receive an early, written appraisal from a senior member of the permanent medical staff.

R7 HR and the senior management team should ensure that all new staff – permanent and locum – receive a personalised induction and training so that they can fulfil their responsibilities from the first day of their employment. Their training should be updated as appropriate. *Urgent*

8.35 We asked Mr MacLachlan about Dr Moyano's employment status and job when she first met him in August:

> *"Q: I realise that you had a lot on your mind but who did you think was doing your on-calls before you started doing them again in September, or did you not think about it?*
> *A. I assumed that Anthony Lighten was still working and doing my on-calls. I didn't know he had been replaced by Dr Moyano.*
>
> *Q. She didn't arrive until 14 August which is when you got back from holiday. You must have noticed that Mr Lighten was not there then?*
> *A. Yes, when I came back.*

Q. So you came back from holiday at more or less the same time that Dr Moyano started.
A. Possibly, I don't know that.

Q. So you were not aware when you came back from holiday that Dr Moyano was your locum?
A. No, I don't think that I was. I thought she was a registrar.

Q. No, she wasn't, she was a locum consultant covering your on-calls. Then she covered for John Day for a few days, and then she covered for Fiona Nelson when Fiona was away. During that time, you thought she was a registrar?

A. I thought she had been originally employed as a registrar but I have since found out that she was employed as a consultant. That would not have been wholly inappropriate".

8.36 This lack of awareness about Dr Moyano's status is reflected in the responses Mr MacLachlan gave to police questions on 27 July 2007:

"*Did you have any concerns with regards to Moyano's qualifications to carry out the work that she was expected to carry out whilst a Locum?*

I had no concerns about her qualifications but was aware of her recent lack of gynaecology operating experience.

Q: What qualifications are required for a person to be able to carry out a diagnostic hysteroscopy?
A: The Royal College of Obstetricians and Gynaecologists expect all UK training Registrars to be competent at carrying out diagnostic hysteroscopy unsupervised as part of the Core Competencies that are signed off before that doctor obtains the Certificate of Completion of Training (CCT). I am not aware of what the Spanish regulations are, but understand that a doctor with a Spanish CCT may apply for Consultant post directly in the UK and Jersey.

Q: What qualifications are required for a person to be able to carry out a resection?

A: Hysteroscopic resection requires the use of a larger diameter hysteroscope which has the capability of transmitting electric current to assist in removing (resecting) tissue from the uterine cavity. To achieve this skill the doctor would be required to attend a training course or have equivalent supervised experience in this technique (RCOG level 2). This is a higher level than that required for the CCT. If a polyp is found in the cavity of the uterus then it may be possible to remove the polyp using a diagnostic hysteroscope and then polyp forceps, rather than have to use a hysteroscopic resectoscope. This would depend on the size and position of the polyp, and the surgeon's skill.

Q; In your professional opinion was Moyano competent to carry out all Gynae procedures unsupervised?

A: No.

Q: Having seen Moyano in a theatre environment would you have felt confident in delegating your theatre list to her in respect of gynae procedures?

A: No.

Q: What is your understanding of how Moyano came to be appointed by the hospital as a Locum?

A: I was on extended sick leave at the time of the her appointment, but at a later time I learnt from Human Resources that Mr Day had telephoned and spoken to Dr Moyano following her formal application to work in Jersey and before she had commenced her contract with Jersey Hospital."

8.37 It is not clear when Mr MacLachlan became aware of Dr Moyano's status. He told us:

"One weekend I realised that she was on call for John Day, and this business of her being a consultant on call had dawned on me rather than being presented to me, but that may have been because I was a bit fazed."

Comment

There was no weekend when Dr Moyano covered for Mr Day. However, on four days in early September Mr Day's booked locum cancelled at short notice and Dr Moyano replaced Mr Day as locum for Dr Nelson on one weekend in October. There is nothing to tell us which period Mr MacLachlan mentioned.

Mr MacLachlan did not realise that Dr Moyano was his locum but assumed she was a registrar. We acknowledge that he may have been preoccupied with family concerns.

8.38 We asked Mr MacLachlan why he had not mentioned Dr Moyano's lack of gynaecological confidence at a meeting of the three consultants on 12 October, when the skills and experience of a number of middle grades were discussed. He told us he could not remember but imagined that: *"it was felt by all of us that there was nothing that needed to be discussed about her"*. He also told us that he did not remember any discussion with Dr Nelson or Mr Day about what he understood to be Dr Moyano's lack of confidence in gynaecological surgery.

Comment

We do not know if Dr Moyano's lack of confidence in surgery reflected a lack of competence. We expect that the GMC will provide the answer in due course.

These uncertainties would not have occurred if the recruitment process had included formal induction, which should have included a detailed and recorded appraisal and a formal meeting between Mr MacLachlan and his locum to discuss the allocation of duties. A team culture among the consultants would also have made it likely that Mr MacLachlan's knowledge of Dr Moyano's lack of confidence and experience and his view of her status would have been revealed to his consultant colleagues.

It appears that Ms Leed, a junior administrator, did all that was expected of her. However, the lack of a rigorous recruitment process, including formal appraisal and induction on arrival, created a situation where there was limited shared understanding about Dr Moyano's status, abilities, experience or responsibilities.

8.39 On 15 August Dr Moyano was offered a second contract of employment to cover Dr Nelson's leave between 8 and 22 September. We asked Ms Leed why she had been offered this position. She told us:

> *"I think it is normal practice, if a consultant agrees to doing a job, that if there are any more consultant locums coming up in that department we would offer it at the beginning...We have done that previously, on quite a few occasions, and I think...there was only one occasion in my career that it has actually happened that that first locum did not work out and we had to then retract the second contract from that person. So from a continuity for the department and paperwork point of view, it makes sense to secure them for any many locums going forward as we can, for that department...and then for the occasional one that did not work out, we can sort it out after the event.*
>
> *Q. Okay. So you would not necessarily have discussed that with Dr Nelson?*
> *A. We would have discussed it with somebody. We would not have just taken it as read that we could give them the whole rest of the year.*
>
> *Q. You would have asked her, wouldn't you?*
> *A. Yes. We would have asked one of the consultants, yes."*

8.40 Mr Day cannot have been the consultant because he was on holiday.

Comment

It is sensible to use tried and tested locums where possible and the process Ms Leed described has advantages, particularly as any offer of further work can be withdrawn if the person turns out to be unsatisfactory. However, it has the

***disadvantage of giving an impression of acceptance and approval which in the absence of formal and robust appraisal may engender confidence in a locum's abilities for which there is no empirical evidence*.**

Employment

First consultant contract 14 August to 4 September

8.41 During this contract Dr Moyano was the on-call consultant on:

- 15 to 16 August (24 hours)
- 21 to 23 August (48 hours)
- 29 to 30 August (24 hours)
- 1 to 4 September (72 hours).

8.42 During this time she:

- carried out a diagnostic hysteroscopy, laparoscopy and left ovarian cystectomy in the day surgery unit on 22 August
- assisted Mr MacLachlan with a sacrocolpopexy post repair and a laparoscopic ovarian cystectomy on 25 August.

A full list of Dr Moyano's surgical procedures appears at appendix G.

Second consultant contract 4 to 8 September

8.43 Dr Moyano had a short contract to cover Mr Day's absence when his booked locum was unable to come at the last minute. During this contract she was on call from 8.00am on 6 September to 8.00am on 7 September (24 hours).

Third consultant contract from 8 to 22 September

8.44 Her next contract was to cover for Dr Nelson's leave. During this time she was on call:

- 8.00am on 8 September to 8.00am 11 September (72 hours)
- 8.00am on 14 September to 8.00am 19 September (120 hours)
- 8.00am on 21 September to 8.00am 22 September (24 hours).

8.45 During this contract she:

- carried out a diagnostic hysteroscopy on 12 September assisted by Dr Ali Elfara, specialist register, in the main theatre
- assisted Dr Elfara on 12 September with a hysteroscopy, colposcopy and laparoscopy.

Absent from the hospital 22 September to 1 October

8.46 Dr Moyano did not have a contract between these dates but before she left the island, it had been agreed that she would return on 2 October as a locum for Dr Elfara.

8.47 Ms Leed said in a memo dated 26 March 2007:

> "*During her third contract (8th-22nd September) Mr MacLachlan came to see me regarding giving Dr Moyano a clinical attachment contract for the weeks when she wasn't required for any locum posts. This would be an unpaid attachment, under the supervision of one of the consultants, but would give her the opportunity to develop her skills in certain areas whilst "shadowing" the consultants.*

Mr MacLachlan also told me to offer her any future locums that arose, at any grade, including Dr Elfara's annual leave from 2nd-16th October [7] when she would work as a locum registrar."

8.48 We showed Mr MacLachlan Ms Leed's memo of 27 March 2007 and asked him why he had been so keen for Dr Moyano to be offered locums "*at any grade*" if he had been aware of her lack of confidence. He said:

"I probably would have said she is fine but for certain things. Give her anything to do any work – you have seen the College document about assessing the suitability of locums and making sure the work you give them is appropriate and not leaving people in theatre whom you have not assessed. I wouldn't say give her anything and she can do everything – I certainly would not say that. I knew because Moyano had told me that on her gynae she was not at all confident, and she assisted me in theatre on about eight cases as it turns out, and I asked her on more than one occasion if she would like to do the laparoscopy and she said no. Therefore, it is pretty clear to me that she was not confident in taking on that. If I said give her any locums, it would have been not that she can do anything ...There is a subtle difference."

8.49 In the event the clinical attachment did not proceed and Dr Moyano took a break, having been on call for 13 out of the previous 22 days, before returning to take up the contract from 2 to 19 October to cover Dr Elfara's leave.

8.50 While Dr Moyano was away, she received an email from Ms Leed asking if she would like to provide locum consultant cover for Mr MacLachlan and Dr Nelson on various dates between 19 October and the end of the year.

[7] The contract actually ran to 19 October.

Comment

Ms Leed understood Mr MacLachlan to be saying that Dr Moyano could be offered locum consultant posts, and, indeed, that he was happy for Dr Moyano to be his locum in October/November and again in December. This supports his assertion to us that he had confidence in Dr Moyano's ability to carry out the work of locum consultant.

8.51 Dr Moyano accepted the offered locum positions by email on 29 September, adding:

> *"It is much better for me to do staff grade than consultant to be involved more in gynaecology that is what I want. Monday we will see."*

Fourth contract period, when she was a locum registrar from 2 to 19 October, and a locum consultant from 5 to 9 October

8.52 On 2 October Dr Moyano started working as a locum registrar, covering for Dr Elfara until 19 October.

8.53 Human resources sent an email the same morning to a number of people, including Mr Day, Mr MacLachlan and Dr Nelson informing them that Dr Moyano would cover:

- Dr Elfara as a locum registrar from 2 October to 19 October
- Mr MacLachlan as locum consultant from 30 October to 6 November
- Mr MacLachlan as locum consultant from 16 December to 29 December.

8.54 Documents and copies of emails in Dr Moyano's HR file also suggest that she was going to provide consultant cover from Thursday 5 to Monday 9 October and also locum cover for Dr Nelson from 19 to 23 October.

Comment

Anybody reading the email of 2 October would understand that although Dr Moyano was providing locum cover for a registrar in training, there were no concerns about her skills or abilities because she had been offered three subsequent locum consultant positions.

HSSD has standard contacts for locum doctors, with blanks to fill in for the nature of the job, the on-call or other duties, the length of the contract and details of the remuneration. On this occasion Dr Moyano's contract made it clear that she was covering for Dr Elfara, and that she would be paid as a staff grade. However the contract mistakenly said that the job was a consultant post. A number of interviewees suggested to us that this might have caused confusion about her status. We think not. Dr Moyano knew that she was covering for a registrar, all her duties, and her salary, were those of a registrar/staff grade, and the email of 2 October from Ms Leed made it clear that she was a locum registrar and not a locum consultant during this period. What might have caused some confusion was the fact that everyone knew she would be providing consultant cover later in October and that she was actually working both as a registrar and a consultant between 5 and 9 October. However any confusion about her status cannot have set up false expectations about her expected competence, which seems to have been generally accepted as being that of a consultant.

It is well understood and obvious that a doctor does not lose her skills and abilities as a consultant simply because she provides locum cover for a registrar in training. Interviewees told us that Mr Day had covered for registrars for an on-call shift when the hospital was short staffed and that he must then have carried out the duties of a registrar. We expect that other consultants at the hospital have done the same when necessary.

The on-call rota

8.55 Most clinical work in the hospital is planned and takes place during the day in outpatient clinics, on the wards, or in the operating theatres. However, it is always necessary to have arrangements to deal with emergencies and unscheduled events, which may arise from planned activities or independently of them. This is done through the 'on-call' system.

8.56 All the major departments of the hospital have an on-call registrar or staff grade doctor, who is expected to respond to any situation that arises. These departments also always have an on-call consultant who must be available to discuss issues with the on-call registrar/staff grade and to go into the hospital to help at the request of the on-call registrar. Requests for help might arise in the event of a serious problem beyond the expertise of the registrar or more mundanely if there are a number of unscheduled events and the registrar and other staff on duty cannot deal with them on their own.

8.57 Obstetrics and gynaecology is a major department of the hospital and deals with many unscheduled events. Predicting time of birth cannot be exact so the hospital must be able to respond to a woman in labour at any time. Furthermore, although most births are unproblematic, when problems arise they can have devastating and lifelong consequences if they are not dealt with quickly and appropriately, so the hospital has to be ready to respond with a high level of expertise, and rapidly, to any problems at any time.

8.58 The on-call registrars in the department of obstetrics and gynaecology have a high level of responsibility as the senior doctors on site outside normal working hours.

8.59 The consequence of this system is that for much of the time fewer demands are made of on-call consultants than are made of on-call registrars. An on-call registrar should be able to deal with an emergency caesarean operation, an assisted delivery or an ectopic pregnancy and although a consultant is likely to be contacted to give approval if an emergency operation is needed, the consultant may not be actively

involved in these emergencies while they are on-call. This seems to have been the position in Dr Moyano's case – she was the on-call consultant for a total of 17 periods of 24-hours in August and September, none of which seemed to have given rise to concern, incident reports or other problems. She helped with a number of apparently routine operations but was the lead surgeon on only one or two occasions, on 12 September.

Comment

On 2 October Dr Moyano started working as a locum registrar and as the following paragraphs reveal her move to the front line role quickly resulted in problems of confidence and communication. However, as these problems did not relate to clinical competence, they did not give cause for alarm about patient safety.

Week beginning 2 October

8.60 On 2 October Dr Moyano was on the rota to help in Mr Day's gynaecology outpatient clinic in the morning and with his theatre list in the afternoon. However, Mr Day was away so Dr Moyano assisted his locum Mr Douglas Dumbrill with:

- a hysterectomy (removal of the uterus) and bilateral salpingo-oophorectomy (removal of the ovaries and fallopian tubes)
- Examination Under Anaesthetic (EUA) cervical polyectomy, hysteroscopy and biopsy
- EUA and smear
- hysteroscopy plus dilatation and curettage.

She was also the sole surgeon repairing an episiotomy.[8]

[8] Episiotomy: a surgical incision through the perineum made to enlarge the vagina and assist child birth.

8.61 She was the on-call registrar/staff grade from 8.30am on 3 October until 8.30am on 4 October and also on duty in the day surgery unit where she:

- carried out a laparoscopy and hysteroscopy under Mr Dumbrill's supervision
- assisted Mr Dumbrill with diagnostic laparoscopy, hysteroscopy and dye study
- assisted Dr Dnes with hysteroscopy, endometrial biopsy
- carried out a hysteroscopy and biopsy supervised by Mr Dumbrill.

This was Mr Day's fortnightly Tuesday morning day surgery list.

8.62 After Dr Moyano's on-call duty finished on 4 October she was on duty in main theatre. Mr Dumbrill was the locum consultant and she assisted with a laparoscopy, EUA, hysteroscopy and biopsy for one of Mr Day's patients.

8.63 Mr Dumbrill now works in South Africa. We spoke to him on the phone. He remembered Dr Moyano well because they had worked together at King's College Hospital in London. Mr Dumbrill remembered working in theatre with Dr Moyano in Jersey. His general recollection was that she was unremarkable: she gave him no cause to doubt her abilities but he had no expectation of great aptitude because he knew that she was a fetal medicine expert. He did not recall that she was unwilling to play her part in the operating theatre.

8.64 He said it was a slightly odd situation because he was a locum consultant and she a locum registrar at the hospital at the time, whereas earlier in August or September their roles had been reversed.

8.65 On 5 October Dr Moyano was on duty in Mr Day's antenatal clinic, seeing patients.

First incident report

8.66 It appears that while Dr Moyano had been on call on 3 or 4 October she had been present when a patient, A, had given birth. The woman had expressed concern

about Dr Moyano to the midwifery sister on duty. The concerns were discussed with the head of midwifery, Elaine Torrance, when she came on duty on the morning of 5 October. She went to see patient A.

8.67 Ms Torrance told us that patient A had told her that Dr Moyano did not communicate with her properly, either during the birth or during the subsequent suturing of her perineum and that this was still causing her anxiety.

8.68 Patient A said that the epidural anaesthetic she had been given during labour began to wear off during suturing and she was suffering increasing discomfort and pain. She felt she could manage this if she knew how much longer suturing would take. She and the midwife asked Dr Moyano this but received no response.

8.69 Ms Torrance reassured patient A that she had been right to express her concerns and said that she would look at the notes and speak to the midwife and to Dr Moyano and tell her the outcome.

8.70 As she left patient A, Ms Torrance met Dr Moyano, who intended to perform a postnatal examination. Having checked with patient A that she did not wish to see Dr Moyano, Ms Torrance had a discussion with Dr Moyano about what had happened. She explained that the lack of communication had left patient A upset and tearful and asked why Dr Moyano had not talked to patient A when both she and the midwife were asking for information.

8.71 Dr Moyano explained that she had been unhappy that the epidural had started to wear off and that the midwife had not topped it up. She said she was concentrating on repairing the perineal episiotomy. Ms Torrance asked Dr Moyano if she had asked the midwife to top up the epidural. She said she had not. Ms Torrance said it would be best if she did not see patient A again. Dr Moyano accepted this without objection.

8.72 Ms Torrance then spoke to the midwife who said she knew the epidural was wearing off and had asked Dr Moyano if she should apply a local anaesthetic by spray and injection to make the procedure more comfortable. Dr Moyano had not responded,

even though the midwife had repeated the offer and the midwife felt in a difficult position because Dr Moyano did not respond. She said she had found Dr Moyano uncommunicative.

8.73 Ms Torrance then spoke to Dr Moyano, who was working in the antenatal clinic that morning, to the midwifery sister on duty and to the midwife who had been present at the birth. She asked Dr Moyano and the midwife to work together to develop guidance on epidural top-ups following birth. The sister on duty that day and the anaesthetists subsequently carried out this work.

8.74 Ms Torrance tried to see patient A on the evening of 6 October but she had already gone home, so she wrote to her to tell her what she had done.

Comment

These events did not result in an incident form as they should have, but the lack of one did not prevent a prompt and efficient response from the head of midwifery, whose job it would have been to respond to any incident form generated on the labour ward.

Ms Torrance saw the incident as an example of poor clinical practice (not ensuring adequate anaesthesia during suturing) but Dr Moyano's technical suturing skill does not seem to have been criticised. The problem seems to have been attributed to a difficulty in communication and the lack of a policy.

Patient A's concerns received a prompt and thorough response. The action taken and remedy agreed on were proportionate and targeted. We see no reason why any other action should have been taken.

Second incident report

8.75 On 6 October Dr Moyano was the on-call registrar/staff grade from 8.30am until 5.00pm and then the on-call consultant from 5.00pm. Mr Dumbrill was the on-call consultant during the day.

8.76 Dr Moyano had been assisting at a birth and had decided that the patient, B, should have a pudendal block (injection) for pain relief. Dr Moyano did not want to do this single-handed, so she called for Mr Dumbrill, who gave the injection.

8.77 On 9 October, patient B told the midwife dealing with her discharge that she was scared of Dr Moyano's attitude and felt she did not know what she was doing. The midwife spoke to Ms Torrance, who retrieved the notes and saw that Dr Moyano had been with the patient for only 10 to 15 minutes and that Mr Dumbrill, having given the injection, had been present until the baby was born.

Comment

Once again, this incident appears not to have generated an incident report but the action taken was the same as if it had.

Ms Torrance was right to look at the notes and we do not dispute her professional judgement that they revealed no cause for alarm.

We note that this birth must have taken place between 8.30am and 5.00pm, as Mr Dumbrill was the on-call consultant and so available to help when Dr Moyano needed it. At 5.00pm Dr Moyano went from being the on-call registrar to being the on-call consultant, which presumably would have created a difficulty if the on-call registrar had asked for her help in administering a pudendal block. These real and hypothetical examples show the difficulty of establishing whether or not Dr Moyano had the skills expected of a locum consultant.

Week beginning 9 October

8.78 Dr Moyano was the on-call registrar from 8.30am on 9 October to 5.30pm on 10 October (36 hours).

8.79 During this time she carried out ERPC (evacuation of the retained products of conception) in the main theatre, without difficulty.

Third incident report

8.80 She also carried out a caesarean section on patient C, which triggered an incident report because it was unplanned and followed a failed forceps delivery. Ms Torrance had introduced a system whereby certain events would automatically trigger an incident report, so that trends could be identified in an attempt to improve practice. Caesarean section following failed vaginal delivery was one of these trigger events and the creation of an incident report carries no implicit criticism.

Comment

There is no suggestion that Dr Moyano behaved in any way inadequately at any level in relation to this event.

8.81 Dr Moyano was the on-call registrar from 8.30am to 5.00pm on 11 and 12 October. These days appear to have been uneventful.

8.82 She was then on-call from 8.30am on 13 October to 8.30am on 14 October (24 hours). Mr Day was the on-call consultant until 9.30pm on 13 October and Mr MacLachlan was on-call from 9.30pm on the 13 until 8.30am on the 14 October.

8.83 Four incident reports involving Dr Moyano (relating to two patients) were generated during this on-call period.

Fourth and fifth incident reports

8.84 During the evening of 13 October Dr Moyano carried out a caesarean section on patient D that resulted in heavy bleeding after the birth. She was having difficulty controlling the bleeding, so the midwife called Mr Day, the on-call consultant, to help. Mr Day lives on the other side of the island and it would have taken him some time to get to the hospital, so the midwife contacted Dr Khalid Ahmed, who lives nearby to see if he could help until Mr Day arrived. Dr Ahmed arrived at the hospital shortly after and found that Dr Moyano had the bleeding under control. He helped tidy up and inserted some stitches. When Mr Day arrived he saw that all was well and that he did not need to go into the operating theatre.

8.85 An incident report was made because an emergency caesarean section is on the trigger list for incident reports. Ms Torrance saw the report next time she came on duty. As was her custom, she looked at the patient's notes to see if there were any issues and was concerned to see that Dr Irina Dnes rather than Dr Moyano had written them up. It is good practice for doctors and nurses to write up their own notes, so another incident report was created, detailing Dr Moyano's failure to write up her own notes. Ms Torrance spoke to Dr Nelson about the matter because the patient was one of Dr Nelson's patients, and asked her to speak to Dr Moyano about it, which she apparently did.

8.86 When we spoke to Dr Ahmed about this incident he said he would have expected Mr Day to be concerned at Dr Moyano's handling of the matter. However, Ms Torrance told us that the midwife had not expressed any concerns to her about Dr Moyano's conduct or competence, which she would have expected to happen if she had had such concerns:

> *"That is one thing that I was really clear about when I came to Jersey was that if midwives are concerned about any doctor's practice, you jump over and go straight to the consultant and if you can't get that consultant, or you don't like what that consultant says, you ring another one. They are good at that. They are a really good safety net in that aspect."*

8.87 Ms Torrance also told us that the midwives were keeping a close eye on the junior doctors because one of them (who has since left the hospital) was on a special programme to try to build up his skills, which had been found lacking.

Comment

It seems that the midwife's sense of urgency when she contacted Dr Ahmed had subsided by the time Mr Day arrived and that neither Mr Day nor Ms Torrance had reason to believe that Dr Moyano had not dealt with the matter satisfactorily.

If those present during the incident, the midwives and to a lesser extent Dr Ahmed did not feel there was an issue of competence to report to their seniors, it is not surprising that their seniors were untroubled by any clinical concerns.

8.88 Dr Moyano carried out a further caesarean section on a patient of Dr Nelson's during the same on-call period.

Sixth and seventh incident reports

8.89 Sometime after 9.30pm when Mr MacLachlan was the on-call consultant, a midwife called Dr Moyano to repair a third-degree tear caused during a vaginal delivery on patient E that the midwife had carried out.

8.90 An incident report was generated because third-degree tears are on the trigger list. Dr Moyano had not been at the delivery and so was not responsible for the tear. No concerns were expressed about Dr Moyano's work in repairing the tear. However, the midwife had been concerned during this procedure because Dr Moyano had apparently asked another registrar, who was neither on call nor on duty, to assist. It is established good practice to ask for help where necessary, but Dr Moyano should have contacted Mr MacLachlan, the on-call consultant. The midwife was concerned about this breach of procedure so she called Mr MacLachlan to tell him. He came into the hospital and spoke to Dr Moyano about what she should have done. He also told the midwife that she had been right to contact him. The midwife completed an incident

report about this so that Ms Torrance would know what had happened; no action was needed because Mr MacLachlan had already spoken to Dr Moyano. Mr MacLachlan confirmed to us that this incident raised no concerns with him about her clinical practice.

Comment

It is not clear why this matter was reported to Mr MacLachlan. No doubt it is correct that an on-call registrar should contact the on-call consultant if she needs help, but Dr Moyano had had the experience, earlier in her shift, of Dr Ahmed being called in by a midwife, even though he was neither on duty nor on call. The concern may have related to the fact that the doctor whose help Dr Moyano sought was a registrar on special measures because of concerns about his practice. These special measures had been instigated by Mr Day with the help of Ms Torrance.

Whatever the rights and wrongs of Dr Moyano's breach of protocol, it did not relate to her clinical competence.

Summary of incident reports

8.91 Seven incidents involved Dr Moyano in her first two weeks as a locum registrar:

- two complaints by women on the labour ward
- three 'trigger list' incident reports not suggesting any fault by Dr Moyano
- two incident reports about Dr Moyano's compliance with hospital policy on seeking help and writing notes.

8.92 For the purposes of this investigation, we discount the 'trigger list' incidents because they say nothing about Dr Moyano's competence and raise no concerns about her conduct.

8.93 The trigger list was an early innovation of Ms Torrance, introduced within weeks of her becoming head of midwifery in 2005. She had brought with her a culture of ensuring and improving patient safety through systematically noticing, recording, monitoring and analysing any incident that might have an impact on patient safety or improved patient care.

8.94 For instance, a caesarean section where a woman was fully dilated was on the trigger list because it was evidence that a planned vaginal delivery had become an emergency. This can happen for good reasons but by putting all such events on the trigger list, Ms Torrance and her colleagues could look closely at the note for any missed clues that a caesarean would be necessary or for any indication that the decision to perform one had been taken too soon. In this way trends could be identified and good practice based on real cases could be promoted.

8.95 Incident reports had been introduced some time before Ms Torrance arrived, but a perception had grown up that a member of staff who reported making a mistake, even if it had not resulted in harm to a patient, was likely to be blamed or punished for it. As a result, there was a reluctance to submit incident reports. Having a trigger list was one way of overcoming this reluctance because it uncoupled the connection between making a report and reporting a mistake.

8.96 The midwives on the labour ward were particularly alert to the possibility of junior doctors needing close observation at that time. As mentioned above, one of the junior doctors had been causing concern and Mr Day and Ms Torrance had drawn up a programme of training and supervision for him. Midwives had been among those raising concerns about his practice. The programme was put in place in July, providing that the doctor would be supported by two middle-grade doctors who would act as clinical supervisors; that he and his clinical supervisors would keep a reflective diary to provide assurance that changes and improvements were being made; and that the doctor and his clinical supervisors would liaise weekly with Mr Day to inform him of progress.

8.97 For all these reasons, Ms Torrance expected that midwives would report to her any concerns, particularly about junior doctors. She was inviting over-reporting rather than under-reporting, so she did not expect all reported concerns to indicate any particular risk to patient safety.

Comment

Each of the incidents that gave rise to concern about Dr Moyano was dealt with promptly and appropriately.

The first two concerns were raised by patients on the labour ward who were made to feel uncomfortable or worse by Dr Moyano's failure to keep them informed and to give them confidence in her ability. The midwife in each case did not note this distress at the time, nor did any of them raise concerns of their own. This is not to criticise them; it is likely that the patients were more concerned with what they were going through than with making complaints about the doctor; they would have felt able to talk about their unhappy feelings only once their treatment was over and they were asked about their experience.

In each case, action was taken as soon as concern had been expressed; Ms Torrance looked at the notes, spoke to the patients and in the case of patient A took remedial action as set out above. We have no doubt that if Ms Torrance had found evidence of clinical problems in these cases she would have brought it to the attention of Dr Moyano's seniors.

The two cases on 13 October appear at first sight to be more serious but on closer investigation less so. They did not involve patient safety; the patients being treated were not upset by Dr Moyano; and the midwives who completed the incident report forms did not suggest to Ms Torrance that Dr Moyano was putting patients at risk. There is good evidence that they would not have held back if they had concerns.

With hindsight, it is possible to see a connection between these events; a lack of confidence on Dr Moyano's part and a difficulty in communicating. This is plain enough in the first two cases but can also be seen in the two incidents on 13 October where in the first case it seems Dr Moyano may not have felt confident in her written English and in the second she called in a fellow registrar rather than the on-call consultant. She had spent a lot of time with this registrar because they spoke the same languages – so she could converse more freely with him than with her English-speaking colleagues. Interviewees suggested to us that this might have been why she asked him rather than Mr MacLachlan for help.

The concerns midwives and patients raised between 4 and 13 October were investigated thoroughly and dealt with proportionately. They did not provide enough evidence of incompetence or misconduct to justify any immediate escalation of response or enquiry.

It seems clear that an on-call registrar or middle-grade doctor is more likely to be busy than an on-call consultant. The weekly rotas show that registrars and staff grades were frequently on call for 24 hours at a time. No doubt this is in line with tradition but perhaps not with modern views on patient safety or acceptable working practices.

8.98 Dr Moyano had a free weekend after finishing her busy 24-hour shift on 14 October at 8.30am.

Week beginning 16 October

8.99 Dr Moyano was back in the hospital on Monday 16 October, working in Mr Day's gynaecology outpatient clinic in the morning and helping him in the afternoon with three operations in the main theatre:

- a hysteroscopy
- a posterior repair
- a reduction of scar.

8.100 This was the first time Mr Day and Dr Moyano had worked together in the operating theatre. He said:

> *"…she ably assisted me with a case which took over two hours in which I excised a painful scar with abdominal wall reduction."*

8.101 Mr Day also recalled two occasions when Dr Moyano helped him with his antenatal patients. They had scans which showed minor abnormalities in the brain ventricles of their babies. The screening blood tests were normal. The likelihood that the babies were affected by Down's syndrome was small but the abnormal scans worried the patients so he rang Dr Moyano from the antenatal clinic to see if she could rescan and reassure these women. On both occasions she said that she would be pleased to help and either saw them immediately or soon after. Mr Day recalled that in one case Dr Moyano scanned a patient and came to the clinic to collect another. In both cases she put their minds at rest and the women were delighted with the service and explanation they received.

8.102 Dr Moyano's activities on 17 October are detailed in section 7 and appendix E. Dr Moyano did not return to work after Mrs Rourke's death. Her subsequent contracts were cancelled.

Comment

In piecing together Dr Moyano's activities we had access to four different lists detailing the operations she had apparently been involved in. Some appeared on all the lists, some on two or three, some on only one. The operations shown in this section are those where we have been able to confirm from the patient's notes that Dr Moyano was involved in some way. More details are given in appendix H. It seems likely that we have recorded all the operations she was involved in, but it is not satisfactory that we have had to engage in detective work (with the full cooperation of the staff) to establish something as basic as who did what during each operation. We discovered that the medical records of private patients operated on at the hospital are taken back to the private rooms

of the consultant, without copies being kept at the hospital. This has obvious patient safety implications in the event of an emergency.

Recommendations

R8 The chief officer and information governance lead should ensure that patient records are clearly numbered under a single system and that all records are filed safely and in correct sequence *by hospital number*, not by name. Any records on a particular patient held by another medical organisation, for example a private consultant or another hospital, should be filed in the original patient record folder.

R9 The chief officer and information governance lead should ensure that no original patient records are removed from hospital premises under any circumstances. Where a request for records is made, for example by another hospital, a private consultant or in the course of litigation or similar review (and with the patient's consent), the records should be photocopied and only the copies sent.

R10 All staff should ensure that records - including patient records and departmental rotas – are accurate and comprehensible and include last-minute amendments and changes.

Conclusion

Dr Moyano qualified as an obstetrician and gynaecologist in Spain and worked there as a consultant, specialising in fetal medicine but also carrying out all the tasks of an on-call obstetrician and gynaecologist.

She obtained registrar posts in England in prestigious units, working in fetal medicine. Her referees from these units thought well of her, although they could not comment on her general obstetrics and gynaecology skills. The reference forms were not detailed or robust enough to ensure that useful information would

be provided about Dr Moyano's suitability for the locum post for which she applied.

She was recruited by HSSD to act as Mr MacLachlan's locum to cover his on-calls in August and early September while he was on light duties after sick leave.

HSSD did not have a detailed, robust, written recruitment process for locums and there was no requirement that HR should be provided with evidence of a face-to-face appraisal with a consultant before a locum began work. As a result, Dr Moyano was not properly appraised on arrival. Mr Day was aware of the need for a appraisal, but went on leave before Dr Moyano arrived and believed on the basis of a telephone conversation with her on the 16 August that one of his colleagues had carried out an appraisal. Mr MacLachlan had a conversation with Dr Moyano shortly after her arrival, which dealt with her experience and expectations, but he did not consider this an appraisal because he had just returned from leave and was not aware that she was new, that she was his locum or that she was a consultant.

Dr Moyano was well regarded at Jersey General Hospital, completed three locum consultant contracts in August and September and had agreed to provide locum cover to Dr Nelson in October and to Mr MacLachlan in October/November and in December.

A number of incidents gave rise to the creation of incident forms after Dr Moyano started working as a locum registrar on 2 October. However, none of these was seen to relate to her clinical competence.

9. The allegations against Mr Day and Dr Moyano

9.1 In this section we look at some of the claims, allegations and assumptions communicated to us about Mr Day and Dr Moyano insofar as investigating them falls within our terms of reference. We have done so because many of these allegations received wide publicity at the time of Dr Moyano's trial in January 2009 and our perception is that they have taken on the status of truth for some people, including some who have spoken to us. Our own findings do not support these allegations in the main and so we felt it would be confusing and unhelpful if we did not refer to the specific allegations and explain how we reached our conclusions on the evidence.

Mr Day

9.2 Dr Moyano was the only person on trial as a result of Mrs Rourke's death, but she was not the only person whose actions were under scrutiny: a significant part of the defence case involved criticising Mr Day on the basis that if he had acted professionally, Mrs Rourke would not have died.

9.3 Dr Moyano's advocate accepted that she had made an error of judgement but suggested that she did so because of the *"horrible predicament that she was put into by Mr Day on 17 October 2006"*. During the trial he made a number of allegations against Mr Day, which he summarised in his closing speech:

> *"…he arrives late. He's got an overcrowded list of patients. He does all the surgery on patients 1-8. He disappears to his private rooms, abandoning Dr Moyano. When called from the operating theatre he does not return. He does not say "Stop the procedure". He returns when he hears that the patient is unwell. He forgets his reading glasses. He embarks on surgery which is beyond his skills. He makes a complete mess of it, and he causes more damage to the patient. Then, as if that is not bad enough, he finds Dr Moyano and in a dictatorial way he tries to create her evidence for her."*

9.4 He said Mr Day had instructed Dr Moyano to resect the polyp and alleged that he was:

> "*…speaking constantly on his mobile phone whilst he was in the operating theatre…*
>
> *…If Mr Day had not messed up the remedial surgery, Mrs Rourke would have had a 90 per cent chance of survival. Mrs Rourke would have lived. We would not be here today.*
>
> *Mr Day's errors on that day were far worse than Dr Moyano's. He abandoned his list to pursue his private patients. He knew he had done wrong when he had to rush back. He was obviously feeling guilty when he entered the theatre. He had been caught out.*
>
> *His patient was injured for the simple reason that he had left early. He knew he was in trouble. He wanted to cover his tracks. He wanted to fix this in house and keep it quiet. That's why, members of the jury, he made these dreadful, dreadful, decisions with the remedial surgery."*

9.5 Neither the prosecution nor the defence called Mr Day to give evidence so he had no opportunity to explain his thinking or his actions. However, the allegations against him received wide publicity in the Jersey Evening Post and interviewees have told us that some people believe them, not least because Mr Day did not publicly deny them.

9.6 In seeking to establish the truth of what happened we have paid particular attention to these allegations and address them specifically here. Mr Rourke, in particular, needs to know whether his wife died because of Mr Day's "*sustained indifference to his patients*" and his "*inexcusable behaviour*", as alleged during Dr Moyano's trial.

Did Mr Day arrive late for his list?

9.7 The theatre is booked from 9.00am to 12.30pm for the day surgery list, so by starting at 9.23am Mr Day started late that day. However, it is not clear that this is particularly significant, either as evidence of unprofessionalism or as an element of the events that led to Mrs Rourke's death.

9.8 We have been provided with computerised records of the day surgery lists for Mr Day, Dr Nelson and Mr MacLachlan for periods in 2006. They cannot be relied on in detail because they contain internal evidence of inaccuracies, but in general terms they show that all three doctors sometimes started before 9.00am but more commonly started later, that all three sometimes finished before 11.30am but sometimes not until after 1.00pm and that Dr Nelson's team appeared to be the best timekeepers, with the other two teams equally erratic.

Comment

If the start of the list depends only on the readiness of the operating surgeon, these statistics suggest that starting on time was not an important consideration for any of the consultants, although Dr Nelson was a better timekeeper than the other two. We consider that starting late does not necessarily indicate thoughtlessness or laziness because consultants have to juggle many commitments and responsibilities and make judgements about how they do this. It also seems possible that late starts are sometimes caused by the unreadiness of other members of the team. The requirement for consultant anaesthetists to be available for the private patients, who are usually at the beginning of the list, is bound to lead to delays from time to time if anaesthetists are caught up in some other activity when they are due in theatre. It seems unlikely that anyone except Dr Graham Prince was concerned about the time the list started on 17 October.

9.9 It was suggested at the trial that Mr Day left the hospital to see patients in his private consulting rooms eight to ten minutes' drive from the hospital. Mr Day's private Tuesday afternoon clinic ran from 2.30pm, but he had patients booked from

noon that day. Mr Day told both us and police that he had phoned his secretary during the morning list to cancel these appointments. His mobile phone records and the phone records of the hospital show that a short call using the hospital phone was made to his private rooms at 12.02pm and a shorter one on his mobile at 12.10pm. His private clinic diary for 17 October shows that the appointments of patients booked in before 2.30pm were cancelled. The first of these patients has written to confirm that she recalls arriving for her noon appointment and being told by the receptionist that it had been cancelled, with the receptionist apologising that she had not been able to contact her before she left to come to the clinic. This fits with Mr Day's mobile phone call to his secretary at 12.02pm. His next patient has also written to confirm that she recalls arriving for her appointment, being told that Mr Day had been detained a short while and then being told that all appointments were being cancelled and rebooked. She recalls that she was the last to leave and met Mr Day arriving as she was leaving, so she went back in and was seen by him. This fits exactly with what Mr Day said in his statement of 20 December 2006:

> "*As I exited the lift, a Mrs Gallagher who's appointment had been at 12.15pm, was about to enter the lift. Although she had been told by Wendy that I had cancelled her appointment and an alternative had been made, it is not unusual for a patient to hang on, especially if they know I will be attending later. In the circumstances I said I would see her immediately.*"

Comment

We do not consider that Mr Day left his list to attend to private patients so we do not consider that the late start of his list caused him to behave in an unprofessional manner towards Mrs Rourke or contributed to her death.

Did he have an overcrowded list of patients?

9.10 Mr Day had nine patients on his list, which was as many as he had had on a day surgery list in 2006. He had nine patients on his list on four other occasions that year. The time in theatre for these was:

- 2 hours 51 minutes
- 3 hours 49 minutes
- 3 hours 17 minutes
- 2 hours 50 minutes

He had one session that lasted 3 hours 59 minutes, with eight patients, and two which lasted for 3 hours 55 minutes with seven patients.

9.11 Dr Moyano said in her statement that Mr Day said during the morning that he needed to get away by midday and that he asked if Dr Bappa or Dr Williams could come over. We have asked a number of those present in theatre that day about this and they have no recollection of any such comments. Mr Day remembered he wanted to talk to Dr Bappa about the work plan he was constructing for Dr Williams but he had not wanted him to come to the day surgery unit. He told us he would never demand that Dr Moyano or anyone else take over his list:

> *"No, I never say things like that. I never ever say things – it is entirely voluntary: are you interested/would you like to/is it all right/do you mind?"*

9.12 Mr Day said that although the theatre was booked until 12.30pm, he tried to ensure that the last patient on the list was on the operating table by 11.30am because he understood that patients on his list had to vacate their beds by 12.30pm so that the beds could be prepared for patients on the afternoon list. He could usually achieve this, which was why he sometimes booked private patients from noon but he sometimes overran because he had no influence over the length of the list. Documents we have seen show the start time of the last case into theatre for all three consultant's day surgery lists between October 2004 and October 2006. These show the last patient was in theatre before 11.30am 40 per cent of the time and on a further 28 per cent of occasions the last patient was in theatre before noon.

Comment

Day surgery staff told us that patients for the afternoon list are asked to arrive at 12.30pm, but also told us that if some of the patients from the morning list were still using the beds to recover, this could usually be accommodated. The statistics above suggest that Mr Day's approach to the timing of his operating list was shared by his colleagues.

On the basis of these statistics, it is clear that the list was too long to be likely to have the last patient on the table by 11.30am, but probably not too long if the hospital's expectation was that Mr Day would go on operating until 12.30pm. However, whether or not it was too long for the smooth running of the day surgery unit, there is no evidence that Mr Day was in a rush to deal with the patients. If he had felt under pressure to get on with his list he would not have allowed Dr Moyano to undertake the laparoscopy on the second patient, nor let her deal with patients 4, 7 and 8.

If the list was too long by best-practice standards, this was not Mr Day's responsibility. The pre-admission nurse created the list, including the private patients. The only evidence that Mr Day wanted to leave early comes from Dr Moyano and is contradicted by the stronger evidence that Mr Day cancelled his pre-clinic appointments and remained in the day surgery unit until Mrs Rourke was in theatre.

Did he do all the surgery on patients 1 to 8?

9.13 The records show and Dr Moyano herself confirms in her statement of 8 November 2006 that she undertook the laparoscopy on patient 2, the hysteroscopy on patient 7 and a vaginal examination under anaesthesia plus dilatation on patient 8. Mr Day also recalled that Dr Moyano undertook a hysteroscopy and biopsy on patient 4, which the records also show. These were all surgical procedures. There was no benefit to Mr Day in allowing her to undertake these procedures: for the first three he was directly observing Dr Moyano and for the fourth he was in the day surgery unit, on

hand in case he was needed. He had to deal with the private patients by himself, but he included Dr Moyano in the procedures of four of the five public patients dealt with before Mrs Rourke. He carried out the laparoscopy on patient 3 by himself as he wanted to show the SHO, Dr Sullivan, how careful you have to be with a very thin patient because of the position of the aorta.

Comment

The implication of this allegation is that Mr Day made no effort to assess Dr Moyano's skills before leaving her to deal with Mrs Rourke. The documentary evidence does not substantiate the allegation and we accept Mr Day's evidence that he was assessing Dr Moyano's gynaecological skills when he was in theatre with her.

Did he disappear to his private rooms, abandoning Dr Moyano?

9.14 He did go to his private rooms and there is evidence from Dr Moyano that she did not wish him to do so. In her 8 November statement she said:

> *"Mr Day said to me that he needed to leave the hospital and that he would have to leave me alone to deal with the last two cases. I said that I did not want to do these alone. He did not answer straight away. Later Mr Day said that it would be fine. I repeated that I did not want to do the procedures alone and again, after a little time, Mr Day said that it would all be fine. He was, during this time, talking intermittently on his mobile phone. I made it clear to him that I did not wish to undertake the procedure without supervision, but felt that he was not listening to me. I did not think that he was serious that he would leave."*

9.15 Mr Day's recollection differed. In his statement of 20 December 2006 he said he wanted Dr Moyano to carry out the final two procedures because he needed a break, having been operating continuously for two-and-a-half hours. We know he

remained in the day surgery unit during the eighth procedure and spoke to Mrs Rourke before her operation, which supports his claim. He said in his statement:

> *"I went into the theatre again and told Dr Moyano of my discussion with Mrs Rourke. Dr Moyano had already moved to the scrubbing area to do the case, as had Sister Mottram. I again asked Dr Moyano whether she was happy to proceed with the case and she replied "yes". This was hardly surprising given that a hysteroscopy was not a technically demanding operation, is relatively simple and one of the commonest in routine obstetrics and gynaecology (far simpler and less risky than the laparoscopic procedure Dr Moyano had carried out earlier in the list). Indeed it was essentially the same procedure that she had successfully completed on patient 8.*
>
> *I then asked her, as a matter of courtesy if she was "happy" for me to move on and go. Although I did not hear any reply, it was clear to me by her demeanour and attitude that she was focusing on the patient and already moving to begin the operation. She made no comment or statement to the effect that I should not leave and did not express any concern whatsoever. If she had asked me to stay at that stage, naturally I would have done. Moreover, had I had any concerns whatsoever as to her ability I would not have delegated this (or indeed any other) procedure to her."*

9.16 The versions given by each doctor support their own claims to have been acting properly: Mr Day claimed he had good reason to believe that Dr Moyano was competent and happy to be left with the last two procedures. Dr Moyano claimed she was clear she did not want to be left.

9.17 We asked the other people present in theatre that day - Dr Sullivan, Ms Mottram, Ms Hanson and the operating theatre attendant if they heard any of these exchanges between the doctors - none had. This is not conclusive because they all also confirmed that theatre is busy and communication can be more difficult because of the masks scrubbed doctors and nurses wear.

9.18 We therefore looked at the surrounding evidence to see if it could help us decide whether Mr Day had left because he believed Dr Moyano was happy to continue on her own or despite knowing that she wished him to stay.

9.19 Mr Day had cancelled his pre-clinic appointments, so he did not have any urgent engagements. He knew that Mrs Rourke was a member of staff but did not think it was right to alter the arrangement he had made for Dr Moyano to carry out the procedure because he believed she wanted to do it. He knew she was an experienced doctor who had worked in Spain as a consultant and in Jersey for the previous two months without incident (as far as he was aware) and for most of that time had been a locum consultant. He knew that she was undertaking a number of further locum consultancies for his two colleagues in the next two months. He had seen her competently carry out a delicate operation, laparoscopy, that morning, as well as three hysteroscopies and he knew that the procedure to be undertaken for Mrs Rourke was a diagnostic one she must have carried out many times.

Comment

All this is consistent with a belief that she was happy to be left.

9.20 What surrounding evidence is there that Dr Moyano did not wish to be left? We have Mr MacLachlan's evidence that she had not wanted to help him with a laparoscopy in September, but clearly she had been actively involved in surgery that morning with Mr Day. We know that she expected only to observe that morning but we also know that she had participated fully in the morning's work. We also know Dr Moyano was expecting to do only a hysteroscopy and D&C for Mrs Rourke, procedures that she had carried out for many years. Her CV shows:

> *"I was involved in the care of obstetric patients in the high dependency unit (HDU), I cared for women with pregnancy-specific disorders such as pre-eclampsia (PET), intra-uterine growth restriction (IUGR), threatened preterm labour, preterm rupture of membranes, multiple pregnancy and maternal conditions such as diabetes, systemic lupus, erythematosus (SLE), renal disease*

and HIV etc. The on-call rota involved cover for emergencies for approximately 6 days every month and during this time I would be responsible for labour ward, the HDU and the review and/or admission of approximately 50 obstetric or gynaecological patients and management of early pregnancy complications, like miscarriage, dilatation and curettage (D&C) ectopic pregnancy surgery and the termination of pregnancy.

Although I no longer practice general gynaecology, most of my experience was gained during four years of general registrar training in obstetrics and gynaecology. This included modules covering gynaecological surgery (at least one list a week), gynaecology and breast oncology, endocrinology and infertility. The surgical procedures I performed included laparoscopies, hysteroscopy, vaginal surgery as well as open abdominal procedures (hysterectomy, myomectomy and minimal access surgery). During my subspecialist period I continued to provide gynaecological cover on call.

After completing my training in obstetrics and gynaecology I specialised in fetal medicine and worked as a consultant in the pre natal diagnosis department at HCB. The department pioneered the introduction of screening for Down's syndrome and a one stop clinic for the assessment of risk for trisomy 21 at 11-14 weeks, in Spain. My duties involved principally scanning high risk patients (first trimester nuchal scans, 20 week anomaly scan, fetal well-being, serial growth and early pregnancy). I was responsible for over 60% of the invasive procedures CVS and amniocentesis and assessing management and follow-up with Doppler and/or cordocentesis of pregnancies affected by Rhesus alloimmunization and other causes of anaemic fetuses and fetal infections. Also the diagnosis and evaluation and counselling of chromosomal abnormalities and termination of pregnancy. I worked with a multidisciplinary team of geneticians, physicians, microbiologists, haematologists, biochemists and pathologists, as well as paediatricians and other obstetricians subspecialised in chronic maternal illness such as SLE, diabetes and HIV. Other duties included running the weekly labour ward, the HDU, and elective caesarean section list, the care of obstetric inpatients and emergency obstetric and gynaecological patients…

I was requested to return to Spain by the head of obstetrics and gynaecology at HCB to work as a senior consultant and cover study leave for the head of the prenatal diagnosis unit…"

9.21 We also have Dr Moyano's evidence to police. On 2 March 2007 she said *"…hysteroscopy I think is a procedure I can do because I feel absolutely competent…it's because it's one procedure that has many similarities with the dilatation and evacuation in a miscarriage procedure"*. She went on to say that she had carried out this dilatation and evacuation procedure between 200 and 300 times.

9.22 She was asked if she had felt on 17 October that she would have been competent and capable of carrying out the procedures on the list. She said it would have caused her no concern to carry out the list if Mr Day had not been able to *"because all of them were hysteroscopies or laparoscopies"*.

Comment

On the face of it, Dr Moyano's own evidence was contradictory at this point in her interview with police. It suggested that she did not want to be left but also that she felt quite competent to carry out all the procedures on the list. However, an explanation for this apparent contradiction emerged as the interview progressed.

9.23 She confirmed that when she saw the polyp during the hysteroscopy for patient 7 she told Mr Day what she had found to see: *"what he wants to do. If he wants that I proceed, or he wants to do it"*. She explained that she was working as a registrar so she had to ask the consultant what to do, even though she had been working as a consultant herself shortly before. She said that when she told Mr Day about the polyp he came back in and removed it, but that she would have preferred to remove it herself *"I can do the resection of a polyp"*. Later she said: *"…there was a polyp there and he has to know there is a polyp there, and I have to know what he wanted me to do"*.

9.24 She also confirmed that she knew that if she was not happy to carry out a procedure she could say so and ask a colleague to do it.

9.25 The police asked why she had not wanted Mr Day to leave. She replied that he was the consultant and part of the team. She said she had no concerns about her ability to perform the last two or three procedures on her own.

9.26 We asked Mr Day why he had felt that it was acceptable to leave the hospital. He told us:

> "*Well, because I always do. Well these are minor cases, and over the years one has been pleased for junior staff to do these cases…I am about 3 or 4 minutes away if they want me and I come back…if you go, say, to the Hallam Street Hospital it would take longer to get from one end of the hospital in Hallam Street than it would be from my rooms back to the hospital. This is very close and really one is available and you have lots of examples where I will be in my rooms and I will be called back: I am not on call, someone has a problem with an operation, so it is very much a flexible arrangement.*"

Comment

Dr Moyano would have liked Mr Day to stay, apparently because she felt it was the correct thing for him to do, not least to be available for her to refer to. We have seen no evidence that she felt abandoned. Her own evidence is that she felt competent to carry on. We consider that the weight of the evidence supports Mr Day's claim that he believed Dr Moyano was happy to carry on without him and that his belief was reasonable.

When he was called from the operating theatre is it true that he did not return?

9.27 Yes, this is true. The implication is that he should have returned but the evidence does not support this. Dr Moyano does not claim that she asked Mr Day to return. If she had, his failure to do so would have left him open to criticism. In her 8

November statement she says she asked Dr Sullivan to find him but not that she asked him to return. She said in her police interview: "*I asked Dr Sullivan to call him because I don't know what he wants, if he wants that I do or he wants to do it…*" and when Dr Sullivan reported back that he had left the day surgery unit she said *"Well, try and find him because I want to know what he wants, what I do."*

9.28 She went on to explain that she needed to speak to Mr Day because she had not anticipated removal of the polyp so she needed his permission to continue. She said that when she had been working as a consultant she would have expected this of her registrar. We note that in relation to her identification of a polyp on an earlier patient on 17 October, her police interview contained this exchange:

> "*Dr Moyano: ...I saw that there was a polyp. And I informed Mr Day that there was a polyp, what he wants to do. If he wants that I proceed or if he wants to do it...*
>
> *Q: Why do you feel the need to ask Mr Day...?*
>
> *A: Because I am a registrar*
>
> *Q: You're...?*
>
> *A: I am, I was registrar.*
>
> *Q: You were registrar?*
>
> *A: Yes.*
>
> *Q: Albeit you've been employed in the past as a consultant?*
>
> *A: Yes, but doesn't matter.*
>
> *Q: So as a registrar, you'd have to ask the consultant?*
>
> *A: Yes.*
>
> *Q. Even though the week before you had been a consultant?*
>
> *A: Yes.*
>
> *Q: Really?*
>
> *A: Yes, really.*
>
> *Q: Okay...Apart from the courtesy of asking the consultant, was there any other purpose for asking Mr Day...what he wanted you to do?*

A: Because...he's who is going to decide who is going to do the procedure, or what kind of procedure we are going to do...

Q: But say, for argument's sake, the week before, when you had been a consultant, you would have made those decisions yourself or somebody would have come to you to make those decisions.
A: Yes

Q: And just because it says registrar on this week's contract, so to speak...
A: Yes, that I should follow the orders.

Q: Is that how it works?
A: Yes, is how. ...I cannot do things because I want...or even if I know how to do it. There is another person that is more responsible..and needs to be informed, always."

9.29 She went on to say that although Mr Day had resected the polyp without offering her the option, she would have accepted an offer to resect the polyp so long as she was clear that it was not a fibroid:

"…I can do the resection of a polyp, but the resection of a fibroid I prefer don't do it…because…I think it's more difficult."

9.30 Dr Moyano tried to resect what she believed to be Mrs Rourke's polyp with diathermy, despite the weight of evidence being that Mr Day did not instruct her to resect the polyp, and despite her having safer options. This suggests someone confident of her abilities.

9.31 Dr Moyano's advocate suggested that Mr Day did not return because it would have inconvenienced his private patients. This seems unlikely, for the reasons explained earlier. He had already cancelled his pre-clinic appointments on that day, and although two of his patients were at his rooms on the off-chance that he would be able to see them earlier, there is nothing to suggest that he would have put their

convenience above the safety of a patient in the hospital. Mr Day had been treating public and private patients in Jersey for many years and his reputation was that of a doctor who gave the same care and attention to his public patients as to his private ones. He told us:

> "*It was not unusual for me to book private patient appointments at 12.00, as my morning list should have finished by then. On the other hand, it would not be unusual for me to telephone my private secretary and ask her to explain to those patients that I had been delayed. They would invariably be understanding of this, knowing that the way I allocated my time was often governed by emergencies or unforeseen events.*"

Comment

We consider that Mr Day did not return to the hospital because he saw no reason to do so. He understood that Dr Moyano was contacting him in accordance with good practice, as was indeed the case.

Mr Day was criticised at Dr Moyano's trial by experts whose experience of working with public and private patients is in the NHS, where the separation is far more rigid than on Jersey. Whether Mr Day was at fault for booking these patients is a contractual issue outside our terms of reference.

Is it correct that Mr Day instructed Dr Moyano to carry on and resect the polyp?

9.32 There are a number of different accounts of this which we think are worth setting out in detail.

9.33 In her statement of 7 November Dr Moyano recalled:

> *"Mr Day answered. Dr Sullivan told him about the polyp. Dr Sullivan then asked me, I presume in answer to a question from Mr Day, what size the polyp was. I looked to her, again moving to my right. The Sister, I think, repeated the*

question. Through Dr Sullivan I told Mr Day that the polyp was about the same size as in the earlier case. Mr Day told me, through Dr Sullivan, that I should remove the polyp and send the sample to pathology/the laboratory. Dr Sullivan told me that she thought Mr Day was not in the hospital, but in his private rooms."

9.34 Dr Sullivan recalled in her statement of 10 November 2006:

"*During the procedure Dr Moyano asked me to call Mr Day as she thought this patient had a polyp as well. I spoke to Mr Day on his mobile phone. He enquired after the size of the polyp and Dr Moyano replied that it was similar to the previous case. Mr Day asked me to get in contact with Dr Ahmed, staff grade in Obstetrics and Gynaecology."*

9.35 In his statement of 20 December 2006 Mr Day said:

"Whilst I was standing in front of my secretary's desk, I received a phone call on my mobile telephone from Dr Sullivan to say a polyp had been found and asking what Dr Moyano should do. My reply was to either remove it if Dr Moyano was comfortable to do that, or just biopsy it and curette the uterus as the patient had been consented for hysteroscopy and biopsy. If a surgeon is in distress they will, in my experience, always want to speak on the phone themselves but this was not the case and I only spoke to Dr Sullivan. I said that if she needed some local advice she could see if Mr Ahmed was available. There was no urgency or concern in this conversation whatsoever…"

Comment

Clearly, Mr Day did not tell Dr Moyano to **"resect"** ***the polyp, as both of them recall that he used the word*** **"remove"** ***and there are other ways of removing a polyp than by resection - for instance by using forceps.***

What is the evidence that Mr Day instructed *Dr Moyano to remove the polyp, rather than, as he claims, suggesting removal as one of a number of options?*

9.36 Recollections of what was said differ slightly but both Mr Day and Dr Sullivan remember that an option suggested in the first phone call was to ask Dr Ahmed for advice. Dr Moyano did not at first remember this but her memory must have been at fault because it is clear from Dr Ahmed's evidence that he was called and that he referred Dr Sullivan back to Mr Day.

9.37 Dr Moyano said in her initial statement that she removed the polyp in response to Mr Day's instruction in the first phone call. Subsequently, during her March 2007 police interview, she repeated this. It was only during the trial that her advocate acknowledged that there had been a call to Dr Ahmed following the first conversation with Mr Day. He went on to suggest that there had then been a second call to Mr Day after the call to Dr Ahmed, using Dr Sullivan as a go-between, and that it was in this call that Mr Day had told Dr Moyano to resect the polyp. He suggested there was then a third call to Mr Day reporting that a false passage had been created.

9.38 Dr Sullivan said in her statement of 10 November:

> *"I phoned Dr Ahmed who was doing ultrasound scanning. He was busy and could not attend at that moment and asked if I could contact Mr. Day again. I contacted Mr. Day again and Dr Moyano informed me that she thought she had resected the polyp, but might have created a false passage."*

9.39 Mr Day said in his December statement:

> "*I received a second telephone call. This time I think that Dr Sullivan made the call and then I spoke to Dr Moyano. I was informed by her that a false passage had been made at some stage which happens from time to time."*

9.40 The phone log for the day surgery unit on that day shows only two calls to Mr Day's mobile while Mrs Rourke was in the operating theatre.

Comment

The evidence of the witnesses and the phone records was that there were only two phone calls. Dr Moyano accepted at trial that the first call included advice from Mr Day to contact Dr Ahmed and she, Mr Day and Dr Sullivan agreed that there was a call to report the accident. It follows that there was no second call to Mr Day in which he told Dr Moyano to resect the polyp.

The evidence suggests that Mr Day never instructed Dr Moyano to remove or resect the polyp but that he suggested that she could remove it as one of a number of options if she felt comfortable doing so.

Dr Moyano acknowledged in her police interview that the tissue she removed from Mrs Rourke's uterus was not a polyp but a piece of the lining of the uterus. The post-mortem examination did not reveal a polyp.

Did Mr Day return when he heard that the patient was unwell?

9.41 Mr Day returned as soon as he was told that Mrs Rourke was hypotensive (had low blood pressure). This was obviously the correct action: Mrs Rourke was his patient and he was responsible for her.

9.42 This comment was made by Dr Moyano's advocate as one of many criticisms and the implication is that he returned because he felt guilty about instructing Dr Moyano to deal with the polyp.

Comment

The weight of evidence is that he did not instruct her to resect the polyp so it seems unlikely that his return to the hospital was motivated by guilt rather than professional concern.

Did he forget his reading glasses?

9.43 Mr Day told us he had reading glasses for ordinary purposes but kept a special pair for work in the main theatre, which are clean, not scratched and always with an up-to-date prescription. He did not need these glasses in day surgery because all the procedures involve scopes, monitors and magnifiers, for which his uncorrected vision is adequate. He called for his theatre glasses even though he did not really need them because he always had them for main surgery, which this turned out to be. Mr Day told us his glasses had a weak prescription and that he was not impeded in operating by the lack of his theatre glasses.

Comment

We cannot say one way or the other whether Mr Day's competence was affected at the beginning of the operation by the lack of his glasses. This could only be done by expert appraisal, which is beyond our terms of reference.

Did he embark on surgery beyond his skills? Was this because he was trying to cover up his dereliction of duty in leaving the hospital before the end of his list? Did he know he was in trouble? Did he want to cover his tracks and fix this in-house and keep it quiet?

9.44 The comments of Mr Butcher, set out in section 7, provide a dispassionate view of the work of all four surgeons during the rescue operation and give a view of the likely thinking behind those actions. Mr Butcher had read the evidence of the experts instructed by the prosecution and the defence at the trial (who did not always agree with each other) and took this into account in forming his opinion. We know that the GMC is looking at this case and we are confident that if it disagrees with Mr Butcher and finds any of the doctors breached their professional duties, it will say so. We have not been asked to deal with that issue.

Comment

We found no evidence that Mr Day was motivated by guilt that afternoon. As set out above, we consider that the weight of the evidence supports the view:

- ***that he legitimately believed that Dr Moyano had the skills of an experienced consultant obstetrician and gynaecologist***
- ***that he legitimately believed that she was capable of, and willing to, carry out the procedure for which Mrs Rourke had given consent***
- ***that he had not left the theatre because he was in a rush to get to his private rooms***
- ***that he had not ordered her to resect or remove the polyp***
- ***that she had no need to use diathermy to remove the polyp, and could have used forceps.***

Did he find Dr Moyano and in a dictatorial way try to create her evidence for her?

9.45 Mr Day said in his statement that Ms Angela Body, the directorate manager of surgery, had asked him to ask Dr Moyano to write a log of Mrs Rourke's original operation as it happened. When we asked Mr Day he said that it was either Ms Body or Dr Richard Lane who had asked him to do this. He went on:

> *"I sat on the bed, she was writing on a desk, the patient's table you put across the bed and she would write a bit. All I did was put in a few prepositions here and there and Mrs Body came by and I said "You must read this and agree that Dr Moyano knows what she is saying and things", so Dr Moyano read it out. Mrs Body said "Are you happy with that?" "Yes, I'm happy with that". Dr Moyano signed it, Mrs Body countersigned it."*

9.46 He told us he had been trying to be helpful to his colleague. This approach is borne out by a letter he wrote before the post-mortem examination to the Deputy Viscount in which he makes the point that some of the damage to the vein would have been caused during the rescue operation, rather than by Dr Moyano.

9.47 Dr Moyano does not comment on this aspect of the day in her statement or her police interview and it seems that her advocate relied on the evidence of Ms Body to support this allegation.

9.48 Ms Body said in her court evidence that she saw Dr Moyano and Mr Day in a side room shortly after Mrs Rourke had died and that as she walked in "*Dr Moyano was reading out some of the statement that she had written down and…Mr Day said to her 'Write down that I advised you to bring this patient back in six weeks'*". Ms Body felt that Mr Day should not tell Dr Moyano what to say in her statement and arranged for him to be taken home by Dr Lane to get him out of the hospital.

9.49 Dr Moyano's advocate claimed that Mr Day was creating her evidence, implying he was doing so to protect his own position. However, what Ms Body overheard is in line with Dr Moyano's subsequent witness statement and police interview. We have not been able to trace the original handwritten statement of 17 October and have seen no reference to anyone else having seen it, so we cannot comment on its contents.

Comment

There is a direct conflict between the evidence of Mr Day and Ms Body as to the circumstances that led him to be helping Dr Moyano with her statement. We cannot resolve this contradiction. However, we conclude that, whatever the circumstances, Mr Day should not have helped Dr Moyano with her statement because he was also involved in the incident.

Nothing supports the proposition that he was seeking to tamper with Dr Moyano's evidence. The record of Dr Moyano's police interview clearly shows that her spoken English is far from perfect, at least when she is under stress. We do not find it implausible that she would have welcomed help in writing her statement.

Was Mr Day speaking constantly on his mobile phone while he was in the operating theatre?

9.50 This criticism is based on comments in Dr Moyano's statement. Other people in the operating theatre made no mention of this in their statements and no one could remember this behaviour.

9.51 Mr Day's mobile phone records for 17 October show that the only calls he made on it that day before leaving the hospital were one to his home at 12.05pm lasting less than two minutes, one to his private rooms at 12.10pm referred to in section 7, which lasted for 10 seconds and one at 12.33pm lasting 23 seconds which was unrelated to the events of the day.

Comment

It seems to us that others present on the day would have noticed if Mr Day's phone was constantly ringing. They have no such memories. The only calls Mr Day made from his mobile that morning were during a 10-minute period between patients. The weight of evidence is against the allegation that Mr Day was constantly on his mobile phone.

9.52 Dr Moyano's advocate also criticised Mr Day for his handling of her recruitment and in particular his failure to phone Dr Moyano until Ms Leed reminded him to do so on Friday 11 August. However, Ms Leed prepared a memo of what she could recall about Dr Moyano's recruitment, dated 26 March 2007. She says in it that when she spoke to Dr Moyano and offered her the job on 11 August, Dr Moyano:

> "*…confirmed that she had spoken with Mr Day but was still unsure about whether she wanted to accept the job as her specific duties were still not clear to her. I once again asked Mr Day to contact her…*"

9.53 Ms Leed accepted that this memo was probably more accurate than her recollection of events when she was giving evidence. Mr Day recalls having two conversations with Dr Moyano, one on 9 August and one on 11 August.

Comment

It is understandable that this criticism would be made by Dr Moyano's advocate, because Ms Leed's evidence in court was to the effect that Mr Day had to be reminded to call Dr Moyano.

The weight of evidence appears to be that Mr Day did what was asked of him that week, looking at Dr Moyano's CV and telephoning her when the HR department asked him to do so.

9.54 A number of witnesses told us that the accident would not have happened if Mr Day had known that Mrs Rourke was a member of staff because he would have made sure that she was earlier on the list. We considered whether this was a legitimate concern because it would have been just as much a tragedy if another patient had been last on the list and had died. We could not be sure that there would have been a fatal accident if the order of the list had been different and so we believed we should look at this issue.

9.55 Staff being treated at the hospital are not entitled to special privileges but as a matter of professional courtesy, if it is known that a member of staff is receiving treatment, they will be acknowledged as colleagues, will usually receive their treatment from a consultant rather than from a middle or junior-grade doctor and will probably be placed near the beginning of the list.

9.56 There is no reason why Mr Day should have known in advance of 17 October that Mrs Rourke was a member of staff. Dr Wilson's referral letter, which mentioned that Mrs Rourke was a nurse on Beauport ward, was addressed to Mr Day but went directly to the outpatient clerk, who booked Mrs Rourke in for an outpatient appointment in Mr Day's clinic. He was on study leave that day, so Mr Dumbrill, a locum staff grade took his clinic. Mr Dumbrill was familiar with the workings of the hospital because he had

been a permanent member of staff but he did not draw the attention of Mr Day or the pre-admission nurse Ms Pycraft to the fact that Mrs Rourke worked at the hospital.

Comment

Mrs Rourke was last on the list, so it seems likely that Ms Pycraft, who decided its order, did not know she was a member of staff.

Mr Rourke told us his wife would not put herself forward and it seems likely that she did not draw attention to her status as a member of staff when she saw Mr Dumbrill or Ms Pycraft. If Mr Day had been doing his outpatients list that day, no doubt he would have noticed from Dr Wilson's letter that Mrs Rourke was a member of staff and no doubt Mr Dumbrill noticed this as well. However, it seems that this was not mentioned to Ms Pycraft and the pre-admission form makes no reference to her being a member of staff.

Ms Pycraft, who undertook the pre-admission assessment for the day surgery unit, could not remember her meeting with Mrs Rourke, which supports the idea that Mrs Rourke did not mention this when they met. The pre-interview assessment form therefore makes no mention of the fact that Mrs Rourke worked at the hospital.

It may be that if Ms Pycraft had known that Mrs Rourke was a nurse, she would have put her nearer the front of the list.

9.57 The nurse currently in charge of the day surgery unit, told us that all other things being equal, members of staff are listed directly after the private patients, who appear at the beginning of the list. This is to ensure that the member of staff not only gets the services of the consultant surgeon but also of the consultant anaesthetist who is there for the private patients but not necessarily for the public ones. There could be reasons for doing things differently, for instance a public patient would go first if they had a latex allergy; and a private patient would have to go last if they had MRSA.

9.58 We went through the list for 17 October because we were curious about the apparent randomness of the ordering; a private patient, then three public patients, then two private patients and then the remaining three public patients. Ms Robertson said it was a good idea on a day surgery list to put people having the more lengthy or serious procedures on early, as this gave them the longest time to recover after surgery. Laparoscopy is a fairly complex procedure for day surgery. It can take up to an hour and the patient may feel sore and unwell for some time after they wake up, so it is a good idea to put them on first. This might explain why patients 2 and 3, both public patients, were dealt with before patients 5 and 6, who were private.

Comment

Mr Day cannot be criticised for not knowing before 17 October that Mrs Rourke was a member of staff. It is not certain that she would have been earlier on the list even if Ms Pycraft had known.

Mrs Rourke's death and the subsequent investigations by the police and us have put Mr Day's working practices under scrutiny and found areas where his working practices could have been improved. However, we think that a minute examination of the working practices of any professional on an ordinary day chosen at random will reveal failures to comply with best practice. This does not mean that the practitioner is unprofessional or acting against the interests of his or her patients. We have found no evidence that Mr Day knowingly or carelessly put Mrs Rourke at risk of harm.

Dr Moyano

9.59 The prosecution alleged at Dr Moyano's trial that she was not competent to carry out the procedure on Mrs Rourke. A number of the people have told us that she should never have been employed as a locum consultant in the obstetrics and gynaecology department of the hospital. We therefore examined the evidence to try to form our own view.

Should Dr Moyano have been given the three locum consultant contracts that she worked in August and September?

9.60 Dr Moyano's CV shows that she worked as a gynaecology on-call junior consultant in Barcelona in 2002 and as a gynaecology on-call senior consultant in Barcelona in 2005. She applied for the job in Jersey in 2006, and accepted the offer after discussing the details in two telephone conversations with Mr Day. Her advocate suggested that she wanted to talk to Mr Day before accepting the post because she was conscientiously assuring herself that she was competent to take on the job. However, in her police interview she said that the prospect of continuing with her ultrasound work was an important attraction.

9.61 She was asked if there was any area of work that she would have said "*If I have got to do that then I am not interested*" and she replied "*Well, if the job didn't have anything about fetal medicine I wouldn't accept*". So the significant factor for her appeared to be the opportunity to do fetal medicine, rather than the presence of other tasks, except she said that she would not have wanted to be responsible for any oncology work.

Comment

Dr Moyano's references and testimonials produced at the trial suggest she is a careful, thoughtful and dedicated doctor. Even such people can be over-confident about their skills and abilities but it seems unlikely that Dr Moyano would have accepted the first contract unless she felt competent to do the work or would have continued to accept fresh contracts if she had found on arrival that she was out of her depth.

9.62 It was suggested at her trial that her comment in her email of 29 September that "*…it is much better for me to do staff grade than consultant to be involved more in gynaecology that is what I want…*" was evidence of her lack of confidence in her own abilities. She might also have preferred more junior locum jobs because they would give her more hands-on experience of surgery and/or would probably pay better

than consultant posts: her salary for the three weeks she covered for Mr MacLachlan in August/September was £5,460, and for the two weeks for Dr Nelson in September £4,200. However, for the 17 days she covered for Dr Elfara, she was to be paid £7,200, which reflects the greater demands on registrars and middle-grade doctors.

9.63 Dr Moyano's preference for staff-grade posts did not stop her from accepting three locum consultant posts for October to December 2006.

9.64 Mr MacLachlan had an early conversation with Dr Moyano, probably on her first day at work, in which she discussed the areas in which she wished to improve her skills. He also offered to help if she needed any gynaecology assistance when she was on-call consultant. He told us that in fact she never called on him for help when she was on-call consultant. We had formed the impression, from the information provided to us, that Mr MacLachlan had had reservations before 17 October 2006 about Dr Moyano's ability to carry out the routine work of an on-call consultant, including such gynaecological work as might come her way. A number of those who spoke to us told us that they had formed the same impression. However Mr MacLachlan told us that this was not the case:

> "*... all the time that I was with her, I didn't see any incompetence. I saw some hesitancy in that first week in September or whenever the date was in the first operating list which she did with me, but that was appropriate for somebody who had just been invited to theatre, and that didn't make any difference whether she was a consultant or a registrar. The ability to do a laparoscopy remains whether you are a registrar or a consultant, whether it is on call or not. I would not expect her to do some complicated laparoscopies but I wouldn't expect myself to do certain things because I can't do them....*
>
> *Q: ....What you are saying is that, so far as you are concerned, she was perfectly capable of carrying out all the duties of an on-call consultant but that doesn't include being able to do a resection.*
> *A: That is true."*

9.65 Even if Dr Moyano was not competent to carry out the resection using diathermy, this would not in itself be evidence of her unsuitability to be a consultant. Other methods can always be used and diathermy skills require special training, which not all gynaecology consultants obtain. Mr MacLachlan told us:

> *" It was mad to leave her alone to do a resection.*
>
> *Q: Yes, but it wouldn't have been mad to leave her alone to do an hysteroscopy?*
> *A: No.*
>
> *Q: Or, indeed, to do an hysteroscopy and a polypectomy using forceps?*
> *A: Yes."*

9.66 Nothing in the records, either when Dr Moyano was a locum consultant or when she was a locum registrar suggests she was an incompetent doctor. There is evidence, particularly towards the end, that she had communication problems with colleagues and patients and that she sometimes lacked confidence but these problems do not provide clear evidence of medical incompetence.

Comment

Only a professional appraisal can establish if Dr Moyano was competent. We can say only that there is no clear evidence that she was unfit to work as a locum consultant in August and September 2006.

Mr MacLachlan's evidence to us, taken with our conclusion that Mr Day did not instruct Dr Moyano to remove the polyp, let alone suggest that she use diathermy, would seem to indicate that, in leaving Dr Moyano to carry out the final procedure, there were no perceptible issues of patient safety that Mr Day failed to consider.

We have received contradictory information about the views staff in the department were thought to have had, prior to 17 October, about Dr Moyano's skills and abilities. It is important that the commissioners gets to the bottom of this, as it has obvious patient safety implications.

Recommendation

R11 The commissioners should investigate what the staff in the obstetrics and gynaecology department knew or believed up to 17 October 2006 about Dr Moyano's skills and abilities. ***Urgent***

Was Dr Moyano competent to carry out the procedure on Mrs Rourke on 17 October?

9.67 In considering this aspect of the case, we have separated the diagnostic and therapeutic aspects of the surgery.

9.68 There is evidence that Dr Moyano was inexperienced in gynaecological surgery or at least out of practice. Mr MacLachlan recalled a conversation with her when she said she wanted to improve her skills in general obstetrics and gynaecology. He also recalled that she declined when he invited her in September to undertake a diagnostic laparoscopy. The trial prosecutor said her CV showed that her "…*principal training and experience in…hysteroscopy…was gained in 1998-2002…*" and that in the intervening period before coming to Jersey she was focusing on fetal and maternal medicine.

9.69 On the other hand, Dr Moyano was clear in her police interview that she was experienced at undertaking hysteroscopies. Both the obstetrics and gynaecology consultants called to give expert evidence at her trial agreed with her advocate's suggestion that she had the skills and experience to carry out diagnostic hysteroscopy. Furthermore, in her CV she says:

> *"As a final year SpR the hospital required me to be responsible for the training of two junior registrars and GP trainees every day for a period of 4 months in the labour ward, in HDU and in Obstetrics and Gynaecology emergency. I*

supervised them to carry out all the procedures and assessments required. I was expected to report to my consultants when I considered it necessary."

9.70 Although post-graduate training for the Spanish CCT only takes four years as compared to seven years in the UK, Dr Moyano explained, in her police interview, that the training in Spain is far more focused, not least because it takes place in a single hospital, rather than in different hospitals every six to 12 months, as in the UK. Furthermore, Dr Moyano's CV shows she continued to undertake on-call duties in gynaecology when she was a junior consultant in Barcelona in 2002 and when she was a senior consultant in 2005. A number of interviewees told us diagnostic hysteroscopy was a basic gynaecological procedure which doctors specialising in gynaecology start to learn from the beginning of their training.

Comment

The clear weight of evidence therefore is that Dr Moyano was correctly confident in her ability to carry out the diagnostic hysteroscopy for Mrs Rourke.

The evidence for her ability to use the resectoscope therapeutically is more evenly balanced.

9.71 The fact that Mrs Rourke's uterus was perforated is not proof that Dr Moyano should not have been using the resectoscope. A number of consultant gynaecologists, including those working at Jersey Hospital, told us that perforation of the uterus is not uncommon. Indeed, the information leaflet provided to patients who are to have a hysteroscopy puts the likelihood of perforation at 8 in 1,000 (0.8 per cent). These perforations can be made by a sound, a hysteroscope or a resectoscope.

9.72 The evidence that Dr Moyano had the necessary expertise comes mainly from her statement of 8 November 2006 and from her police interviews in March 2007. In her statement she says:

"I considered how best to proceed. Although unhappy at being left alone to undertake the procedure. I knew that I had done such procedures before and considered myself competent to perform it, subject to first assessing the nature and complexity of the particular polyp."

And in her police interview she says that she has used diathermy at least 40 times during laparoscopies and resections of the cervix, most recently in 2005. When discussing Mrs Rourke's procedure she said:

"…I thought that because I had done this type of procedure before, because this polyp was a pedunculated polyp with no other complication, then I thought that I could do this."

9.73 At her trial, Dr Moyano's advocate put forward, as part of the defence case, that she had used the resectoscope after being placed under unfair pressure by Mr Day and that her judgement was at fault at this point.

Comment

It seems that by the time of her trial in January 2009 she was far less confident of her skill than she had expressed herself to be in November 2006 and March 2007.

What matters is not whether Dr Moyano thought she had the necessary skill but if she did in fact have it and if not, why she thought she did.

We cannot come to any conclusion on this point in the absence of a discussion with Dr Moyano and detailed evidence about her skills and abilities. A professional appraisal would be necessary and we understand that Dr Moyano's fitness to practice is to be assessed by the General Medical Council, which will no doubt look at this aspect.

We have been provided with the edited version of Dr Moyano's police interviews that were read out during her trial, and also with the full version. The edited version runs to 60 pages and the full version to 176 pages. We assume that the purpose of the editing was to remove repetitious material and material which was irrelevant for the purposes of the trial. Some of the material we have quoted has been taken from the unedited transcript and will not be found in the edited version.

10. The interim serious untoward incident investigation

Introduction

10.1 This section provides a chronological account of the conduct of the hospital's serious untoward incident report. It goes on to describe the report and the actions taken since.

10.2 The content of the chronology is drawn from surviving records such as emails, letters and other documents. It takes no account of telephone calls, informal meetings or conversations unless they are mentioned in the documents.

October to November 2006

10.3 Rose Naylor, director of nursing and governance, wrote to all HSSD staff on the morning of 18 October telling them about the sudden and tragic death of Mrs Rourke the previous evening. Mr Pollard and the hospital management team declared a serious untoward incident and asked for the death to be investigated. This was in line with the then policy *Management of Serious or Untoward Incidents August 2005* which states:

> *"A serious or untoward incident can be described as:*
>
> *An accident or incident when a patient, client, member of staff, or a member of the public suffers serious injury, major permanent harm or unexpected death, (or the risk of death or injury), on hospital or other health and social care premises or other premises where care is provided, this includes vehicles, or where the actions of health and social care staff are likely to cause significant public concern*
>
> *This may include a major clinical incident or a major safety incident involving clients, patients, visitors or staff."*

10.4 The policy goes on to give examples of serious or untoward events. The second of these is "*Unexpected/unexplained death(s) or serious injury arising out of the direct patient/client care including suspected suicide*".

10.5 On 18 October Ms Naylor asked Dr Prince, consultant anaesthetist to be the medical lead on the investigation. Michala Clifford, senior HR manager to HSSD and Ann Kelly, lead nurse for children, were appointed to work with him. A meeting was held to discuss the incident. Those present included Ms Body, Dr Prince, Dr Lane, Ms Naylor, Ms Clifford and Ms Kelly. The investigation was to be conducted under the process set out in the then serious untoward incident policy document. As normal in most hospitals, the investigators were expected to carry out the work in addition to their day-to-day tasks. The serious untoward incident team had no written terms of reference. In most mainland hospitals in 2009 it would be usual to have written terms of reference for the investigation of such a serious incident.

10.6 Dr Prince had anaesthetised the first patient on Mr Day's list on the morning of 17 October before going to a scheduled teaching commitment. He played no part in Mrs Rourke's care, treatment and management and did not know her. Ms Clifford and Ms Kelly were not involved in the incident and neither knew Mrs Rourke.

10.7 Later that day Ms Kelly contacted the nurses involved and visited colleagues in the day surgery unit. In recognition of the distressing events, she offered to cover Mr Kynman's on-call duties. She also emailed Dr Prince and Ms Clifford about the practicalities of the investigation.

10.8 Ms Kelly and Ms Clifford met to discuss the investigation on 19 October. Ms Kelly emailed Dr Prince after their meeting. She asked Ms Naylor for a copy of Mrs Rourke's notes.

10.9 Dr Prince spoke to colleagues involved in the incident on 20 October 2006 and asked them to provide a statement of related facts. He followed this up with an email that day addressed to, among others: Dr Moyano, Mr Allardice, Mr Day, Mr MacLachlan, Mr Ingram, Dr Regina Thomsen, Dr Ilangovan and Dr Lane. He asked that all statements

be cleared with defence organisations. He would send individuals a letter confirming his request. He told them that Peter de Gruchy, the Deputy Viscount, had also asked for statements.

10.10 Dr Prince then wrote to all doctors and nurses involved in the incident on 17 October. His letter reaffirmed the contents of his email and asked for the statements to be returned to him by 27 October. He said the serious untoward incident team "*may ask to interview you to get further clarification*". The letter confirmed that "*the purpose of the SUI is to ensure that if any mistakes were made, the organisation responds to them and learns for the future".* The letter made clear that all those involved in the incident had access to a free and confidential counselling service provided by a consultant clinical psychologist and colleague.

10.11 The serious untoward incident panel formally confirmed the appointment of the investigation team on 20 October and recorded this.

10.12 On 23 October Ms Naylor informed the investigation team in a confidential email that police were conducting an investigation of the incident and said that Dr Lane "*…has taken further advice this afternoon from the police regarding our internal investigation – they are happy for us to proceed with our investigation including collecting our statements but do not want us to interview any staff before they have the chance to interview them".* The email went on to say that Dr Lane and Mr Pollard were meeting Mr Day to inform him of the change.

10.13 Detective Sergeant Sam Smith emailed Dr Lane and Richard Jouault and asked for information about Dr Moyano. Mr Jouault responded.

10.14 On 31 October Detective Chief Inspector Chris Beechey confirmed in an email to Mr Pollard the police's intention to interview staff and attached a letter he proposed to send.

10.15 On 8 November Dr Prince, Ms Clifford and Ms Kelly met to discuss the conduct of the investigation.

10.16 At a meeting with health and social services legal advisers on 8 November Ms Clifford was advised that the police had not taken statements from Dr Moyano and Mr Day and they could not be interviewed "…*until the police investigation is complete*". Ms Clifford advised Dr Prince and Ms Kelly on 9 November by email that it is "…*highly unlikely that we'll be able to access them (the statements)*".

Mid-November 2006 to May 2007

10.17 Ms Clifford informed the legal advisers on 16 December that Mr Day and Dr Moyano were under police investigation and that neither had released statements.

10.18 Mr Day released his statement on 20 December, the day he wrote it.

10.19 On 22 December Dr Lane asked the legal advisers to try to help secure Dr Moyano's statement. The legal advisers wrote on 12 January 2007 to Dr Moyano's lawyers asking for the statement to be disclosed. The request was declined pending the criminal investigation.

10.20 In mid January the hospital told the legal advisers that the police had agreed that the hospital could prepare to conduct a serious untoward incident investigation. The legal advisers therefore pursued disclosure of Dr Moyano's statement in January, February and March 2007. They made the point to her lawyers that the hospital considered the failure to disclose was impeding the investigation and that this could affect patient safety.

10.21 On 22 March 2007 it was confirmed to the hospital's legal advisers that Dr Moyano had not released her statement on legal advice. On 4 April Dr Lane raised the matter in a letter to the GMC.

10.22 On 11 April Dr Moyano's statement was disclosed for the purposes of the investigation.

10.23 On 24 April Mr Pollard wrote to Mr Day telling him that all statements had been received. On 21 May Ms Clifford, Dr Lane and Richard Jouault informed the legal advisers the SUI investigation had 'commenced'.

10.24 Ms Naylor spoke at interview about the impact on the hospital and staff of the delay conducting the SUI:

> *"I have to say we felt frustrated throughout the process, because we recognised our staff were in mourning for a colleague, somebody had lost their wife and mother, there were concerns around everything else around this incident, and in effect the organisation was silenced. As a management team we couldn't even be seen to support our staff. We did walkabouts and things, but we couldn't make announcements, we couldn't do general debriefings or anything like that, and that is very difficult for us because we felt completely tied and stuck in the middle of it. From our point of view, a normal SUI we'd go down the normal route where we'd start to investigate it straightaway and we follow the full process through. For staff that's a good process because they feel they've had their say, they get some closure, they see changes made in practice and the fear for them evaporates very quickly."*

10.25 Unlike the NHS, the health service in Jersey does not have a local agreement with police about what to do when they become involved in a patient safety incident. The memorandum of understanding *Investigating patient safety incidents involving unexpected death or serious untoward harm: a protocol for liaison and effective communications* signed by the National Health Service, the Association of Chief Police Officers and the Health & Safety Executive in 2006 sets out how the three organisations should work together. This includes discussions between the health provider and police about the conduct of an investigation to ensure the safety of health services. The foreword to the agreement says "*…in taking forward such investigations, we recognise that the safety of the public and of patients is our first priority and that this requires a collaborative approach*".

10.26 Timely progress on the serious untoward incident investigation appears to have been seriously impeded as a result of the police investigation and the potential criminal proceedings.

Recommendation

R12 The chief officer should begin discussions with the States of Jersey Police and the Deputy Viscount about developing a local protocol setting out working relations in the event of a patient safety incident. This should be supported by guidelines for hospital staff and senior investigating officers. The 2006 protocol between the National Health Service, Association of Chief Police Officers and Health and Safety Executive, along with the associated guidelines, would provide a helpful starting point. ***Urgent***

Comment

The hospital management team promptly declared the death of Mrs Rourke a serious untoward incident on 18 October in keeping with the 2005 policy.

They appointed a senior and experienced intensive care doctor to conduct the internal investigation and asked two colleagues – Ms Clifford and Ms Kelly - to work with him. As senior HR adviser to HSSD, Ms Clifford had an understanding about the appointment of locums but also had other responsibilities to the corporate management team.

Dr Prince took immediate steps to gather information from those involved in the incident and both spoke to and wrote to them about this matter. He reminded them of the free and confidential counselling service available to them.

The police investigation of Mrs Rourke's death was initially on behalf of the Deputy Viscount. It became a criminal investigation on 23 October 2006.

The hospital's serious untoward incident investigation was delayed once it became clear that the police were conducting a criminal investigation. It is clear from the correspondence that Dr Prince was keen to continue the work. Information from HSSD's legal advisers show that the hospital management team also wanted to pursue the matter. The delay had a significant impact on the ability of the hospital to deal with matters of patient safety.

There is no local policy between the health service and the police to cover such matters. The health management team behaved as most mainland hospitals would have done in such circumstances - they deferred to the police and legal advice they were given that the criminal investigation should have primacy. The consequence was that matters of risk and patient safety were not examined in detail in the immediate aftermath of a serious incident and the senior management team could not respond appropriately to the needs of staff, including Mr Rourke.

May to December 2007

10.27 Interviewees and documentation suggest that the investigation began in earnest in early May 2007 as a result of continuing concern from the HSSD senior management team and the medical staff committee about matters of patient safety and Mr Day's exclusion. The availability of all the witness statements also allowed the investigation to get underway. One interviewee said "*…then around about May of 2007 there was another meeting where we were all brought together by Richard Lane I think and told that we ought to start doing something for the SUI because the police had told them that they have given permission for us to start investigating, but we were not allowed to have any access or interviews to the people involved, but we could interview other people around the process*". Another said "*…the feeling then was, well you can proceed to look into areas that have no bearing on the criminal investigation*". This advice appears to have been given by both the police and HM Solicitor-General. At this point the team still consisted of Dr Prince, Ms Clifford and Ms Kelly.

10.28 On 22 May the team met to discuss how to conduct the investigation given the restrictions. They divided up the work:

- Dr Prince – theatres, equipment and IT systems
- Ms Clifford – locums and checking RCOG guidance
- Ms Kelly – consent and hospital policies.

10.29 In early/middle of May 2007 the investigation team appeared to be pressing to get the work underway and emails from that period show a senior technical officer in information services increasing the team's access rights to the confidential serious untoward incident folder on the hospital computer system.

10.30 Ms Kelly met Lis Martins, clinical risk manager, to discuss hospital policies on 7 June.

10.31 On 18 June Dr Prince met Moyra Journeaux, Ms Julie de la Haye and Ms Judith Gindill to discuss matters to do with theatres and the day surgery unit. He made a note of the discussion.

10.32 On 20 June Ms Naylor co-opted Jackie Harley from nurse workforce planning and who had experience of SUI investigations. Ms Harley confirmed in interview that she had:

> *"…been, particularly in 2006, involved in probably about six, seven, at different stages, and working as part of a pair or part of a trio, so I'd already undertaken quite a lot of serious untoward incident reviews."*

10.33 Dr Prince met Ms Body on 29 June to discuss theatres. He made a note of the meeting.

10.34 Ms Kelly and Ms Clifford met on 3 July to discuss hospital policies.

10.35 On 6 September 2007 Dr Prince wrote an email to Ms Clifford about the matter of the serious untoward investigation and Mr Day's continuing exclusion from work. He copied the message to Mr Jouault, Dr Lane and Ms Kelly and Ms Harley. It appeared that the National Clinical Assessment Service had advised Ms Clifford in August that Mr Day could not return to work until the investigation had been completed. Dr Prince appeared not to have known about this until the medical staff committee on 5 September when he saw the NCAS letter for the first time.

10.36 Dr Prince's email also suggested a meeting with Detective Chief Inspector Chris Beechey to:

> "*…explore the possibility of relaxation of restrictions on our investigation now the police have decided that John is not to be prosecuted.*"

10.37 Mr Jouault replied the same day:

> "*…that the investigating team meet up with Dr Lane and myself at the earliest opportunity to put everyone in the picture following the summer break.*"

10.38 Dr Prince met Mr Jouault and Dr Lane on 18 September to discuss the conduct of the serious untoward incident investigation and be briefed about Mr Day's continuing exclusion. He expressed concern about the lack of progress with the investigation and the identification and management of risk. Dr Prince also asked who was in charge of the investigation. Mr Jouault and Dr Lane confirmed that Dr Prince was leading it.

10.39 Ms Kelly and Ms Clifford met Mr Jouault and Dr Lane for a similar briefing on 25 September. Mr Ingram attended on behalf of the medical staff committee. Those present agreed that a 'pre-SUI' review would be conducted. Ms Martins was appointed to help with this. Her personal note of the meeting recorded the purpose of the review as to "*…review current systems and arrangements, using information currently available; look at current risks/concerns*".

10.40 In an email to the team dated 26 September Ms Kelly confirmed that:

> "*…to conduct a 'SUI' is not possible at the present time under the guidance of the Solicitor General. However, in the meantime whilst we await the end of the legal processes we would like to identify any processes, policies etc that have come to our attention through reviewing the records that may impact upon patient care in the future.*"

10.41 States of Jersey Police charged Dr Moyano with gross negligence manslaughter on 28 September 2007.

10.42 The team organised a meeting in the education centre on 25 and 26 October 2007. The management team agreed that Ms Martins would facilitate the meetings.

10.43 On 23 October 2007, Dr Prince confirmed that he had done some preparatory work for the meeting, including reviewing material on vascular surgery and the use of locums. Dr Prince shared this with the rest of the team and Ms Kelly commented about the preparatory work in an email dated 22 October 2007.

10.44 Dr Prince also wrote to Mr Ingram on 22 October sending him two documents from the Vascular Surgery Society of Great Britain and Ireland. He pointed out that one of the documents "*…covers the issue of in-house surgical emergencies, implying that under certain circumstances the vascular surgeon should consider transfer to a remote centre*".

10.45 Dr Prince had a telephone conversation with Ms Hobson, CSSD manager, regarding training of CSSD staff.

10.46 Mr Ingram replied to the email on 2 November:

> "*Will Butcher was over last week….I mentioned to him the problem about catastrophic vascular emergencies occurring on island. He agrees a small*

working group should look at the problem and he would be happy to come over for the day and discuss matters with relevant people."

10.47 Dr Prince wrote back to Mr Ingram on 8 November: "*I will see if I can get the management to move forward with this*". On 8 November Dr Prince wrote to Mr Jouault and Dr Lane about emergency vascular services. He said in his email "*…this is one of the strands of the SUI. Can we start negotiating with Mr Butcher to come here and review our emergency vascular surgery response*". Mr Jouault replied that day to say that Dr Lane was on leave and offered to meet.

10.48 Dr Prince and Mr Jouault exchanged further emails about the vascular review. The exchange ended with Mr Jouault suggesting he talked to Ms Naylor and Ms Body about the likely cost of the proposed review.

Two-day meeting on 25 and 26 October

10.49 The investigation team met on 25 and 26 October. There is a detailed, typed record of the deliberations, including an account of what could and could not be achieved given the police restrictions. On the first day the team identified ten topics for further examination. They included:

- Theatre equipment
- Vascular services
- Standards for locum appointments
- Consent policy
- Management of private and public patients
- Review of patients pre-operatively
- Record-keeping
- Systems for managing absence/time management/conflicting demands
- IT systems and identification of responsible surgeon
- Governance in theatres.

10.50 The group prioritised the ten topics using the national patient safety risk assessment matrix.

10.51 The record of the meeting has a section for each topic and provides a detailed record of what the team considered the underlying issues. The risk assessment shows the likelihood and consequences of an event and awards each a low, moderate or high rating. The team identified 23 high-risk issues.

10.52 The serious untoward incident team met on three occasions – 13 and 22 November and 4 December - to elaborate on their work and to develop recommendations. Dr Prince took the lead in drafting the report. Other members commented and contributed as appropriate.

10.53 Dr Prince emailed the serious untoward incident team on 11 December inviting them to comment on the draft report in advance of his submitting it on their behalf.

10.54 Dr Lane emailed Mr Jarvis, a consultant obstetrician and gynaecologist in the UK, on 31 October to say:

> *"The trial of Dr M before a jury has been set for next May (2008) and this will be quite unique for Jersey. In the meantime our Solicitor General has asked us not to proceed with our serious untoward incident enquiry or any disciplinary process…we do still wish you to oversee our definitive serious untoward incident procedure in due course but this appears now to be still many months away."*

10.55 The interim serious untoward investigation report was sent to Mr Jouault, Dr Lane and Ms Naylor on 15 December 2007. It had been completed in less than two months since the meeting in October and some 14 months since the death of Mrs Rourke on 17 October 2006. The report was not sent to Mr Mike Pollard, chief officer.

10.56 Mr Pollard told us he was given early advice not to involve himself in the serious untoward incident investigation. He felt the hospital had been disadvantaged by his lack of involvement:

> "*…because the organisation needs to know that I recognise that something has gone wrong and that we need to learn from it in the mature way that people do in a healthcare organisation. I should be able to demonstrate my personal empathy with people who have suffered a loss, which I have been unable to do.*"

10.57 Mr Jouault wrote to the investigation team on 19 December. He congratulated them on the report and raised three points of detail for them to consider:

- *"Should HSSD develop clear protocols to cover emergency vascular surgery incidents? I would have thought this should read 'how should HSSD develop clear protocols. Don't think there can be a situation whereby we shouldn't develop them.'*
- *Job planning ties work to pay levels. As such the decision to restrict payment for consultant staff to 10PA (Programmed Activities) whatever their agreed workload is a significant risk to HSSD as it invites consultants to unilaterally restrict their HSSD workload without HSSD having made arrangements to fill the gap. 'Not sure I fully understand the full implications of this statement. It may need further exploration and clarification in the document.'*
- *HSSD should consider the use of CCTV in theatres to clarify the line and activity during a crisis. This may ultimately prove to increase risk but it is being explored in some centres (Truro). 'Don't understand the possible increase in risk, this will need further explanation.'"*

10.58 He said:

> "*I think the external restrictions placed upon the Department regarding the SUI to date have been extremely well managed in your thoughtful report. If anything the exclusion of comment regarding the main players in the incident*

has allowed for some pertinent organisational issues to take prominence. Once again, well done."

Comment

The serious untoward incident investigation began in earnest in May 2007. This appeared to be a direct result of pressure from the senior management team and the medical staff committee and the availability of witness statements. Police and legal advisers made clear to the serious untoward incident investigation team from the outset that they could not interview any of those involved in the incident. The investigation was thus seriously restricted in its scope and nature.

The team divided up the investigation and worked on their various tasks over the summer. Ms Naylor appointed Ms Harley to provide extra support. This was helpful, given the complexity of the task and the team's comparative inexperience.

In addition to working on the investigation, Ms Clifford also had responsibilities for advising on and managing Mr Day's exclusion from work during this period. We think these two roles were incompatible. In Dr Prince's mind at least, Ms Clifford's involvement in the exclusion of Mr Day lead to uncertainty about her role in the investigation. The senior management team should have recognised the conflict and dealt with it, regardless of Dr Prince's view.

January to April 2008

10.59 Dr Prince presented the interim report to Mr Jouault[9], Ms Naylor and Dr Lane on 4 January 2008. The rest of the investigative team were not at the meeting. No record exists of the discussion but Dr Prince prepared a presentation pack that we have seen.

[9] Mr Jouault went on secondment as acting chief officer at the planning & environment department on 31 January 2008. He returned to his post in health and social services on 27 August 2008.

10.60 Dr Prince told us:

"So essentially I went through what I thought were the issues and they all said 'That is great, well done, that is absolutely tremendous, I think everybody ought to hear about this', and they had this plan that we would present the review to the senior management team on 12 February."

10.61 In fact, the presentation to the senior management team did not take place because Dr Prince, the hospital management team and the HSSD legal advisers were concerned that wider disclosure would prejudice Dr Moyano's trial.

10.62 On 11 January 2008 Dr Lane wrote to Mr Butcher, the visiting vascular surgeon from Bournemouth, asking his advice on the provision of emergency vascular services. The letter said: *"I know you are aware of our concerns here in Jersey regarding the provision of emergency vascular services. Nick Ingram has told me that you would be willing to give advice on this matter and therefore I write formally to invite you to undertake this task"*. An extract from the December version of the interim report was attached to the letter.

10.63 The planned presentation to the senior management team on 12 February was cancelled and replaced with a meeting of a smaller group. Its purpose was to "*…discuss what action needs to be taken following the LR SUI*". Meetings of this smaller group were cancelled on 15 and 22 February.

10.64 On 17 February Dr Prince emailed members of the serious untoward incident team asking for their comments on a draft letter he proposed to send to Ms Naylor. This was in advance of the meeting on 22 February. Dr Prince said:

"I am meeting up with Rose Naylor, some of you and some of the senior managers on Friday morning 22nd February. I wanted to send this letter to inform the proceedings and I hope you will find that it reflects your sentiments. I felt that in some areas of the report I had not clarified the reasoning for our conclusions in as much detail as in others. ***This letter is designed to ensure***

that there is no lack of clarity as to where urgent activity is required*. (Our emphasis)."*

10.65 Dr Prince sent his letter to Ms Naylor on 19 February. It said:

"*The SUI team absolutely understand and support the decision to restrict access to sensitive information which may have an impact on forthcoming court proceedings. It does remain the responsibility of the team to ensure that the SUI process moves forward as best as is possible even under these delicate circumstances.* ***We thought it sensible to clarify in writing where we felt efforts should be made to improve standards****. (Our emphasis)."*

10.66 The letter identifies six areas of work: theatre equipment, vascular services, standards for locum appointments, policy management, management of conflicting demands, record-keeping and IT. Phrases in the letter include, for example: "*significant risk*", "*serious concerns*", "*these shortcoming need to be urgently rectified*". A copy of the letter appears at appendix I.

10.67 The meeting originally organised for 15 February took place on 11 March. It appears from the records that this was a meeting of the serious untoward incident panel. Those present included: Mr Jouault, Ms Naylor, James Le Feuvre, Dr Prince, Ms Clifford and Ms Martins.

10.68 Dr Prince said at interview: "*We eventually held that meeting, and I think some people…felt a bit criticised by it*". He went on to say "*…that after that meeting I don't think anything really did happen for the best part of a year*". Another serious untoward incident team member said: "*That was it. We'd done the report, Graham took it to the panel, and to be fair, that was the last I heard of it*".

10.69 Dr Lane contacted the hospital's legal advisers on 18 March and told them that the SUI was causing upset. The legal advisers suggested it be made clear that the investigation report was interim and that the matter would be revisited after the trial.

10.70 On 19 March a further meeting took place between Ms Naylor, Mr Le Feuvre, Mr MacLachlan and Ms Body. We have seen no record of this meeting beyond a single sheet of paper in documents Ms Kelly gave us. The note also suggests that concerns were expressed – it is not clear by whom – about the fact that the serious untoward incident team had not consulted Mr MacLachlan or Dr Nelson. A written statement Ms Body sent to us in May 2009 suggests the meeting agreed to take the interim report sent by Dr Prince on 15 December 2007 "*out of circulation leaving only an amended version of 15 April 2008*". Dr Lane confirmed at interview that Mr MacLachlan had expressed concerns about the report.

10.71 On 15 April Ms Martins emailed an amended version of the interim report to Dr Lane.

10.72 On 16 April Dr Lane met Mr Butcher, visiting consultant vascular surgeon from Bournemouth. Mr Butcher produced a note entitled *Major haemorrhage planning for Jersey General Hospital following the meeting*. He listed seven actions.

May to December 2008

10.73 Dr Lane telephoned the legal advisers on 16 May 2008 and asked them to review the current version of the interim investigation report. The legal advisers were not involved in any meetings or internal correspondence on this issue and so gave their advice in relative isolation. They replied to Dr Lane on 27 June – the advice having been delayed so that Dr Lane and the legal advisers could attend an interlocutory hearing in relation to the criminal trial. On 27 June the legal advisers responded with some brief advice - which we have not seen – and suggested some amendments. They did not make changes to the document itself but were told by Dr Lane that the changes would be made to reflect their advice.

10.74 The legal advisers have made clear to us that Dr Lane did not instruct them to review the report in order to make it less critical of the hospital or more critical of individuals.

10.75 Detective Sergeant Smith also wrote to Mr Jouault on 18 September 2008 "*…requesting sight of all the documentation that has been accumulated in the SUI process*". Mr Jouault consulted Dr Prince, Ms Clifford, Ms Martins and Dr Lane about the email before responding to Detective Sergeant Smith.

10.76 On the same day she also emailed Mr Jouault and asked "*…please can you let me know whether the SUI is just in relation to DAY or whether MOYANO will also be under internal investigation in due course?*" Detective Sergeant Smith also asked "*Please could you also advise as to the current situation with internal proceedings?*"

10.77 In response, on 19 September Mr Jouault emailed Detective Sergeant Smith saying his "*…understanding regarding the SUI process is that further investigation is pending completion of the legal process*".

10.78 It appears that Detective Sergeant Smith was sent Dr Prince's original version of the interim serious untoward incident report.

10.79 Dr Prince emailed Mr Jouault saying that there was nothing to fear about releasing the serious untoward incident report to police but *"any conclusions are of doubtful accuracy because of the restrictions placed by the SUI team by the police and lawyers"*.

January 2009

10.80 Dr Moyano's trial started at the Royal Court on 5 January 2009. On 6 January Dr Prince met Mr Jouault, Dr Lane and Mr Le Feuvre to ask them about progress implementing the recommendations of the interim report. He was particularly concerned to know what had been done to address the matter of locums and vascular emergencies. According to Dr Prince, those present thought both matters had been dealt with.

10.81 Dr Moyano's trial ended on 27 January 2009. The Health Minister announced this independent investigation on 20 February 2009 when he said *"(I) can confirm that a company, **independent of Jersey**, called "Verita" has been commissioned to lead on the Serious Untoward Incident Investigation into the tragic death of Mrs Elizabeth Rourke, who died during routine surgery at the General Hospital in October 2006".*

The interim serious untoward incident report

10.82 Dr Prince sent the first draft of the interim report to the serious untoward incident panel on 15 December 2007. The 14-page document was entitled "*Review of serious untoward incident resulting in the death of Mrs Elizabeth Rourke – Interim report*". It was set out as follows:

- Details of the incident team
- Introduction
- The serious untoward incident process
- Positive practice points
- Risk assessment and recommendations
- References.

10.83 The report described the restrictions under which the team worked and said "*It is intended to complete the SUI at a future date once the legal process has run its course*". It also said that the "*usual (SUI) process is an exercise in root cause analysis. Inherent in this process is the complete collection of all information relating to the incident. Because this is prevented by legal process we cannot guarantee that all of the underlying causes have been discovered".*

10.84 The report set out nine positive practice points including:

> *"There was good monitoring in the recovery room and a rapid response initiated following the realisation that the patient's blood pressure was not measurable."*

and

> *"Once the emergency became apparent the surgeons, anaesthetists and nurse worked collaboratively, trying a number of techniques in an attempt to stabilize Mrs Rourke. During this time additional surgeons were called to offer their expertise. Other departments also worked collaboratively providing the necessary blood products and services to support the process."*

and

> *"The staff involved in the incident were very supportive of the Serious or Untoward Incident process which was started but stopped pending the police investigation."*

10.85 The report went on to highlight six risk areas – theatre equipment, vascular services, standards for locum appointments, policy management, management of conflicting demands, record-keeping and IT - and made 35 recommendations.

Comment

Dr Prince and the team produced a good quality interim report less than two months after the October 2007 meeting, albeit 14 months after the incident.

The team recognised in the interim report the limitations of their investigative work. The report did not contain a chronology of events or any testimonial evidence. The team acknowledged the good practice on the day. They also identified six areas of significant organisational weakness and made some specific recommendations for the serious untoward incident panel to consider. Some of these were disputed by others in the surgical directorate.

The serious untoward incident panel thought the report important enough to suggest wider dissemination of its findings at a specially convened meeting. This meeting was cancelled after discussion in case it prejudiced the criminal trial. Dr

Lane also took immediate action in response to the issues raised about vascular emergencies.

The subsequent cancellation of various meetings prompted Dr Prince to write a letter to Ms Naylor on 19 February. The letter is measured but underlined the serious risks and shortcomings that, in the serious untoward incident team's opinion, needed to be rectified. It is not clear what impact this letter had.

The amendments to the interim serious untoward incident report

10.86 There appear to be three versions of the interim report. The first is dated 15 December 2007 and is the version Dr Prince sent to the serious untoward incident panel. The last is dated July 2008.

10.87 The nature of the amendments to the report included amendments to the main text and the recommendations. For example, the December 2007 version contains a section about the standard of locum appointments. The text from that version says:

> *"It is clear from reading the statements of the other healthcare professionals in the Department of Obstetrics and Gynaecology that there was a lack of understanding of Dr Moyano's level of surgical competence and of the wider responsibilities of Consultants when working with locums. The NHS have had clear guidance on the appointment of locums for a decade (4). Most UK trusts have developed clear policies to ensure adherence to the principles of this guidance (5). The NHS guidance document sets out clear standards on:*
>
> - *Appointment procedures*
> - *Induction*
> - *Supervision*
> - *Performance management*
> - *Feedback to locum agencies*

It is clear that the management of Dr Moyano's appointment fell well short of current best practice in most of these areas."

The amended text in the July 2008 version reads:

"The processes used to recruit the locum registrar as a locum Specialist Registrar and Consultant to work in the field of obstetrics and gynaecology did not pick up her possible lack of experience in this area. The checks that were made of the locum registrar's Curriculum Vitae did not highlight these areas.

The NHS have had clear guidance on the appointment of locums (4). UK trusts have developed clear policies to ensure adherence to the principles of this guidance (5). The NHS guidance document sets clear standards on:

- *Appointment procedures*
- *Induction*
- *Supervision*
- *Performance management*
- *Feedback to locum agencies."*

The two recommendations remain in the July 2008 version but another has been added:

"As part of their induction process non-consultants should be reminded of their duty to work within the standards set out by the GMC in their document 'Good Medical Practice' (2006) which states:

- *e) Recognise and work within the limits of your competence*
- *f) Work with colleagues in the ways that best serve patients' interests"*

10.88 The amendments to the interim report seemed to be made following:

- the meetings on 11 and 19 March
- advice with legal advisers.

10.89 The changes to the text appear to have been made by Ms Martins and Ms Naylor and not by Dr Prince, although he was the principal author of the interim report.

10.90 Dr Lane and Ms Naylor said at interview that the changes were made because some parts of the report referred to Dr Moyano by name and because other people in the organisation disagreed with some of the facts, findings and recommendations. Mr MacLachlan confirmed this at interview and later in a written submission.

10.91 Dr Lane explained that:

> "*Initially, that was Graham Prince who then wrote a draft SUI which subsequently was amended to being an incomplete SUI for completion after the court case and, as you know, we have moved on from that and we have not completed it.*"

10.92 We showed the July version of the interim report to Dr Prince and asked for his views about the changes. He said he thought the tenor of the report had changed in that it had become less critical and that some of the commentary had been removed. He also commented that some of the recommendations had been removed or amended. He had not seen the revised report until we drew it to his attention. Similarly, it was evident when we interviewed Mr MacLachlan that he did not know about the revised report.

Comment

It was not unreasonable for the SUI panel in their capacity as commissioners to challenge the findings and conclusions of the report or to ask their legal advisers

to review the document, especially given the impending criminal trial. The SUI panel has been open with us about these changes.

However, Dr Prince and the team were not informed of or consulted about the amendments and we think they should have been. Ideally, they should have made the changes, taking account of the comments from others.

Neither Dr Prince nor Mr MacLachlan seems to have known about the amended report. We think this resulted from a failure in communication rather than from anything else.

Mr Jouault and Dr Lane evidently regarded the report as interim only and believed that a full serious untoward incident investigation would be commissioned once the criminal process was complete.

Our overall impression is that the amended report is less critical of management and systems and more critical of individuals. We have no reason to believe this change in emphasis was intentional.

Action on the recommendations

10.93 The 2005 serious untoward incident policy says:

> "*…the purpose of this policy is to put a system in place that ensures that the risk of a similar accident occurring is reduced. For this reason every effort should be made to promote the learning from such serious events, including health and safety issues,* ***and to ensure that recommendations are implemented and learning is shared with teams.***" (Our emphasis)

10.94 It goes on to say that "*…it is essential that recommendations be implemented in order to reduce the risk of recurrence*".

10.95 We looked therefore at what progress the hospital had made implementing the recommendations of the interim report. We asked for an up-to-date self-assessment of progress to help us with this task. Dr Lane and Ms Naylor confirmed at interview that no individual was charged with overseeing the implementation of the recommendations of the report. Rather, responsibility for implementation was shared among four people. They confirmed that the SUI panel had received no formal reports about progress. The 2009 SUI policy makes it clear that learning lessons, improving safety and implementing recommendations is important. The policy says:

> *"The purpose of this policy is to put a system in place that ensures that the risk of a similar accident is occurring is reduced. For this reason that every effort should be made to promote the learning from such serious events, including health and safety issues, and to ensure that recommendations are implemented and learning is shared within teams.*
>
> *It is essential that recommendations be implemented in order to reduce the risk of recurrence.*
>
> *The Governance Board will ensure that recommendations are implemented, paying particular attention to those requiring additional support, significant investment or organizational change. This will be monitored via the Risk Register and the Governance Board reporting arrangements."*

10.96 They also confirmed that the head of risk management had made an assessment of progress made during the course of 2009. The report about this was sent to us on 28 September. We asked for further clarification in early October 2009 and the document sent to us by the management team is at appendix J.

Comment

We think one person should have been charged with implementation of the actions arising from the interim report. Given the significance of the incident, we think the SUI panel should have received regular reports on progress.

The progress report provided by the hospital in October shows that most of the recommendations of the July 2008 report have been implemented.

We have not been shown the underlying evidence to support these claims but have no reason to think they are unfounded. We look forward to seeing the audited evidence of changes on our return in six months.

Recommendation

R13 The chair of the SUI panel should put in place a robust system for ensuring that recommendations arising from investigations (where accepted) are implemented. The outcome of changes should be reported to the panel and made available to hospital staff.

Part two

This part of the report describes the hospital generally, including its stand-alone nature and progress on introducing governance. It comments on the management structures including the involvement of clinical staff in running the hospital. It explains more about the surgical directorate. It provides important background information and allows Mrs Rourke's death to be seen in a broader context.

11. Jersey General Hospital

Jersey General Hospital

11.1 Jersey is a British Crown Dependency 100 miles from the English coast and near the coast of Normandy, France. With Guernsey, Alderney, Herm and Sark it forms the Channel Islands. The island is 45 square miles. The principal industries include financial services and public administration.

11.2 Jersey General Hospital provides routine secondary healthcare to the population of the States of Jersey. Emergency care is provided to visitors to the island. Healthcare is funded from taxation.

11.3 The hospital has 270 beds and more than 2,000 staff. It provides acute hospital care to 91,000 people resident on the island and to visitors. It is the only hospital on the island. Acute care is provided from two hospital sites: Jersey General in the town centre in St Helier and Overdale on the outskirts. About 11,000 surgical operations are carried out each year.

11.4 The hospital had a turnover of £83 million in 2008. This is about half the total spending on health and social services. Care and treatment are influenced by developments on the UK mainland e.g. NICE guidelines, and HSSD takes part in various clinical networks and audit programmes. For example, mental health and maternity services are benchmarked against services in the UK. The hospital reports infection control data to the Health Protection Agency. The hospital is not subject to routine inspection by a regulator such as the Care Quality Commission; neither does it contribute to the national reporting and learning system run by the National Patient Safety Agency.

11.5 The hospital grew during the 1990s. The number of consultants employed in the hospital increased from 20 or so in 1990 to 49 in 2009. These workforce changes resulted from changes to rotas (making them less onerous), retirements (sometimes

resulting in the division of one consultant's work into two new posts) and the hospital taking on new work.

11.6 Specialist services are provided by up to 19 hospitals on the UK mainland (see appendix K for the complete list). Consultants also visit the island to provide specialist outpatient services.

11.7 The Picker Institute's 2008 survey shows that the hospital is popular among patients with 94 per cent of inpatients rating it as good or excellent. This compares favourably with hospitals on the mainland.

11.8 Interviewees told us that about 40 per cent of the island's population had private healthcare insurance. Care is provided both on and off the island. Consultants are encouraged to carry out private practice so long as public patients do not have to wait longer than three months for care and treatment. The hospital's facilities are routinely used for private care and operating lists are often a combination of public and private patients with the split usually 70:30. The hospital receives £2 million a year from caring for and treating private patients.

11.9 Primary care is provided by family doctors in private practice. Individuals fund this care, paying for consultations and tests. General practitioners receive a co-payment from the government for each consultation. People of limited means may be exempt from paying GP fees.

11.10 The following is significant to the care, treatment and management of Mrs Rourke. The Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust provides vascular services to the hospital. Until August 2009, Mr William Butcher, consultant vascular surgeon, visited the island every few months and held joint clinics with Mr Nicholas Ingram, consultant general surgeon. No elective vascular surgery (arterial surgery) is carried out on the island and all 'fit' patients who present with emergency conditions, for example aortic aneurysm, are transferred by air ambulance to Bournemouth. The hospital in Jersey has dealt successfully with vascular emergencies in the past, including one involving a young patient a year or so before

the incident involving Mrs Rourke. Jersey has no motorways or significant knife or gun crime. Consequently, the hospital does not deal with levels of major trauma or life-threatening bleeding that mainland hospitals might.

11.11 The hospital provides the range of services to be found in a district general hospital on the UK mainland. However, a district general hospital on the mainland is likely to serve a larger population and to be able to rely on specialist services being reasonably close at hand.

11.12 Jersey General hospital does not offer hysteroscopy to outpatients; anyone requiring such a procedure will need to be booked in as an inpatient or a day patient. Outpatient hysteroscopy is commonplace in the UK, where it is carried out without anaesthetic but we have been told that the perception of the local medical profession is that the women of Jersey would prefer to have the procedure under general anaesthetic.

11.13 Jersey's population is ageing with an increasing number of residents 85 or older.

11.14 The strategic vision for health over the next 10 to 15 years is set out in New Directions: A Plan for Health and Wellbeing in the 21st Century. It involves a range of States Departments and other agencies taking concerted action over the long term and has three overriding policy aims.

11.15 The first is to promote healthy lifestyles, a healthy environment and a high level of education; the second is to manage chronic diseases, such as diabetes, depression, chronic heart failure and respiratory heart disease, to ensure that the most efficient and effective range of services are provided; the third is to ensure that older people enjoy long and high-quality lives with the maximum level of independence.

11.16 Proposals that focus on *"the sustainable hospital"* are an integral part of New Directions. In summary, organisational structures and processes that support patient care are to be redesigned over time to sustain the hospital well into the future.

11.17 These include arrangements to reduce reliance on junior doctors in training, developing specialist nursing roles, admitting acute patients through an expanded medical assessment unit and minimising the transmission of infection and improving patient privacy by building more single rooms.

General management

11.18 The hospital comes under the management of the health and social services department. The corporate directors are the chief officer, the director of corporate planning and performance (who is also deputy chief officer) the medical director, the director of nursing and governance. They are joined by five directorate managers for – surgery, medicine, mental health, social services and public health[10]. They have a wide span of control including responsibility for hospital, community and social services.

11.19 The chief officer is described on the Jersey Government website as responsible for, among other things:

- Improving clinical and managerial standards
- Demonstrating value for money
- Ensuring that the care of each individual patient and client is of the highest standard.

11.20 The chief officer is a member of the States of Jersey corporate management board and reports to the chief executive.

[10] The management structure of health and social services can be seen on the HSSD website http://www.gov.je/Health/who_we_are/Managment+Structure+of+Health+and+Social+Services.htm

11.21 The hospital's corporate directors work closely with the Jersey Government's team of ministers responsible for health and social care. These responsibilities include formulating policy and strategic decision-making.

11.22 The directors and a team of general managers/nurses are responsible for the day-to-day management of the hospital and form the wider senior management team (SMT). The chief officer and directors in conjunction with the SMT make operational decisions.

Comment

With a board remit covering all of health and social services, the chief officer can of necessity only devote a proportion of his time to operational hospital matters. The hospital is a large and complex organisation which would benefit from having its own manager – and therefore figurehead – to work down through the organisation.

Recommendation

R14 The chief officer should appoint a hospital director to manage the hospital day to day. This person would act as the focus for all hospital matters. There should be clear separation of responsibilities between the chief officer (strategic) and the hospital director (operational). ***Urgent***

11.23 The SMT meets three times a month on Tuesday afternoons. One of these is the formal SMT meeting; the second is a governance board meeting, the third a New Directions meeting. More than 20 senior managers sometimes attend these SMT meetings. A formal record of these meetings is kept.

Comment

The minutes of the formal SMT meeting sometimes lack the clarity of detail that might be expected of the main executive decision-making body in HSSD and it is

sometimes difficult to see, for example, the nature of the SMT discussion and whether matters have been appropriately allocated, followed up and concluded. The absence of a good written record weakens the hospital's ability to build and retain an organisational memory.

Nursing management

11.24 The director of nursing and governance, Ms Rose Naylor, is a member of the SMT. She is full time and reports to the chief officer. Ms Naylor is supported by four nursing heads of medicine, surgery, mental health and midwifery and five lead nurses.

11.25 Ms Naylor told us she had line management responsibility for the governance support team, the nursing and midwifery education team and workforce planning but not for the general nurses who work on site, who are managed in their directorates.

11.26 She also told us she chairs the SMT governance board meetings.

Medical management

11.27 The hospital has a full-time medical director, Dr Richard Lane, who is also a member of the SMT. He was appointed in 2002 to what was then a new position and also reports to the chief officer. At first he undertook the role part time, combining it with his post of consultant anaesthetist which he has now given up. He is to retire in April 2010 and a replacement will be appointed.

Recommendation

R15 The chief officer should appoint a new medical director in advance of the current medical director's retirement so as to ensure a smooth transition.

11.28 Dr Lane saw his role as being responsible for:

> *"…the professional quality and capability of all the doctors in secondary healthcare and for providing strategic input at the most senior level."*

11.29 He is supported by the three clinical directors, one each for surgery, medicine and mental health who in turn are supported by 17 clinical leads. The directorate managers are responsible for the line management of the clinical directors and (through the clinical directors) for all other doctors.

11.30 The clinical directorate structure was introduced in the hospital in 2006 "…*to ensure that there is more clinical involvement in the most important decisions which the organisation has to make*".

11.31 Our review of SMT minutes shows that the three clinical directors are not central to the deliberations of the SMT formal meetings. The clinical director for surgery has not attended such meetings as an SMT member since June 2008, because of his clinical commitments; the clinical director for medicine could only attend three of the 11 meetings in the year ending June 2009 for similar reasons – as well as not having a middle grade – while the clinical director for mental health has never attended formal SMT meetings.

11.32 The clinical director for mental health regularly attends the SMT governance board meetings although the clinical directors for surgery and medicine do not.

11.33 None of the clinical directors attended the SMT New Directions meetings.

11.34 No doctors except the medical officer of health or her deputy attended the first three SMT formal meetings in 2009.

Comment

The lack of significant clinical director involvement and input at SMT meetings is a major organisational weakness which devalues the clinical director role and results in the medical staff being inadequately engaged in the managerial process.

Clinical directors and clinical leads need to be allocated sufficient protected time to discharge such important roles effectively (see also 2.30 of the addendum).

Recommendation

R16 The new medical director should review the roles, responsibilities and authority of clinical directors and leads with a view to strengthening their part in running the hospital. These should be set out in job descriptions and reflected in individual job plans.

11.35 Dr Lane explained that since becoming full time in early 2008 his priorities had been to implement the performance appraisal system for doctors and to manage a number of disciplinary matters.

Performance appraisal

11.36 The performance appraisal policy for medical staff is modelled on that used on the mainland and was further developed in 2008 by the introduction of 360-degree appraisals[11].

11.37 The medical director told us he was keen to progress this initiative but could not devote as much effort as he would have liked to implementing it until he became full time:

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[11] A 360-degree appraisal is a system or process in which employees receive confidential, anonymous feedback from the people who work around them.

"Up until two or three years ago, there was no, or very little, acknowledgment of appraisal … Eventually, they have seen they have to do it in Jersey. This year, we have managed to get them all – apart from three or four so far – to do a 360 degree appraisal… and also to undertake some appraisal amongst each other, having given them some fairly rudimentary but some training about appraisal. We tried to launch this some years ago, and it failed. Nobody had any interest whatsoever. I was then part-time medical director, full-time anaesthetist, and I didn't have the wherewithal to get it going."

Job planning

11.38 The 2005 health and social services policy on the terms and conditions of service for consultant medical and dental staff states that job planning is to be based on partnership between managers and clinicians.

11.39 It goes on to say that the consultants' job plans – to be reviewed annually - must list all the health and social services duties of the consultant, along with the number of programmed activities for which s/he is contracted and paid, and the consultant's objectives and agreed supporting resources.

11.40 It further states that a job plan must set out the consultant's management responsibilities, the accountability arrangements, both professional and managerial and the consultant's personal objectives.

11.41 The job-planning policy dates from 2005 but several consultant medical staff we spoke to said the job planning process was poor and that they did not have meaningful job plans:

"We are all paid ten sessions and yet a lot of us have been assessed that are doing 12 or 13 sessions, so there are some issues around that, and if we are going to accept this locum policy where we are going to have to provide prospective cover, then that ought to reflect on our job plans and we should be given maybe a session – you know we need to negotiate that."

11.42 Overall, we heard a good deal of testimony about the effectiveness or otherwise of the medical management arrangements. Some of the doctors we interviewed described the structures and relationships as in their infancy, although they were fairly confident about how they were developing. Some criticised their general management colleagues, thought that lines of accountability and responsibility were often unclear and that policy initiatives took a long time to implement.

Comment

It is essential that the medical and non-medical managers develop and share a sense of purpose.

Locum policy

11.43 The hospital had no consistent locum policy before March 2009 and few of the processes governing how locums were recruited were written down. Information was merely passed from one individual to another.

11.44 There are now two policies concerning locums, both the subject of much discussion and only recently agreed in the hospital.

11.45 The first of these policies, issued in March 2009, entitled *"for the appointment and employment of locum doctors"* outlines the management arrangements along with the procedures for appointing, training, supervising, reviewing and managing locums. The policy identifies the medical director and senior HR manager as responsible for ensuring that the rules are followed.

11.46 Clinical directors and lead consultants are responsible for ensuring there are enough medical staff to provide safe care. They are responsible with the directorate managers for authorising the use of locums.

11.47 The policy makes clear that locum doctors should be suitably qualified and that the work and responsibilities allocated to them should not exceed their training and competencies.

11.48 An addendum to this policy says the HR department will send to the main theatre manager and day surgery lead nurse the names, length of stay and details of locum doctors, including area of expertise and experience, before the locum starts work.

11.49 The HR department uses an internal checklist to ensure that the appropriate checks are carried out and the right people and departments notified of a locum starting work.

11.50 The HR department has made a significant start in documenting the various internal protocols that they now follow.

11.51 The second policy, a *"Consultants' Locum Policy"* was formally agreed between HSSD and the local negotiation committee (LNC) in September 2009 becoming effective the following month. In essence, the policy reduces the need for external locum cover and states that its main objective is to have an effective, transparent, fair and sustainable locum policy for consultants irrespective of rota frequency that:

- *"Control and where possible reduce current locum costs*
- *Meet service and operational needs (e.g. governance and risk requirements and waiting list targets)*
- *Provides sufficient flexibility for specialties to devise their own locum cover (within an agreed framework) to the mutual benefit of the affected consultants and the employer and*
- *Once agreed allows the development of a similar policy for staff and middle grade doctors."*

Comment

The chief officer will need to ensure that these policies are properly embedded, that their objectives are met, and any initial problems resolved quickly.

We are particularly interested in reviewing the effectiveness of the locum polices when we return in six months. We commend the development of the internal checklist and the documentation referred to in paragraph 11.50, which commits to paper what had largely been unwritten.

Recommendation

R17 The chief officer in conjunction with the medical staff committee should ensure that policies for the recruitment of locum medical staff are fit for purpose and properly implemented. Recruitment – including reference request forms - documents should be redesigned to ensure that they capture detailed information about an applicant.

Usage (see also 5.19)

11.52 We estimate that in 2006, across all grades, a total of 2,902 locum days were used in the hospital. This compares with 4,403 locum days in 2007 and 3,716 days in 2008. About 54 per cent of these days were at consultant level, falling to 42 per cent in 2007 and 39 per cent in 2008.

11.53 In 2006, 50 per cent of the locum days were to cover annual leave and 33 per cent to cover vacant posts; in 2007, 36 per cent were to cover annual leave and 27 per cent to cover vacant posts; in 2008, 32 per cent of the locum days were to cover annual leave and 55 per cent to cover vacant posts.

Comment

The use of locums to cover vacant posts has increased considerably over recent years, emphasising the recruitment difficulties.

Recommendation

R18 The chief officer and senior management team should minimise the use of locums by tackling the underlying medical staffing problems. Figures for locum usage should be reported to the chief officer monthly. *Urgent*

The medical staff committee

11.54 The medical staff committee (MSC) is the main forum where the hospital consultants can come together as a group to discuss medical management matters and to engage with senior officers. It meets five to six times a year, generally starting at 9.00am on different weekdays, and has secretarial support.

11.55 The chair of the MSC usually serves for two years. The current chairman is Dr Chad Taylor, consultant anaesthetist, who started in February 2008. Previous MSC chairs have included Mr Nicholas Ingram, who was chair throughout 2006, Mr Martyn Siodlak and Dr Lane.

11.56 Dr Taylor told us that the role of the MSC was not clearly defined and that it functioned largely on the basis of custom and practice.

11.57 The chair of the MSC is an ex-officio member – along with two other MSC members - of the LNC.

11.58 The chief officer, the medical director, the medical officer for health, the director of finance and the director of nursing and governance are invited to (the general) part A of the MSC meeting to present their respective reports – as are the chairmen of various committees, such as healthcare records, private patients and medical manpower.

11.59 Dr Taylor told us that having various directors attend: *"…provides an opportunity for the consultants to discuss with the management and vice versa*

everything that is going on in the hospital and the chief executive [officer] *does take it very seriously and has always attended*".

11.60 Part B of the MSC meeting is generally used to consider equipment requests, issues arising from the LNC and personnel matters.

11.61 Our review of the minutes shows that normally between 25 and 30 consultants – just over half of the consultant body - attend the MSC and that the attendance record of those directors invited is generally good.

11.62 The employment of locums has clearly been of interest to the medical staff committee over recent years.

11.63 For instance, an extraordinary meeting of the MSC was held in September 2008 "*to accept or reject the proposed locum policy*" but due to an insufficient majority no decision was reached and the matter was referred back to the LNC (see 11.51 above).

11.64 The incident concerning Mrs Rourke and Mr Day's "*suspension*" were discussed at the MSC meeting on 30 November 2006 and Mr Day's exclusion has been raised at several MSC meetings since.

Comment

The MSC is reasonably well supported by the consultant body and it has the potential to provide an excellent forum for involving doctors in running the hospital. Formalising the committee's remit would help establish its role as a key component of the hospital's committee infrastructure.

Recommendation

R19 The chief officer in conjunction with the committee chair should develop written terms of reference for the medical staff committee to support its role as a key part of the hospital infrastructure.

Patient safety incidents

11.65 Patient safety incidents in the hospital are reported via a computerised patient safety and risk management system called Datix. Datix was implemented in 2006 and phased in across HSSD that year. HSSD logged onto Datix all incidents previously recorded on paper.

11.66 A member of the governance support team said at interview that HSSD staff were now making greater use of the system. Nurses tended to be better at logging incidents than medical and ancillary staff. The HSSD medicines governance committee considers that medication errors are likely to be under-reported.

11.67 The hospital's serious untoward incident panel reviews all incidents reported on Datix and commissions investigations into those that meet the criteria. Panel members are Mr Jouault, Dr Lane, Ms Naylor and Marnie Baudains, directorate manager - social services.

11.68 The annual summary report about serious and/or untoward incidents dated February 2009 says:

> "*SUIs are initiated at the request of the SUI panel. Severity is usually determined by the outcome of the incident in terms of harm to the people involved, for example death,* [sic] *or injury.*"

11.69 Since January 2006 HSSD have commissioned 30 serious untoward incident investigations. Nine were investigated in 2008. Most of the serious and/or untoward incidents were in the medical directorate.

11.70 As of February 2009, 98 members of staff had completed the two-day training programme in root cause analysis and 47 had helped investigate incidents. According to the annual report, incidents took longer to investigate than was desirable and staff needed protected time to undertake them.

11.71 Themes from the investigations include, for example, the need for specific guidelines/policies and the need to improve medical handover and team communication.

11.72 The clinical risk manager said in her most recent annual report that few individuals were providing progress reports about the implementation of recommendations. She noted that the process for signing off recommendations needed to be reviewed.

11.73 The head of risk management and health & safety manager reviews incidents recorded on Datrix and identifies trends. A growing number of incidents are being reported which is in keeping with the experience of hospitals on the mainland.

11.74 Clinical directors do not routinely see data about patient incidents although summary reports are prepared.

Comment

The increased reporting of patient incidents is positive because it signifies a greater openness within the hospital rather than an increase per se. This should continue to be encouraged as should reviews of this data by clinical directors in order that they can address any problems and find solutions.

Clinical directors should ensure they see data about untoward incidents in order that they can address any problems and find solutions.

Recommendation

R20 The chief officer and the consultant body should continue to encourage openness about matters to do with patient safety. They should challenge any tendency for self-censorship. This will allow professionals to acknowledge their own limitations and raise concerns about the practice of colleagues. Staff who report reasonable concerns should be safeguarded and appreciated for contributing to improved patient safety. This is the sign of a strong organisation.

The obstetrics and gynaecology department in 2009

11.75 The events of 17 October 2006 and what has flowed from it continue to effect the department and help is needed to repair it.

Recommendation

R21 The chief officer should bring in independent professional mediation to help the obstetrics and gynaecology department to support and develop the service in the aftermath of this incident.

11.76 The use of locums in the department remains high. Partially this results from Mr Day's absence over the last three years being covered by locums, but the number of locum days used in the department at middle grade-level was higher in 2008 than in 2006 by 137 per cent and from our analysis may be higher still in 2009 (see also 5.21, 11.52 and 11.53).

11.77 Mr MacLachlan told us that since the LNC accepted the new locum policy, the in-house consultants would be reimbursed if covering each other. This means that in obstetrics and gynaecology where they work a one-in-three consultant rota, there will be a maximum of nine weeks a year locum consultant cover. Further, there must now be at least eight weeks' notice of any intended leave in order that appropriate checks can be made.

11.78 We were also made aware at the end of September 2009 of a number of other recent initiatives implemented in the department which will, if embedded, improve both the governance arrangements and the safety culture there.

11.79 For example, work has progressed on the management of blood loss in gynaecology patients – a rare but recognised complication especially with pelvic blood vessels. Mr MacLachlan told us that the department had now put together a simple guide for dealing with unexpected major vascular injury and that the surgical division had recently ratified it. He said there was to be a study day to remind staff of the procedures to follow.

11.80 On staffing, we were told that the use of locums at middle-grade level should now reduce significantly on account of the impending permanent appointments of an associate specialist (to provide leadership for the middle grades) and five other permanent middle-grade staff.

11.81 We learned that only one middle-grade doctor will be permitted to be off at any one time and that Mr MacLachlan, as clinical lead, will screen all such requests.

11.82 We also heard that the outcome was awaited of the business case for a fourth obstetrics and gynaecology consultant, which was submitted in November 2008 to reduce the reliance on locums and to increase consultant presence on the labour ward in line with the Royal College of Obstetricians and Gynaecologists (RCOG) recommendations.

Comment

An urgent decision is needed on the fourth consultant.

Recommendation

R22 The chief officer should confirm the appointments of a fourth consultant to the obstetrics and gynaecology department and a sixth middle-grade doctor. *Urgent*

11.83 We were told that a maternity unit governance group had just been established and that the obstetric staff and midwives met every Monday morning to discuss any obstetric morbidity[12] or interesting cases – and that as well as attending the governance group, the consultants also attended joint obstetric/paediatric management meetings.

11.84 In gynaecology, we learned that an active risk-management meeting involving all staff now took place and that the consultants discussed any significant Datix cases:

> "*They are good at reporting; they are proactive on their investigating and follow up.*"

11.85 Mr MacLachlan also told us that minuted monthly departmental management meetings involving the consultants, management leads, ward sisters and finance officers had taken place since 2007.

11.86 While the implementation of these initiatives will undoubtedly help, there are further policies and protocols which should be introduced to assist with day-to-day arrangements of the department. These should take into account RCOG guidance on Standards for Gynaecology, Diagnostic and Operative Hysteroscopy, Hysteroscopy Procedures, Obtaining Informed Consent, and Medical Staffing.

[12] "Obstetric morbidity" is a collective term of art used to define diseases and adverse outcomes that would not affect women who were not pregnant. Examples include, pre-eclampsia, placental haemorrhage, tearing of the perineum at delivery or retained placenta.

Recommendations

R23 The department should review and adopt policies and protocols to help with day-to-day management. These should take account of the Royal College of Obstetricians and Gynaecologists (RCOG) guidance on Standards for Gynaecology, Diagnostic and Operative Hysteroscopy, Hysteroscopy Procedures, Obtaining Informed Consent, and Medical Staffing.

R24 The clinical lead should use the Royal College of Obstetricians and Gynaecologists (RCOG) dashboard annually to monitor the 'health' of the department.

Comment

The department is to be commended for pursuing these useful initiatives, which if properly embedded will help improve the governance of the department and the safety culture.

It will be important to ensure that regular minuted meetings continue and that they include the three consultants, the permanent middle and junior grade doctors as well as nursing staff.

Recommendations

R25 The chief officer should ensure that organisational arrangements are in place to support good corporate and clinical governance. This includes developing and implementing policies and procedures to cover significant risks, ensuring that incidents are reported, investigated (where necessary) and the changes and improvements implemented. *Urgent*

R26 The three consultants should hold regular minuted meetings and include permanent middle-grade and junior staff. Nursing staff should also join these

meetings. The three consultants should also attend departmental meetings. ***Urgent***

12. The surgical directorate

12.1 Ms Body has been the manager of the surgical directorate since August 2006. She is a member of the SMT and was head of nursing for the directorate. She leads the directorate management team that includes, Mr Martin Siodlak, clinical director for surgery, Mr Kynman, head of nursing for surgery and Ms Torrance, head of midwifery. A finance manager is the fifth member of the team.

12.2 The directorate comprises all surgical specialties in the hospital including general surgery, gynaecology and obstetrics, orthopaedics, anaesthesia, oral surgery, breast care, pain services, colorectal, plastic surgery, ENT, the assisted reproduction service and ophthalmology. It also includes the physiotherapy, radiology, audiology and CSSD departments, as well as the private wing.

Objectives and performance

12.3 The surgical directorate has a budget of £33.5 million and carries out about 11,000 operations and more than 1,000 deliveries a year.

12.4 Ms Body told us that when she took over the post of surgical directorate manager, the budget was £1 million overspent. This had reduced to £100,000 by December 2008.

12.5 As at April 2009, 1,244 of the 1,415 patients on the waiting list (in all specialties) had waited less than three months; 12 patients – including one in gynaecology - had waited more than six months.

12.6 Ms Body said the waiting lists increased in 2008 because the hospital had closed beds and lost nursing staff. This resulted in 4 to 5 per cent of surgical inpatients waiting longer than three months for admission.

12.7 According to Ms Body, the push to achieve a three-month waiting list target started in 2004, soon after Mr Pollard's arrival as chief executive. At that time, some

waiting lists, for example for hips and knees, were about two years. She explained that Mr Pollard gave the consultants some latitude regarding their public/private split if they were hitting their three-month target by allowing them to have a 50:50 split – rather than the usual 70:30 split.

12.8 A key objective of the surgical directorate as set out in the health and social services business plan for 2009 is to develop and implement the change process for the re-organisation of acute beds in the surgical directorate in the short and long term.

12.9 We also learned that the World Health Organisation (WHO) pre-operative/surgical safely checklist was introduced for gynaecology patients earlier this year. This checklist requires the consultant to discuss each case with the scrub nurse and theatre team before each operation begins and has, according to Mr MacLachlan, received favourable comments from the National Clinical Assessment Service (NCAS). The checklist is set out in detail at appendix L.

12.10 It is introduction is in keeping with the position and the mainland whether the NPSA has asked healthcare organisations to ensure its implementation.

Recommendation

R27 The theatre management group should continue to develop the use of the World Health Organisation (WHO) pre-operative/surgical safety checklist and ensure that it is used in all theatres.

Medical staff

12.11 Mr Siodlak, ENT surgeon, has been the part-time clinical director of surgery since November 2006 (there was no clinical director of surgery at the time of Mrs Rourke's death). He is remunerated for these duties at one Professional Activity (notional 4 hours) although we have been told he does much more. He reports to Ms Body for operational matters and to Dr Lane for professional matters. He described his role of surgical director as helping Ms Body to run the department of surgery.

12.12 He in turn is supported by six clinical leads for anaesthesia, head and neck, obstetrics and gynaecology, general surgery, orthopaedics and trauma and radiology:

- Dr Peter Coleman – anaesthesia
- Mr Mike Belligoi – head and neck
- Mr Neil MacLachlan – obstetrics and gynaecology
- Mr James Allardice – general surgery
- Mr Paul Clifford – orthopaedics and trauma
- Dr Pat Nisbet – radiology.

12.13 Mr Siodlak meets monthly with the clinical leads to share information and discuss what is happening in the hospital. Ms Body also attends this meeting, which is minuted:

> *"We don't discuss problems with individual doctors because there are quite a lot of people there, it is a big meeting. We talk about waiting lists, how we can manage with reduced numbers, how we can tackle problems that are building up in the waiting lists – that sort of thing."*

Comment

There are good arrangements for involving the medical staff in management matters in the surgical directorate.

12.14 Mr Siodlak originally attended SMT meetings but according to the September 2008 minutes stopped because of his clinical commitments.

12.15 Mr Siodlak described the performance appraisal arrangements for medical staff as "*just starting*" and said he had three consultants he needed to appraise.

12.16 He told us that a significant amount of job planning took place before he started as clinical director. However, the exercise has not been repeated for about three years because of (the absence of) a locum policy.

Nursing staff

12.17 Mr Gary Kynman formally took up the post of head of nursing for surgery in July 2007, although he had acted up in the position since September 2006 – taking over from Ms Body. His role is both strategic and operational. He has a one-in-five on-call responsibility. He oversees 17 departments and about 270 whole-time equivalent staff and chairs the surgical nurse management meetings.

12.18 He explained that the surgical directorate had experienced significant pressures in the nine months before our interview. These were caused by the closure of ten surgical beds, which had resulted in bed occupancy levels of between 90 and 100 per cent, increased workloads and the cancellation of some non-urgent elective cases. This situation was compounded by the need for the surgical wards to accept a large number of medical patients due to the closure of a further 12 beds in the medical directorate – and was new to the hospital.

Comment

Such high levels of bed occupancy – consistently above 85 per cent - not only run counter to good infection control practice but increase risk generally.

Obstetrics

12.19 Ms Torrance joined the hospital in 2005 as head of midwifery, having worked in a senior position on the mainland.

12.20 The 2008 annual report for maternity and neonatal services describes the midwifery-staffing situation as *"challenging"* and highlights the difficulty the hospital has had in filling a four-year-old vacancy for a neonatal intensive care nurse/midwife.

12.21 It also says that the midwifery department continues to rely on locum medical staff.

12.22 Ms Torrance told us she used to attend the SMT governance board because she was chair of the nursing and midwifery advisory group. She stopped attending when her term of office came to an end.

Relationships

12.23 Two interviewees separately described to us the nature of the working relationships between the directorate's nursing staff and the surgeons. Generally, they felt that the nurse managers would welcome a more participative and engaging relationship rather than what they perceived as a rather old-fashioned consultant/nurse relationship.

Comment

We encourage the fostering of such participative and engaging working relationships where they do not already exist.

13. The day surgery unit

13.1 The day surgery unit at Jersey General Hospital opened in May 1997 with one theatre.

13.2 It is on the first floor of the Gwyneth Huelin wing above the outpatient reception area and is open weekdays between 8.00am and 8.00pm and Saturdays from 8.00am until 3.00pm. A nurse is on call every day.

13.3 The day surgery unit was expanded in 2006/07 to include a second theatre. It now comprises two operating suites, a six-bed recovery area, a minor operations suite, two bays of six trolleys, one bay of five trolleys and five single rooms with en-suite facilities.

Management

13.4 The day surgery unit falls within the directorate of surgery.

13.5 Ms Body was the first day surgery unit manager before she moved to the position of head of nursing surgery. She was followed by Ms Julie de la Haye, who was the manager in October 2006.

13.6 Ms Gindill has been in charge since 2007. She is the lead nurse for both day surgery and endoscopy (which is on a different floor) and is responsible for all staffing matters, budget management and equipment issues. She described her role as both strategic and operational.

13.7 In addition to Ms Gindill, 38 whole-time equivalent nursing staff are employed on the day surgery unit, including one grade 6 senior sister and three grade 5 junior sisters.

Purpose

13.8 Day patients are similar to inpatients in that they are admitted to a ward and allocated a bed, but they are unlikely to spend the night in hospital and usually go home in the afternoon or evening.

13.9 The aim of the day surgery unit – as expressed in its operational policy - is to provide facilities for a range of agreed procedures undertaken as day surgery, predominantly in the general surgery, ophthalmic, gynaecology and oral surgery specialties.

13.10 It subsequently concentrates on the top ten procedures suggested by the British Association of Day Surgery, including grommets, hysteroscopies, laparoscopies, cataract surgery, terminations, mucous resections of the nose, arthroscopies and ingrowing toenails. This range of procedures is known as the *"Jersey basket"*.

13.11 The hospital has a list of minor procedures that can be carried out as day surgery, but it is not automatic that somebody having one of these procedures will be treated as a day patient. If a patient is frail or unwell, lives alone or in unsatisfactory accommodation, they will probably be kept in overnight so that they can be observed for longer after the procedure.

13.12 Not all day cases are processed through the day surgery unit but all intended day cases are entered as a day case on the patient administration system (PAS) when they are registered on the waiting list to allow for accurate statistical retrieval.

13.13 The number of weekly theatre sessions varies between 21 and 22, depending on whether oral surgery is undertaken. Three minor-op sessions are carried out each week and a sclerofoam therapy session every other week.

13.14 The 2009 health and social services business plan is clear about increasing the number of cases passing through the day surgery unit. Specifically, this would include

ensuring that 75 per cent of the Jersey basket be provided through day surgery in general surgery, gynaecology, orthopaedics, oral surgery, ENT and ophthalmology.

Budget and performance

13.15 The day surgery services net budget for 2008 was just over £2 million. This comprised expenditure of £2.7 million and an income generated through private patients of £693,770.

13.16 In 2008, a total of 5858 procedures were carried out in the day surgery theatre – mostly on adults. This compared to 4169 procedures in 2007, 3121 in 2006 and 3450 in 2005. Well over half of all elective procedures in the hospital now take place in the day surgery unit.

The gynaecology workload in day surgery unit

13.17 About 20 per cent of the procedures in the day surgery theatre are in gynaecology.

Policies and procedures

13.18 A day-case surgery operational policy sets out the prevailing rules.

13.19 When a person is due to have a procedure that can be carried out in the day surgery unit, a pre-admission meeting is held so that, among other things, a decision can be made on whether that person is suitable for day surgery or whether they should be kept in overnight. When a patient is seen in outpatients, the doctor fills out a 'to come in' (TCI) card. This will note the procedure, and will also say whether it is urgent, to be done soon, or routine.

13.20 The TCI card goes, with the patient's notes, to the consultant's secretary, who does a letter to the GP, responding to the referral letter and explaining what has been agreed. The TCI card and the notes then go to the TCI clerk, who enters the details

into a computer system and puts the TCI cards on the appointments diary. The pre-admission nurse looks at the cards and depending on the urgency and the type of case puts it into an operating list. Pre-admission nurses know how long different procedures take and they understand about urgency. Having put the case in the operating list, the pre-admission nurse then makes an appointment for the pre-admission meeting. The pre-admission nurse for the day surgery unit at that time was staff nurse Wendy Pycraft.

13.21 An admission document is completed for every patient admitted to the day surgery unit. This covers the pre-admission assessment, the care plan, pre-operative checks, the anaesthetic, intra-operative care, post-operative care and discharge.

13.22 There are two scrub nurses who work on the day surgery list. They alternate with the patients; one of them looking after the first, third, fifth etc patients and the other looking after the even numbered patients. There is also an anaesthetic nurse, an anaesthetist, a surgeon, one or two more junior doctors to assist and learn, a theatre assistant to help with the equipment, a runner in case something needs to be brought to theatre and a recovery nurse, who takes responsibility for the patient when she is wheeled out of the operating theatre and into the recovery room, and who remains with the patient until she has recovered from the anaesthetic.

13.23 At a suitable moment each patient is asked to change either in their cubicle or their room or in the bathroom into a hospital gown. When the surgeon is ready the anaesthetic nurse will come onto the ward to collect the patient and take them to the anaesthetic room, at which point they will get on the hospital trolley which is in the anaesthetic room. The beds in the day surgery unit are hospital trolleys. This means that once the patient gets onto the trolley, she will remain on it until she has recovered from the procedure. The patient is prepared for anaesthesia by the anaesthetic nurse, and then the anaesthetist will come and anesthetise her before she is taken into theatre. The anaesthetic nurse will go into theatre with the patient, and will remain there, unless she is collecting something for the anaesthetist, until the end of the operation.

13.24 As soon as the first patient has been taken out of theatre by the anaesthetist and the recovery nurse, the second patient will be taken to the anaesthetic room and prepared for anaesthesia by the anaesthetic nurse. At the same time the scrub nurse who had been assisting the surgeon will take the trolley of instruments out, the theatre assistant does whatever cleaning and tidying is necessary, the surgeon/s dispose of their dirty clothes, write their operating notes, dress in sterile gowns and scrub in again, the alternate scrub nurse brings her trolley of instruments into the theatre and the anaesthetist goes out to the anaesthetic room to anaesthetise the second patient and take her into the operating theatre.

13.25 A June 2007 document entitled "*An introduction to the preoperative environment*" is available for new staff in main theatre and the day surgery unit. It includes an orientation checklist, a description of the roles of various operating theatre personnel, an induction programme, a training record and a section on reflective practice.

Meetings

13.26 A theatre management group was set up in September 2008 (replacing the day surgery theatre extension project and CSSD user group) covering main theatres, the day surgery unit and CSSD. Its main responsibility is for the strategic planning, monitoring and management of theatre performance.

13.27 A weekly day surgery unit ward meeting deals with practical matters such as the week ahead, staff rotas and the use of lockers as well as well as broader issues such as policies, incidents and audits. Meetings have been held since 2006 and seem to be well attended. Brief minutes are kept.

Part three

In this part of the report we explain the causes of the incident involving Mrs Rourke using a well-established accident investigation tool. We draw on our findings and comments in part one and two.

14. The factors that contributed to Mrs Rourke's death

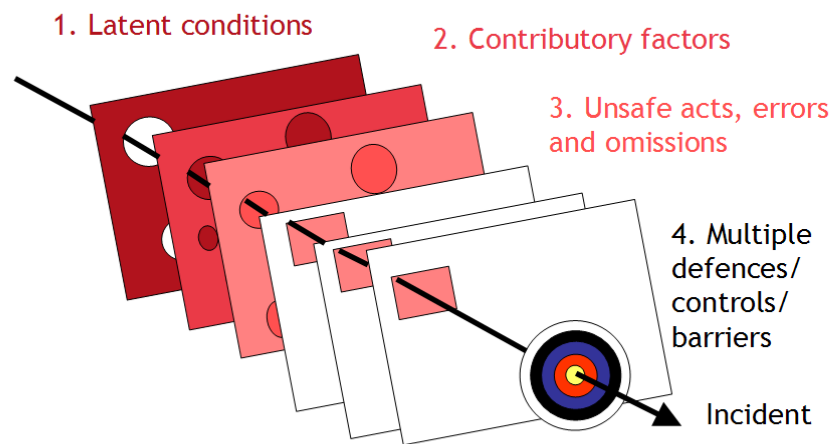
14.1 For the reasons set out in paragraphs 9.59 to 9.73 it is not possible to determine whether Dr Moyano was suitable for the locum consultant posts she was offered by HSSD. If she was, then the perforation and damage to Mrs Rourke's iliac vein were an accident for which no one but Dr Moyano can be held responsible. The General Medical Council should determine the nature of any responsibility.

14.2 On the other hand, if Dr Moyano should not have been employed or re-employed as a locum consultant, the factors that allowed this also contributed to Mrs Rourke's death.

14.3 The fact that we have not been able to determine whether Dr Moyano was suitable for the posts she was given indicates that the hospital systems of risk assessment and risk management were inadequate.

14.4 This section of the report details the failings that may have contributed to Mrs Rourke's death and which will, unless rectified, continue to foster an environment that, in parts at least, is not sufficiently focused on patient safety. Our criticisms apply whether or not the GMC finds Dr Moyano fit to practise.

James Reason's model of incident causation



14.5 We have applied James Reason's model of incident causation, which is used in the risk analysis and risk management of human systems. It was introduced by the British psychologist James Reason in 1990 and has since been adapted to be applied in varying organisations. It likens human systems to multiple slices of Swiss cheese, stacked together side by side. It has gained widespread acceptance and use in healthcare, in the aviation safety industry and in emergency service organisations. It is also known as the cumulative act effect.

14.6 The Swiss cheese model explains why things go wrong from an organisational point of view and demonstrates how an incident can occur when defences and barriers are penetrated. According to the model, those investigating the incident must analyse all levels of the system to understand fully the causes of the incident. The model requires investigators to address latent failures in the sequence of events in addition to the unsafe acts directly linked to the incident.

A) **Latent conditions** are the things that go wrong as a result of people failing to anticipate the impact of their decisions and the conditions they can create in the workplace (for example, how an HR policy can lead to understaffing). Such decisions can create weaknesses in an organisation. Latent conditions may lie

dormant in a system for many years before they combine with contributory factors and active failures to create the conditions for an incident.

B) **Contributory factors** are those that do not necessarily have a direct impact on the incident but play a contributory role. Latent conditions often allow them to occur. For example, if a patient does not speak English and cannot explain that s/he has been given the wrong medication, this can act as a contributory factor.

C) **Unsafe acts, errors and omissions** are committed by people in direct contact with the patient or situation. They can take a variety of forms such as slips, lapses, mistakes or violations. Active failures have a direct and usually immediate impact. An example of this might be someone who injects a patient with the wrong medication. In view of our terms of reference we have not looked at any matters under this heading.

D) **Organisational defences and barriers** in place to try to stop incidents or harm taking place are also described in this model. Barriers can be:

- *physical* such as radiator covers or gloves
- *administrative* such as policies and procedures
- *natural* (time, place and distance) such as when a pharmacist makes up a prescription, they complete another task before checking the drug and dispensing it to the patient, therefore using time and distance to reduce the likelihood of *human error*.

If these barriers fail, and the 'holes' (latent conditions, contributory factors and/or errors) on the Swiss cheese model align, the conditions are right for an incident.

14.7 We think the following factors may have contributed to Mrs Rourke's death on 17 October 2006 and did contribute to an unsafe patient environment.

Latent factors or organisational pre-conditions

- Despite the dedication and skill of many of its staff, in 2006 the hospital had an underdeveloped culture of patient safety and governance. The evidence for this is, for example, the relative lack of policies and procedures, an unwillingness to report serious incidents and a blame-oriented environment.

- The 'distant' senior management team did not engage well with senior medical staff or provide sufficient leadership to the organisation.

- Managerial focus on the day-to-day operation of the hospital was under-developed and clarity about accountabilities, for example the identity of the manager to whom consultant medical staff reported, was lacking. The medical management structures were relatively unsophisticated. For example, appraisal and job planning for consultants had barely taken root by this point.

- There was a growing reliance on locum medical staff, many of whom were no longer the tried and tested individuals of previous years. This was part of a wider national problem about medical staffing. Most overseas doctors specialising in obstetrics and gynaecology who come to the UK want to gain membership of the Royal College of Obstetricians and Gynaecologists (RCOG), become consultants and settle. Opportunities to do so in Jersey were limited and this is likely to have deterred many doctors from applying for training posts. As our analysis shows, the obstetrics and gynaecology department was heavily dependent on locums.

- The hospital had no robust policy for recruiting locum medical staff, including expectations about what to look for in references and a clear division of responsibility between HR medical staffing officers and consultant medical staff about the appointment of locums. The reference form in use was inadequate.

- The lack of a written policy on the procedure for recruiting locum medical staff resulted in no requirement for formal appraisal on arrival, with documentation to

go to human resources; no policy on who saw references and no policy on sharing CVs.

- The hospital had no robust process for induction and early appraisal of the capability of locum medical staff. This led to an assumption that suitability for one locum post implied suitability for all others at the same or more junior levels.

- The long-standing culture of the obstetrics and gynaecology department was of individual rather than team work. The strong impression is of senior practitioners working in relative isolation. This did not allow for regular and timely communication between the three consultants.

- Gynaecology day surgery unit lists were overloaded. The management team appears not to have challenged this.

- Communication between individuals and departments was generally poor.

Contributory factors to the incident on 17 October

- The poorly constructed reference form resulting in an ambiguous response from referees about whether they thought Dr Moyano was unsuitable for the post of locum obstetrics and gynaecology consultant or simply did not know whether she was suitable.

- Failure of a consultant in the department to review the references of Dr Moyano after she was appointed and in the context of her induction.

- No proper appraisal of Dr Moyano on her arrival in post.

- HR contracting Dr Moyano to fill other vacancies in the obstetrics and gynaecology department without checking this with the obstetrician and gynaecology consultants. Dr Moyano appears to have been appointed in August 2006 to cover for Dr Nelson simply because she was available. By September she was established as the locum of choice.

- Dr Moyano's language difficulties. Analysis of the reported incidents points to her having problems communicating with colleagues and patients.

- Late publication of the obstetrics and gynaecology middle-grade duty rota leading to last-minute changes to the deployment of middle-grade staff. A misunderstanding between Mr Day, Dr Williams (a staff grade in the department) and Dr Moyano about the need for Dr Moyano to be in theatres and the nature of her role.

- As a result of annual leave, no consistent anaesthetic cover for the morning list, possibly affecting the atmosphere and working environment in the theatre.

- Having no diagnostic hysteroscope on the theatre tray.

- Dr Moyano deciding to continue with a clinical procedure if she had doubts about her ability (her experience in hysteroscopic resection is unclear from the evidence).

- Dr Moyano failing to tell Mr Day that she had seen bowel and that electricity had been used in the procedure.

Barriers that failed (before and after the event)

- Organisation of the theatre instrument tray so that a resectoscope was available to Dr Moyano without those who prepared it knowing whether she could use it.

- The interim serious untoward investigation – designed to help the hospital learn and improve – has not been acted on with sufficient vigour. A number of factors appear to have played a part in this:

    - the report itself appears to have been the subject of internal discussion and amendment

- the obstetrics and gynaecology department and possibly others did not appear to know about the amended version of the report until 2009

- the chief officer and deputy chief officer have not been able to oversee its implementation (Mr Pollard because he did not get involved for fear of a conflict and Mr Jouault because of his secondment during the crucial period of 2008)

- the management team has been distracted by the continuing exclusion of Mr Day

- no single person being given responsibility for overseeing the implementation of the recommendations.

Appendix A

Terms of reference

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.

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, for example 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.

Appendix B

Letter from Minister to the investigation team

Deputy Anne Pryke
Minister for Health and Social Services
Peter Crill House, Gloucester Street
St Helier, Jersey, JE1 3QS
Tel: +44 (0)1534 442285
Fax: +44 (0)1534 442887

2 July 2009

Mr E Marsden
Managing Director
Verita
53 Frith Street
London, W1D 4SN

Our ref: AEP/TG

Dear Mr Marsden

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

Thank you for your presentation to States members on Wednesday afternoon. I am sure they found it helpful to meet the investigative team and to hear about progress with the work. As I said at the meeting, I am writing in my capacity as the new Health Minister in order to expand on and set out my expectations about the terms of reference and the handling of the independent investigation at the point that the report is ready for delivery. We have already discussed these points and I know that they coincide with your own thinking.

Terms of reference

My predecessor set your terms of reference and I am content to endorse them as I believe they focus on the right matters. However in the commissioner preamble before the terms of reference the second sentence reads as follows:

> *'The investigation has no disciplinary remit and will not consider the acts and omissions of individuals.'*

You have already said that the investigation team is looking in detail at the events of the day including who did what. As I understand it, the team is looking at these events in the context of hospital systems and procedures and patient safety and will be providing the fullest account possible of who did - or didn't - do what, and why, as is judged appropriate by you. I endorse this approach. I can also re-confirm that I am not asking you to carry out an investigation for the purposes of disciplining individuals. However any issues arising from the report will be dealt with under the relevant policies and procedures.

With respect to the first point of the terms of reference I would be grateful if you would also include consideration of hospital and HSSD procedures and practices where the investigation team thinks this to be appropriate.

Submission of draft report and final report

I would be grateful if you would submit your draft report to me, the Greffier of the States, the Deputy Viscount and the Chair of the Health, Social Security and Housing Scrutiny Panel once it is complete. The report will not be sent to the Health and Social Services Department

management team without the explicit, written agreement of me or the Greffier. If you propose to send the draft by electronic means then please ensure that the report comes to our own email addresses and is password protected. The password should be sent to us by means of a separate message.

I expect Verita to retain full editorial control of the draft report while it is fact-checked by the Health and Social Services Department and, if necessary, individuals comment about criticisms made of them. This will ensure that the contents of the final report are the considered views of the investigation team.

Publication and presentation

I re-confirm that I propose to publish your investigation report. I would like to do this in such a manner that your findings and conclusions are widely available. I would also like you and the team to present the findings of the investigation to States members and, separately, to the Health and Social Services Department management team and staff. This is in addition to any press conference that we may hold.

Addendum to your report

At your discretion I would like you to prepare an addendum to your report. This should include matters that come to light during your work that are outside your terms of reference but the investigation team think I should know about. Should you feel the need to prepare such a document then it should be submitted to the same four individuals as set out above.

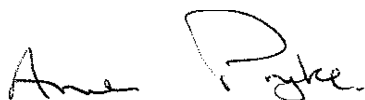
Follow-up

I am determined that the investigation report should not sit on the shelf. I will expect the Health and Social Services Department management team to draw up an action plan in response to your recommendations. I will expect them to explain how the actions will be implemented and monitored. I will want to know who is responsible for each action and the timescale for completion. I want your team to revisit the hospital six months after the publication to check on progress and to submit a written account of your visit to me, the Greffier, the Deputy Viscount and the Chair of the Scrutiny Panel. Based on the findings, I may wish for you to make a further visit to report on progress in the hospital.

Tom Gales, Social Policy Adviser, Chief Minister's Department will, for the time being, act as your liaison officer. Day-to-day matters should be referred to him at the moment. I will further clarify Mr Gales' role and that of the Greffier's office next week. In any event I would encourage you to keep Tom Gales and the Greffier posted if matters of concern arise during the investigation. I know that you are already doing this and I am grateful for that.

I look forward to hearing from you. Meanwhile, I am copying this letter for information to the Greffier, the Deputy Viscount, the Chair of the Scrutiny Panel and Mr Gales.

Yours sincerely



Deputy Anne Pryke
Minister for Health and Social Services

Appendix C

Documents reviewed

The investigation team saw a significant amount of documentation and we have therefore not listed them all in great detail here. We have however set out below in general terms those that we reviewed:

Minutes of senior management team meetings
Minutes of medical staff committee meetings
Various waiting list data
Various staffing lists
Terms and conditions of service for staff
Job descriptions and job plans
Organisation charts
Performance reports
New directions discussion paper December 2008
HSSD business plans
Various strategic, policy and operational documents for the gynaecology service and day surgery unit (DSU) including

- Operational policies 2003/2007
- DSU objectives for 2009
- Organisational, divisional and departmental structures and responsibilities
- Business cases for 4th consultant and additional middle grades in obstetrics & gynaecology
- Staff rotas
- Terms of reference, agendas and minutes for various meetings and committees within DSU, theatres and the obstetrics and gynaecology department
- DSU pre-assessment forms and admission documents
- Patient information leaflets
- Human resources metrics for DSU and the trust's gynaecological directorate as a whole, including staff numbers and grades (WTE and headcount); planned skill mix for each clinical area; sickness absence; vacancies; turnover; bank and agency staff usage during 2006
- Budgetary information from 2006

- Sickness absence data
- Medical locum data
- Various policy and procedure documents relating to the allocation and organisation of theatres
- Waiting list policy for elective admissions
- Inpatient & outpatient waiting times 2006-9
- DSU and gynaecology activity data 2006-9
- British Association of Day Surgery list of recommended procedures as published in 2007 for Gynaecology & Urology
- Various external reports on clinical services at DSU or about the hospital including from the Healthcare Commission and Picker
- Risk register entries since January 2006 and Risk register 2008
- Various protocols and procedures for undertaking clinical case and outcome reviews
- Terms of reference for Gynaecology Risk Management meetings
- Various external and internal auditor's reports relating to gynaecological services at the DSU since 2006
- A range of HR policies and procedures covering recruitment, performance appraisal, training and education, induction, diversity and equality , whistle-blowing, discipline and time off

Various procedures and protocols concerning locum staff, including

- Policy concerning the appointment and employment of locum doctors 2009
- Locum obstetrics and gynaecology medical staff orientation/competency form 2008
- Criteria for the provision of locum cover for annual leave/study leave 2004 (HR document)

Court transcripts and police witness statements

Various documents concerning the SUI report

Various misc confidential papers and emails sent to the investigation team

The Royal College of Anaesthetists

CONFIDENTIAL
Anaesthesia Review Team Report

PREPARED BY
DR J-P VAN BESOUW

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CURRICULUM VITAE OF AUTHOR

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PRIVATE AND CONFIDENTIAL

Instruction

This report is prepared at the request of Mr E Marsden of Verita - tasked by Deputy Anne Pryke, Minister for Health and Social Services to the States of Jersey - in accord with the instructions outlined in Verita's email to Mr. C. McLaughlan, Director of Professional Standards to the Royal College of Anaesthetists, Anaesthesia Review Team dated 9th July 2009 and based upon records and materials provided and prepared by them.

Author

Dr. Jean-Pierre van Besouw. BSc (Hons), MB, BS, FRCA.

I am a Consultant Anaesthetist and Honorary Senior Lecturer (1990-td) to St Georges Healthcare NHS Trust, London SW17 0QT. I am a member of Council of the Royal College of Anaesthetists (RCoA), Chairman of the Board of Examiners (RCoA), and Chairman of the Association of Cardiothoracic Anaesthetists (ACTA). I am Deputy Medical Secretary of the RCoA and a member of its Audit and Internal affairs, Equivalence, Examinations and Training Committees. I am a member of the editorial board of Continuing Education in Anaesthesia, Critical Care and Pain Management -with responsibility for cardiothoracic related content- and a regular reviewer for a number of anaesthetic journals. I am a former Lead Clinician in Cardiothoracic Anaesthesia and Intensive Care (1994-2003) to St George's Hospital. I have been a specialty reviewer for the Health Inspectorate for Wales and member of the RCoA Anaesthesia Review Team tasked with investigating untoward anaesthetic events. I have assisted in the development of assessment tools for the GMC within their Performance Assessment Implementation Group. I represent anaesthesia on the Association of Surgeons CORESS (Confidential Reporting System in Surgery) Advisory Committee. My major area of interest and practice is in the field of cardiothoracic anaesthesia. I have lectured and authored chapters, articles and advisory documents on cardiothoracic anaesthetic related subjects, risk assessment, simulation and examinations and preoperative preparation of patients for surgery.

Potential Conflict of Interest

My wife, Dr. Liliane Field is a Medicolegal Adviser with the Medical Protection Society working from their London office.

1. Records and materials available

1.1. Letter of instruction from Deputy Anne Pryke to Verita- *dated 2nd July 2009.*

1.2. Email letter of instruction from Verita to Royal College of Anaesthetists *dated 9th July 2009.*

1.3. Bundle 1: Medical records of Mrs Elizabeth Rourke in relation to her admission and treatment on 17th October 2006 to the Day Surgery Unit of Jersey General Hospital; *dated as received.*

1.4. Witness statement of Mr John Day, Consultant in Obstetrics and Gynaecology, Jersey General Hospital; *dated 20th December 2006.*

1.5. Witness statement of Dr Regina Thomsen, Senior House Officer in Anaesthetics Jersey General Hospital and supporting documentation; *dated 8th November 2006.*

1.6. Witness statement of Dr Chelliah Ilangovan, Associate Specialist in Anaesthetics Jersey General Hospital; *dated 7th November 2007.*

1.7. Witness statement and letter of Dr Richard Lane, Consultant Anaesthetist and Medical Director, Jersey General Hospital; *dated 1st November 2006 and 11th December 2006.*

2. Summary of Instructions

2.1. Was suitable action taken promptly by Dr Thomsen when she became aware of Mrs Rourke's condition?

2.2. Does your reading of the records, including the anaesthetic records, suggest any failure by the anaesthetists to meet the good practice standards applicable at the hospital during the rescue operation? What do you consider those standards to be – in broad outline?

2.3. Should any of the anaesthetists have challenged the decision to keep the abdominal packs in place during the cardiac arrest?

2.4. Should any of the anaesthetists have challenged the decision of the surgeons to continue to gain control of the bleeding, bearing in mind the professional and geographical context in which the resuscitation was being attempted.

2.5. The first, fifth and sixth patients on the list of 17th October 2006 were private patients, two consultant anaesthetists were called in for these cases whilst a staff grade anaesthetist dealt with the remainder. Do you have any comment to make upon the acceptability of this practice bearing in mind the demographic and geographic constraints of medical practice?

3. Summary of events as recorded

The chronology of the anaesthetic related events in Mrs Rourke's case is obtained from the hospital records supplied in 1.3 above.

3.1. Mrs Rourke was seen at the Day Surgery Unit (DSU) preadmission clinic on 10th October 2006. No significant findings precluding her as a candidate for day surgery were found.

3.2. Mrs Rourke was admitted to the DSU under the care of Mr Day, on 17th October 2006 for hysteroscopy and dilatation and curettage. No specific mention is made of resection of polyps.

3.3. A consent form for *"hysteroscopy/D+C"* was signed by Mrs Rourke and Dr G. Williams; staff grade O&G. Dr Williams noted the risks and complications as *"bleeding, infection, uterine perforation, damage (to) bladder, bowel and blood vessels".*

3.4. Mrs Rourke arrived in the anaesthetic room at 12.30 as the ninth patient on the morning DSU list. Dr Ilangovan was the anaesthetist.

3.5. The anaesthetic record documents that:

3.5.1.A 22g cannula was placed in the left hand.

3.5.2.The patient was induced with Midazolam 2mg and Propofol 200mg.

3.5.3.Ondansetron 4mg and Metoclopromide were given as antiemetics.

3.5.4.Alfentanil 0.5mg and Ketorolac were given for analgesia.

3.5.5. General anaesthesia was maintained with nitrous oxide, oxygen and desflurane via spontaneous ventilation with a laryngeal mask airway-size 3.

3.5.6. Recordings of systolic blood pressure and heart rate were documented at 5 minute intervals from 12.45 to 13.00.

Time	12.45	12.50	12.55	13.00
Systolic BP mmHg	100	80	85	90
Heart rate bpm	65	65	65	65

3.6. On arrival in recovery at 13.05 Mrs Rourke was noted to be easy to rouse, with a respiratory rate of 13, oxygen saturations of 97%, a blood pressure of 87/53 mmHg and pulse rate of 70 bpm.

3.7. At 13.10 Mrs Rourke systolic blood pressure was recorded at 53/- and oxygen saturations of 92%.

3.8. Dr Thomsen – anaesthetic SHO was called. iv. fluid resuscitation was commenced aided by the placement of two large bore cannulae – 18G to right wrist and 14G at the right elbow (ACF).

3.9. Mrs Rourke was transferred back to theatre for emergency laparotomy.

3.10. Anaesthesia was induced at 13.40 by Dr Thomsen. The anaesthetic record documents the following:

3.10.1. Prior to induction two 6mg boluses of ephedrine were given.

3.10.2. Propofol 100mg and atracurium 30mg were given to induce hypnosis and facilitate intubation.

3.10.3. Analgesia was provide by the administration of Fentanyl 0.1mg at 13.45 and incremental boluses of morphine throughout the case.

3.10.4. General anaesthesia was maintained with nitrous oxide, oxygen and sevoflurane with intermittent positive pressure ventilation via a size 8 endotracheal tube.

3.11. The anaesthetic chart documents the course of the case and graphically illustrates the haemodynamic instability of the patient, in accord with the witness statements of those present.

3.12. The series of blood gases illustrates the progressive deterioration in Mrs Rourkes condition.

Time	**pH**	**pO2**	**pCO2**	**ABE**	**Hb**	**Potassium**	**Glucose**	**Lactate**	Comments
13.49	7.29	27.50	5.50	-6.30	-	2.90	-		
14.05	7.19	6.40	6.47	-9.00	6.60	4.50	11.60	2.80	? Venous sample
14.48	7.22	70.20	6.03	-8.70	8.60	6.80	10.00	3.80	
15.40	7.25	36.10	6.28	-6.80	10.30	6.20	19.80	4.50	
16.19	7.25	31.30	6.14	-6.70	5.50	4.90	18.80	4.40	
16.58	7.18	25.50	6.78	-8.70	6.40	3.90	9.10	4.40	
17.32	7.16	10.60	7.67	-8.00	5.90	4.60	8.40	5.20	
18.00	7.17	6.16	6.66	-9.70	6.40	5.20	8.20	5.90	CPR in progress
18.10	6.91	5.06	17.50	-12.10	12.70	5.50	9.60	9.40	CPR in progress
18.25									Pt Died

3.13. The magnitude of the blood loss during the procedure is indicated by the volume resuscitation given.

Blood	9.50 litres
FFP	1.89 litres
Cryoprecipitate	0.20 litres
Gelofusine	6.50 litres
Crystalloid **Total**	1.00 litre **18.76 Litres**

3.14. This equates to more than 3 times the circulating blood volume of the patient.

3.15. The surgical team endeavoured to control the bleeding from the tear in the iliac vessels with limited success.

3.16. Around 17.00 a decision to pack the abdomen was made due to the inability to gain haemostasis.

3.17. Thereafter followed a progressive fall in blood pressure - accompanied by a worsening metabolic acidosis - with ECG changes indicative of myocardial ischaemia culminating in cardiac arrest at 17.40.

3.18. A prolonged period of cardiopulmonary resuscitation followed during which time there was an intermittent return of cardiac output.

3.19. A central line was inserted during the period of CPR by Dr Ilangovan at 18.16.

3.20. At 18.22 CPR was discontinued and the Mrs Rourke declared dead at 18.25.

4. Comment

4.1. *Was suitable action taken promptly by Dr Thomsen when she became aware of Mrs Rourke's condition?*

Dr Thomsen acted in a timely and appropriate way when asked to review Mrs Rourke in the recovery area of the DSU. Her management of the return to theatre was wholly correct given the gravity of the situation. She instituted resuscitation and ensured adequate access for volume replacement. Dr Thomsen is to be commended upon her handling of the situation given her relative inexperience.

4.2. *Does your reading of the records, including the anaesthetic records, suggest any failure by the anaesthetists to meet the good practice standards applicable at the hospital during the rescue operation? What do you consider those standards to be – in broad outline?*

The overall anaesthetic management of the emergency operation was acceptable. The anaesthetic team were struggling to maintain haemodynamic stability in the face of uncontrolled haemorrhage from a tear in a large blood vessel. The anaesthetic chart and the blood gas results indicate that at no time during the operation were they able to get on top of the situation – as shown by the progressive rise in blood lactate over the course of the procedure. Following Mr Allardice's intervention – the third surgeon to attempt suture of the vessel - there was a period of haemodynamic stability. The documentation of the proceedings by Dr Thomsen is exemplary given the gravity of the situation and the instability of the patient. My one criticism of the management afforded to Mrs Rourke by the anaesthetists present was the delayed insertion of central venous access, which only occurred during the period of CPR. This might have provided additional information to aid their management. It is unlikely that within the setting of the DSU that advanced monitoring such as oesophageal Doppler was available, however the use of such may have been beneficial to guiding treatment e.g. in establishing the impact of packing the abdomen on cardiac output.

4.3. *Should any of the anaesthetists have challenged the decision to keep the abdominal packs in place during the cardiac arrest?*

With the benefit of hindsight and upon reviewing the anaesthetic chart, the packing of the abdomen in an attempt to gain haemostasis/haemodynamic stability appears to occur co-terminus with the accelerated decline in Mrs. Rourke's condition leading to her cardiac arrest. One can only speculate upon the precise sequence of events, the most likely scenario is that despite the packing, intra-abdominal blood loss continued in the presence of a coagulapathy and intra-abdominal pressure rose reducing venous return and thus compromising cardiac output. This occurred against a background of progressive acidosis. It is unlikely that once cardiac arrest occurred that removal of the packs would have significantly affected the outcome. The decision to pack the abdomen in order to tamponade the bleeding vessels was however the only option available to the team following the unsuccessful attempts at suturing the iliac vessels. The decision was therefore appropriate and offered the only potential chance of survival to Mrs. Rourke to facilitate her transfer to a vascular unit.

4.4. *Should any of the anaesthetists have challenged the decision of the surgeons to continue to gain control of the bleeding, bearing in mind the professional and geographical context in which the resuscitation was being attempted.*

The laceration of the iliac vessels and failure to gain control of the bleeding following the initial insult led to the patient's ultimate death. The injury to Mrs Rourke would in most circumstance have been fatal, particular in the light of the absence of vascular surgical expertise being immediately available. Although in hindsight the repeated attempts by successive surgeons to suture the lacerated vein might have been prejudicial to the outcome no other obvious solution was available.

The care of any patient should as a matter of course be conducted in an environment of multidisciplinary discourse. It is difficult to determine as to which of the consultants present was "leading" the team. None of the witness statements comment upon what discussion took place within the operating upon the management of the situation. Dr Lane as the most senior anaesthetist present and medical director of the hospital assumed this role in some aspects of the care.

4.5. *The first, fifth and sixth patients on the list of 17th October 2006 were private patients, two consultant anaesthetists were called in for these cases whilst a staff grade anaesthetist dealt with the remainder. Do you have any comment to make upon the acceptability of this practice bearing in mind the demographic and geographic constraints of medical practice?*

Best practice would dictate that an operating list should be undertaken by an anaesthetist and surgeon working as a team supported by junior staff as appropriate. The situation whereby the senior anaesthetist is a Trust grade doctor and where the list contains private patients has the propensity to lead to problems in the management and delivery of the list. The list would be best managed by placing the private patients together at the start or the end of the list and for the person co-ordinating the list to arrange consultant anaesthetic cover with a single anaesthetist in advance of the list and not rely on ad hoc cover being provided on the day.

5. Opinion

Mrs Rourke sustained an intra-abdominal laceration to a major pelvic blood vessel during the course of minor gynaecological surgery. The resulting haemorrhage resulted in haemodynamic disturbance detected at an early stage by the recovery staff in the DSU. Mrs Rourke was assessed by Dr Thomsen who acted in an appropriate and exemplary manner in both her initial resuscitation and induction of the patient for laparotomy. Further anaesthetic management by Dr Lane and Dr Ilangovan was in the main appropriate given the severity of the injury, the resultant blood loss and the inability to gain adequate haemostasis by the surgical team. The documentation of the events on the anaesthetic chart and in the notes is excellent. The records provided show that Mrs Rourke sustained an iatrogenic injury to a major blood vessel, resulting in catastrophic haemorrhage which despite the sustained attempts of the operating department team to control it were unsuccessful and led to her inevitable death.

6. Statement of Truth

I believe the facts I have stated in this report are true and that the opinions expressed are correct.

16th November 2009

Appendix E

Chronology

Events of 17 October 2006

8.00am

Elizabeth Rourke arrives at the day surgery unit with her husband, Bob Rourke, who leaves her by her bed.

8.05am

Dr Moyano arrives on labour ward as she is the on-call registrar for the obstetrics and gynaecology department.

8.15am

Mrs Rourke is seen by Ms Haley, who recognises her as a staff nurse at the hospital, and goes through the pre-operative procedure with her before they both sign the form.

8.30am - 8.45am

Mrs Rourke is consented by Dr Williams, staff grade obstetrician and gynaecologist. He notes her symptoms and that she is being admitted for hysteroscopy/endometrial biopsy but does not wish to have a Mirena coil fitted. Dr Williams notes the risks and complications as "*bleeding, infection, uterine perforation, damage (to) bladder, bowel and blood vessels*" and that Mrs Rourke was "*keen to proceed with the procedure*". The consent form is signed by Dr Williams and Mrs Rourke.

8.45am

Dr Moyano speaks with Dr Sullivan who has not been aware that she (Dr Sullivan) is to be in theatre with Mr Day that morning.

9.05am – 9.23am

Dr Moyano receives a phone call from Dr Williams telling her she needs to attend the day surgery unit because he has to leave at 10.00am.

Dr Moyano is shown the way to the day surgery unit as she has been there only once before.

Dr Moyano arrives at day surgery unit and is briefed by Dr Williams who says he has consented all the patients and that Mr Day will undertake the whole list. Dr Moyano asks Dr Williams to give info regarding the patients, and makes brief notes on her copy of the surgery list. In discussing Mrs Rourke, Dr Williams tells her that she does not want a Mirena coil fitted.

Mr Day arrives, consents private patients, changes.

Dr Williams informs Mr Day that he has consented the patients and will be leaving at 10am and that Dr Moyano is there to assist. Mr Day knows that Dr Williams has been given permission to go by Mr MacLachlan as this has been discussed at a meeting of the three consultants on 13 October. Mr Day sees each patient before her procedure.

9.23am

First patient (private) into the anaesthetic room.

9.26am

First patient in theatre – hysteroscopy and removal of coil (Mr Day performs alone with Dr Prince).

9.45am

First patient out of theatre.

9.46am

Second patient (public) in theatre for laparoscopy and diagnostic hysteroscopy (JD?) with Dr Ilangovan as anaesthetist. Dr Williams informs Dr Moyano that he is leaving to catch his flight, so Dr Moyano and Dr Sullivan scrub in as assistants. Dr Moyano undertakes the laparoscopy while Mr Day does the hysteroscopy. This is Dr Moyano's first time assisting Mr Day in the day surgery unit. She does the laparoscopy under Mr Day's supervision.

10.31am

Second patient out of theatre.

10.31am

Third patient (public) in theatre for laparoscopy prior to reversal of laparoscopics sterilisation – performed by Mr Day and Dr Sullivan.

10.39am

Third patient out of theatre.

10.50am

Fourth patient (public)in theatre for hysteroscopy carried out by Dr Moyano under Mr Day's supervision.

Approx 11.00am

Ms Haley asks Mrs Rourke to get undressed and put on hospital gown.

11.05am

Fourth patient out of theatre.

11.07am

Fifth patient (private) goes into theatre for loop excision of the cervix undertaken by Mr Day with Dr Lane as anaesthetist.

11.25am

Fifth patient out of theatre.

11.26am

Sixth patient (private) into theatre for hysteroscopy undertaken by Mr Day, with Dr Lane as anaesthetist.

11.43am

Sixth patient out of theatre.

11.43am

Seventh patient into theatre for hysteroscopy and endometrial biopsy . Dr Moyano starts the case at the request of Mr Day, cleans and drapes the patient and performs a vaginal examination under anaesthesia then begins the dilation during which the length of the uterus is measured, glycine opened under light visualisation and hysteroscope introduced. A large polyp is seen. Dr Moyano stops surgery. Mr Day returns to theatre, scrubs in and resects the polyp.

12.00pm

Seventh patient out of theatre

12.10pm

Eighth patient (public) into theatre for hysteroscopy and biopsy undertaken by Mr Day and Dr Moyano. Dr Moyano cleans and drapes the patient and performs a vaginal examination under anaesthesia then begins the dilatation during which the length of the uterus is measured without sound. At 9cm Dr Moyano finds it difficult. Mr Day assists with the dilatation. He later recalls that Dr Moyano completed the hysteroscopy. She recalls that he did.

12.14pm

Mrs Rourke taken to anaesthetic room by anaesthetic nurse Ms Sarah Boyes-Varley, then realises that Mrs Rourke is staff. Mr Day comes out to talk to Mrs Rourke and reads her notes when he too discovers she is a member of staff. A cannula is inserted

into the back of her left hand and that she is given intravenous sedation with *midazolam* followed by the induction of general anaesthesia.

12.30pm

Eighth patient leaves surgery.

12.33pm

Mrs Rourke goes into theatre for hysteroscopy and D&C

12.35pm

Mr Day leaves theatre after informing Ms Mottram he is doing so.

12.49pm

First phone call (lasting 2 minutes and 18 seconds) from Dr Sullivan using the recovery room phone to Mr Day.

About 12.50pm

Dr Ahmed bleeped – assisting nurse answered bleep – message Dr Moyano having problem with intrauterine polyp. Dr Ahmed advises Dr Moyano to call consultant as he is in the middle of a scan. Dr Moyano resects the polyp and realises she has perforated the uterus, but does not realise she has cut the left common iliac vein. Dr Moyano tells Dr Sullivan to call Mr Day and advise that there has been a false passage with perforation of the uterus. Dr Sullivan later recalls that Dr Moyano mentions only the false passage and not the perforation.

12.56pm

Call (lasting 1 minute and 10 seconds) to Mr Day via Dr Sullivan to advise him of the false passage. Mr Day advises ending the procedure and says the patient can go home if there is no bleeding and is not in pain.

1.05pm

Mrs Rourke out of theatre into recovery. Her respiratory rate is 13 respirations per minute and her blood pressure is 87/53 with a pulse rate of 70 beats per minute,

which is normal for someone just after an operation. Dr Ahmed arrives at day surgery unit and is told by Dr Sullivan that the problem is resolved; Mrs Rourke is already recovering from the anaesthetic and that there may have been a false passage. No mention is made of full perforation.

Mr Rourke phones and is told his wife is in recovery.

1.10pm - 1.30pm

Mrs Rourke in clinical shock, with a respiratory rate of 10 respirations per minute, blood pressure of 53/0 and a pulse rate of 67 beats per minute. Her bed is tilted and she is given oxygen by face mask. An intravenous infusion saline is commenced but Mrs Rourke does not respond. Two large bore intravenous cannulae are inserted and a Gelofusine (plasma substitute) infusion commenced in recovery. Senior house officer Ms Thomsen is told by Ms Hanson that Mrs Rourke's uterus has been perforated, which is confirmed by Dr Moyano and Dr Sullivan.

1.15pm

Dr Lane bleeped as consultant anaesthetist on call, requested by Ms Thomsen.

Approx 1.20pm

Dr Moyano asks Dr Sullivan to bleep Dr Ahmed and says she has contacted Mr Day as Mrs Rourke is hypotensive. Mr MacLachlan also called. Dr Ahmed arrives quickly and Dawn Dalton phones Mr Rourke.

1.25pm

Mr MacLachlan arrives at recovery room.

1.30pm

Mrs Rourke transferred to the anaesthetic room to be intubated ready for emergency laparotomy and from there she is returned to the operating theatre. Ms Thomsen recognises Mrs Rourke as nurse in hospital.

1.35pm

Mr MacLachlan performs a midline incision into Mrs Rourke's abdomen and finds intraperitoneal bleeding and a hole in the back of the uterus, which is not actively bleeding:

> "*found a perforated uterus and a hemoperitoneum (a significant amount of blood in the peritoneum) four pints of blood in pelvis, starts to pack the abdomen*."

Mr MacLachlan's notes written at 4.00pm say:

> *"…No active bleeding. Retroperitoneal blood L side seen"*

After surgery started Dr Lane arrives and starts trying to arrange intensive care unit bed. Mr Rourke arrives after Mrs Rourke is back in theatre.

Approx 1.45pm and before 1.50pm

Mr Day arrives in theatre and takes over as main surgeon with Mr MacLachlan assisting. Further exploration of the abdomen reveals a 1.5cm hole in the left common iliac vein.

Ms de la Haye, manager of the day surgery unit, arrives, and arranges, with Ms Gindill, for a scribe (TA Brian Andrade)

Approx 1.50pm

Dr Lane sees Mr Rourke and tells him Mrs Rourke's womb has been perforated and they are trying to control the bleeding. Mr Rourke remains on day surgery ward.

Approx 1.50pm

Andree Bree is asked by her manager to take a vascular set and vascular trolley from the main theatre to the day surgery unit and to assist there.

1.53pm

Ms Bree arrives with vascular set in day surgery unit theatre.

Approx 2.00pm

Mr Gary Kynman, nurse manager of the intensive care unit is informed by sister Wharton of a suspected admission to the CCU from the day surgery unit for a patient with bleeding problems. A bed is available.

2.15pm

Mr Day requests that a general surgical consultant is called. Ms Bree asks the switchboard for the name of the on-call surgeon and is told Mr Allardice. Switchboard is about to put sister Ms Bree through to Mr Allardice's mobile when Mr Day tells her to cancel the call and to get Mr Ingram. Mr Day then speaks to Mr Ingram who asks him to attend.

2.20pm

Mr Day's theatre reading glasses arrive.

2.24pm

Mr Ingram arrives in theatre, by which time the uterus has been stitched by Mr Day who has cut the retroperitenem, removed significant amounts of old clot, and clamped and stitched the vein with prolene 3/0 sutures which continue to bleed, although much improved haemostasis is obtained after clamping and before stitching. As Mr Ingram arrives, Mr Day is controlling bleeding with direct pressure from his hand.

2.25pm - 3.30pm

Mr Ingram tries unsuccessfully to control bleeding by suturing the vein.

2.46pm

Mr Day leaves theatre to seek advice from vascular surgeon in Bournemouth.

2.56pm

Mr Day back in day surgery unit with instructions:

"I am sent to ring up the duty vascular surgeon in Bournemouth who was a Mr Butcher. I speak to a Mr Wijesinghe, who says three things to Mr Ingram who has taken over the case at that stage: 'First make sure your peritoneum is divided properly so we can get decent access to the vein and the artery. The artery is really quite over the top of the vein, so we want to really deliver the vein separate from the artery. Divide the peritoneum up and down', which in fact I had already done. 'Mobilise the aorta to some extent'. He said, 'Clamp the aorta for a period of 10 minutes at a time and you will get some relief of the bleeding, and if all else fails put drawing pins into the vein'. So I pass all that in a sort of telephone voice to Mr Ingram."

2.59pm

Mr Day rescrubs and returns to table. Mr Ingram speaks to colleagues in Guernsey and in Bournemouth for advice and to see if someone can come over. He is advised to try to get local control and take Mrs Rourke to Bournemouth. Mr Ingram tries again to obtain vascular control but fails to control bleeding.

3.30pm

Ms Julie de la Haye is asked by Dr Richard Lane to ask Ms Angela Body to arrange for Dr Rice to be flown from Guernsey.

Approx 3.30pm

Mr Kynman goes to Ms Body's office, and she tells him that a day surgery patient needs to be transferred to Bournemouth immediately for emergency vascular surgery as a major blood vessel has been punctured during an elective hysteroscopy. She says they are trying to fly in a vascular surgeon from Guernsey.

3.34pm

Mr Allardice is called on his mobile by Mr Ingram and leaves immediately. Dr Lane tells Mr Rourke that Mr Allardice is on his way. Mr Rourke goes to the ward where he works, Portelet.

3.45pm

While Ms Body is on the phone Mr Kynman establishes that the next scheduled flight from Guernsey is at 5.30pm. This is an unacceptable delay so it is planned to charter a plane.

3.50pm - 4.20pm

Mr Allardice arrives and estimates there are 15-20 people in theatre. He sutures small hole B with 5/0 prolene, gaining control of the bleeding. He stops the ferocious bleeding from large hole D with prolene 5/0 sutures but steady bleeding, easily controlled by finger pressure, continues, so the area is packed.

4.00pm

Mr Ingram phones Dr Rice on Guernsey, either to arrange for him to come over, or to be on standby. Mr Rourke returns, is told they are still trying to control the bleeding.

Approx 4.00pm

Dr Lane goes to main theatre to arrange anaesthetic cover for flight to Bournemouth, as patient is cardio-vascularly stable.

4.01pm

Mr MacLachlan unscrubs and writes his notes.

Time unknown

Mr Kynman returns to CCU and starts organising in-flight transfer. Informed that Daniel Fenwick will be in-flight anaesthetist.

4.11pm

Mr MacLachlan leaves theatre. He goes to find Dr Moyano and takes her over to maternity for a while before returning to a cubicle in the day surgery unit area.

4.15pm

Mr Ingram phones Dr Rice again to cancel his attendance.

Approx 4.15pm

Mr Rourke told Mrs Rourke being transferred to Bournemouth. He returns home to collect belongings and passport to travel with her.

4.20pm

Mr Ingram calls Bournemouth intensive care unit to confirm bed status.

4.26pm

Surgeon from Bournemouth calls day surgery unit theatre.

Approx 4.30pm

Packs removed to see if blood had clotted; ferocious bleeding resumes, vein is clamped and further prolene 4/0 sutures applied which controls 90 per cent of the bleeding but almost entirely obstructs the vein, risking gangrene if not dealt with soon by Bournemouth experts. Dr Lane calls back at Dr Ilangovan's request as Mrs Rourke's blood pressure falling. Decision made to pack and close before transfer.

5.10pm

Swabs inserted into cavity.

5.14pm

Sewing up of cavity.

5.29pm

Wound closure staples inserted.

5.30pm

Mr Rourke phoned by sister from day surgery unit and told the plane will leave at 6.30pm.

5.30pm

Mrs Rourke starts to suffer ST depression. This is immediately after the abdomen packs are being inserted before closing abdomen.

5.33pm

Mr Kynman arrives and confirms ambulance and aeroplane organised. Outside the theatre Mr Day provides him with overview and indicates the patient is a member of staff.

Approx 5.35pm

Discussion between Mr Allardice and Mr Kynman about the need to go directly to the airport rather than via ITU for stabilisation.

5.36pm

Mr Kynman and Mr Fenwick take handover from Dr Ilangovan and discuss if patient fit to fly; ECG ischemic, ST segments down, blood pressure low at 70/30, two units of blood in progress and three peripheral lines are in situ with an arterial line and continuous pulse oximetry.

5.36pm

Hypa fix wound dressing applied.

5.40pm

Mr Kynman recalls:

> *"At this point, I would estimate, 17.36 hours I witnessed the patient develop a bradycardia and within the seconds, the arterial trace was lost. I cannot be absolutely sure which doctor, either Dr Fenwick or Dr Govan, checked for a carotid pulse, which the individual concerned stated no pulse was present. I proceed to check the arterial line and the right femoral pulse. No mechanical problem with the arterial line was obvious and I could not palpate a femoral pulse. The patient was in cardiac arrest, as observed on the monitor and was in a non-shockable rhythm, pulse lost electrical activity.*
>
> *CPR was immediately commenced, I administered IV adrenalin, one milligram, one unit of blood was already transfusing rapidly and the second unit was completed. Blood was available in the DSU. As per deducing reversible causes*

for PEA, I openly discussed the four Hs and the four Ts with the multidisciplinary team that was present. I asked Dr Fenwick to oscitate the chest. He verified the airway was intact with bilateral air entry into both lungs. Dr Govan stated the patient was 100 per cent oxygen.

The provisional diagnosis at this point was hypovolemia. Blood resuscitation was in rapid progress. CPR continued throughout with period discontinuation for an assessment. Adrenaline one milligram was administered once every three minutes, discussion ensued around the reversible causes. A blood gas was sent for immediate analysis and Dr Lane examined the abdomen. I noted how extended the abdomen appeared. Dr Lane explained a number of surgical packs had been inserted by the surgeons to stem the bleeding.

The blood gas results were analysed and calcium gluconate was requested. I did not see if this was administered. The Ph on the blood gas was 7.1 kpa. The use of sodium bicarbonate was discussed and Dr Lane requested 8.4 per cent 50mls to be administered, which I did. CPR was continuous throughout the resuscitation, as was the blood transfusion with frequent exchanges of staff undertaking chest compressions.

At approximately 20 minutes into the resuscitation, the rhythm determined the patient was asystolic. Leads were checked, I suggest IV atropine 3mgs and Dr Lane requested this was administered. CPR continued. At the next rhythm check there was the possibility the rhythm was now fine for ventricular fibrillation and I suggested a DC shock. I administered a 200 dual shock, a bradycardic rhythm was observed, and rate was approximately 50. A femoral and radial pulse were detected. The transfusion was maintained.

After approximately a further minute, the patient was observed to go into a similar rhythm, pre-DC shock, query ventricular fibrillation. I administered a further DC shock of 200 duals. A bradycardic rhythm was observed, a femoral and arterial pulse were detected and a period of stabilisation occurred….There was a definitive output, albeit profoundly hypotensive, but there was an

output. On that basis you would continue as and obviously if your working diagnosis is hypovolemia, you would continue to try and establish an adequate circulatory volume."

5.54pm

Mr Rourke is escorted into theatre and spends a few moments with his wife. Mr Kynman explains to him that Mrs Rourke's pulse remains weak and that a blood transfusion is in progress and she remains unstable. He leaves the theatre after one to two minutes.

6.05pm

Mr Allardice writes his notes, with diagrams and remains in theatre until after death is certified, as does Mr Ingram:

"Called by Mr Ingram at 1535 to help; I arrived in theatre 12min later. NPI, JBD & gynae Reg already had performed midline laparotomy for exsanguinating haemorrhage from a hysteroscopic injury of the left common iliac vein.

The LCIA LIlA & LEIA had been mobilised to one side, exploring the LCIV[1] *which had a ragged tear anteriorly, about 1.5cm longitudinal but also bleeding (venous) more posteriorly from some deep internal iliac pelvic veins (also 2nd small hole in LCIV. Control was very difficult. 5/0 and 4/0 prolene suture of the ragged tear. However the vein was now friable and the tear extended distally (caudally) and resuture necessary. The tear lay directly opposite the junction of the LIIV with the LEIV, thus making control v. difficult. After probably* >[more than] *18 units of blood transfusion, further haemostasis was not possible. Pelvic veins could not be controlled.*

*NPI D/W [*discussed with*] vascular surgeon in Bournemouth & decision made that nothing further could be achieved in Jersey and that we should pack & transfer.*

[1] *Left Common Iliac Artery, Left Internal Iliac Artery, Left External Iliac Artery, Left Common Iliac Vein*

Thus 5 small Raytec swabs and 8 30x30 abdo swabs packed in. Minimal bleeding apparent as this was done.

Total of 31/2 hrs was spent trying to achieve control. Abdomen closed 748 x 2 1 layer at 1730hrs and clips to skin. Abdo pack over incision to absorb steady ooze."

6.10pm

Mr Rourke told by Mr Day and Ms Body that Mrs Rourke has arrested and they have managed to bring her back.

6.13pm

Mr Rourke goes into theatre, holds Mrs Rourke's hand and kisses her, before returning to side room.

6.17pm

Mr Ingram tells Mr Rourke they have done everything surgically possible, but her heart is not coping and he thinks she isn't going to make it.

6.20pm

Central line installed.

6.22pm

Resuscitation stopped.

6.25pm

Mrs Rourke declared dead by Dr Lane. Mr Day and Ms Body tell Mr Rourke his wife has died. Ms Dalton arrives and they go into theatre with a priest. Leave after five minutes.

6.25pm to approx 8.00pm

Dr Lane remains in theatre suite, summoning chaplain and counsellor, informing the Deputy Viscount and chief executive of the situation, and asking Mr Day to inform the Viscount's office.

Approx 8.00pm

Dr Lane speaks to police and ensures they view Mrs Rourke in the operating theatre.

Approx 8.30pm

Dr Lane drives Mr Day home.

17 October 2006

Dr Moyano suspended.

19 October 2006

Mr Day suspended.

19 October 2006

Histology report by Dr Peter Southall reads:

> *"Endometrial polyp*
> *CLINICAL DETAILS*
> *Irregular periods and IMB*
> *MACROSCOPIC DETAILS*
> *Piece of grey tissue measuring 15 by 6 by 2mm, plus a 3mm grey fragment*
> *HISTOLOGY*
> *a polypoid fragment of inactive endometrium is present showing diathermy artefact. Pieces of myometrium are also present.There is no evidence of endometrius, hyperplasia or malignancy."*

Mr Forbes says:

"*Endometrial polyps and fibroids are two different entities but the terminology is confused by the use of the term "polypoid" to describe certain fibroids. Technically speaking, a polyp is merely a growth which is attached by a stalk or stem, and anything which has a relatively narrow isthmus of tissue between the growth and its mother tissue is a polyp. An endometrial polyp, therefore, is an outgrowth of lining of the womb on a stalk, while a polypoid fibroid, or a fibroid polyp, is a growth of muscle and fibrous tissue growing out from the wall of the womb on a stalk.*"

21 October 2006

Post-mortem examination, arranged by police on behalf of deputy viscount, carried out by Professor Roche. Fundus of uterus with perforatum, mesentry with perforatum and left common iliac vein and repair preserved.

NB. The post mortem report says she weighed 78kg, which apparently is more likely to be accurate than the 51kg recorded by Ms Pycraft on 10 October. No polyp is found at the time or subsequently:

Professor Roche, who carried out the autopsy, comments:

"*The appearance at autopsy indicated that there was extensive haemorrhage which had tracked around the inferior vena. This combined with the ongoing bleeding gave rise to the compression of the inferior vena cava after packing and closure. This, in a severely compromised patient, was sufficient to reduce venous return further and to precipitate death. However, without packing to produce local pressure, Mrs Rourke would have died from uncontrolled bleeding. Therefore, in my opinion, death was inevitable at this stage*"

"I write this letter: "We started off with one hole and we ended up with many more. Notwithstanding the difficulty of the operation I would like to draw your attention to this", whereupon the Deputy Viscount copied the letter to all parties and included all the surgeons. Two of the surgeons have never spoken to

me again because obviously I said that they made more holes, which I didn't say at all."

23 October 2006

Criminal investigation begins following discussion between the deputy viscount and the attorney-general.

27 October 2006

… all relevant equipment checked by engineers working for suppliers, at the request of the police, and found to be in good working order.

31 October 2006

Second post mortem examination by Dr Al Badri. Uterus and fallopian tubes retained, six waxed tissue samples made.

Appendix F

Dr Moyano's CV and references (retyped)

DOLORES MOYANO ONTIVEROS

MBBS CCST PhD

Curriculum Vitae

1 August 2006

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Education

1969 – 1978: Misioneras de Nazareth School, Barcelona, Spain

1979 – 1985: School of Medicine Residencia Universitaria Vall d'Hebrón
University Autonoma of Barcelona, Spain
Paseo Vall d'Hebron, 119-129, 08035 Barcelona

Qualifications

School: 1984 Baccalaureate, COU

Medical degree: 1985 MBBS (Barcelona, Spain)

Postgraduate qualifications: 1991 MIR exam
1996 CCST in Biochemistry
1997 PhD thesis awarded, *Cum Laudem*
1998 MIR exam: competitive Spanish Public Heath examination (post number 132 out of 20000 people)
2002 CCST in Obstetrics and Gynaecology with Subspecialty in Fetal Medicine

Professional experience

2006	Clinical Attachment in Maternal and Fetal Medicine St Thomas' Hospital Clinical Attachment in Obstetrics
2005 – 2006	Consultant in Fetal Medicine Hospital Clinic of Barcelona Regional Reference Centre for the Department of Health of Catalonia
2003 – 2005	Research Fellow in Fetal Medicine Harris Birthright Research Centre for Fetal Medicine
2002 – 2003	Junior Consultant in Fetal Medicine and Obstetrics Hospital Clinic of Barcelona
1998 – 2002	Specialist Registrar in Obstetrics and Gynaecology Hospital Clinic of Barcelona
1996 – 1997	Research Fellow in Biochemistry Hospital Universitari Sant Joan Déu

1992 – 1996 Specialist Registrar in Biochemistry
Hospital Universitari Sant Joan Déu

1985 – 1991 GP in Emergency Department
Costa Ponent Baix Llobregat
Barcelona

1989 – 1990 Intern in Gastroenterology
Hospital Sta Creu i Sant Pau
Avd Padre Claret
08025 Barcelona

1986 – 1988 Intern in Internal Medicine
Hospital Cruz Roja
Hospitalet de Llobregat
Barcelona

Clinical Experience

After being awarded my medical degree, I worked as a General Practitioner in a Public Health Emergency Department in Barcelona for six years. During this time I also completed two years training in the Departments of Internal Medicine and Gastroenterology in the Hospital Cruz Roja Hospitalet and the Hospital Sta Creu i Sant Pau, Barcelona.

After passing the board examinations for specialist training, I trained in Biochemistry for four years, working in the Hospital Universitari Sant Joan de Déu, Barcelona, a tertiary reference centre for paediatric inborn errors of metabolism. I was closely involved in the introduction of the maternal serum screening for Down´s syndrome that we established at the hospital. I studied metabolic changes in children with enzymatic defects and problems of hepatitis C and HIV as well as pregnancies and fetuses at risk of maternal and fetal conditions. This stimulated my interest in Obstetrics and Gynaecology and after passing the competitive Spanish Public Health board examination for specialist training, I trained as a specialist registrar (Sp R) in Obstetrics and Gynaecology at Hospital Clinic of Barcelona and then worked as a consultant in Fetal Medicine and Obstetrics.

Obstetrics

The Hospital Clinic of Barcelona (HCB), is the regional reference centre for the Department of Health of Catalonia and has the best academic record in Spain. The Obstetric Unit is also one of the most important units in obstetric and fetal medicine in Spain. It is a tertiary reference centre for fetal diagnosis and intrauterine therapies and other maternal medical conditions that complicate pregnancies. The unit has world recognition for intrauterine fetal therapy, shunts, laser ablation in twin-twin transfusion syndrome (TTTS) and diaphragmatic hernia procedure. The Department manages 4,500 confinements a year supported by a Neonatal Centre of excellence for the referral of extreme preterm newborns and other neonatal complications.

During my SpR training, I worked in Obstetric and Gynaecological clinics, looked after inpatients in both services, and covered the labour ward and the operating lists. I attended approximately 500 deliveries, including spontaneous vaginal delivery,

instrumental deliveries (mid rotational kjelland forceps and low forceps) and caesarean section (planned, prematurity, full dilation, emergency, in twins: breach, grand extraction), breach delivery and cerclage. Due to my specific interest in fetal and maternal medicine, during the third and four year period, I was involved in the care of obstetric patients in the high dependency unit (HDU), I cared for women with pregnancy-specific disorders such as pre-eclampsia (PET), intra-uterine growth restriction (IUGR), threatened preterm labour, preterm rupture of membranes, multiple pregnancy and maternal conditions such as diabetes, systemic lupus erythematosus (SLE), renal disease and HIV etc. The on-call rota involved cover for emergencies for approximately 6 days every month and during this time I would be responsible for labour ward, the HDU and the review and / or admission of approximately 50 obstetric or gynaecological patients and management of early pregnancy complications, like miscarridge, dilatation and curettage (D&C), ectopic pregnancy surgery and the termination of pregnancy.

My work at HCB gave me the opportunity to collaborate with professionals from many other fields. HCB is a public hospital and I treated patients from a wide range of social and cultural backgrounds. The Department I worked in was the referral center for victims of rape in Barcelona, who were examined in the presence of a pathologist. It is also the referral unit for pregnancies affected by AIDS. I therefore have considerable experience of dealing with a wide mix of different situations, racial groups, social classes and I am familiar with a wide range of pathology. I had close contact with colleagues from many departments including Infectious illnesses, psychiatry, GPs, police, pathology, social workers, as well as obstetricians from other hospitals.

Gynaecology

Although I no longer practice general gynaecology, most of my experience was gained during four years of general registrar training in Obstetrics and Gynaecology. This included modules covering gynaecological surgery (at least one list a week), gynaecology and breast oncology, endocrinology and infertility. The surgical procedures I performed included laparoscopies, hysteroscopy, vaginal surgery as well as open abdominal procedures (hysterectomy, myomectomy) and minimal access

surgery. During my subspecialist period I continued to provide gynaecological cover on call.

Fetal Medicine

After completing my training in Obstetrics and Gynaecology I specialised in Fetal Medicine and worked as a consultant in the Prenatal Diagnosis Department of HCB. The Department pioneered the introduction of screening for Down's syndrome and a One Stop Clinic for the Assessment of Risk for trisomy 21 at 11-14 weeks, in Spain. My duties involved principally scanning high-risk patients (First trimester nuchal scans, 20 week anomaly scan, fetal well-being, serial growth and early pregnancy). I was responsible for over 60% of the invasive procedures CVS and amniocentesis and assessing management and follow-up with Doppler and / or cordocentesis of pregnancies affected by Rhesus alloimmunization and other causes of anaemic fetuses and fetal infections. Also the diagnosis and evaluation and counselling of chromosomal abnormalities and termination of pregnancy. I worked with a multidisciplinary team of geneticians, physicians, microbiologists, haematologists biochemists and pathologists, as well as paediatricians and other obstetricians subspecialized in chronic maternal illness' such as SLE, Diabetes and HIV. Other duties included running the weekly labour ward, the HDU, the elective caesarean section list, the care of obstetric inpatients and emergency obstetric and gynaecological patients.

I decided to come from Barcelona to London for further study at the Harris Birthright Research Centre for Fetal Medicine, King´s College Hospital (KCH) under the supervision of Professor Nicolaides, for more advanced learning of Fetal Medicine and particularly fetal heart defects with Professor Allan. I consider it is the most pioneering and advanced place in the world to train in this new subspecialty.

The Harris Birthright Centre for Fetal Medicine (HBRC) is a tertiary referral centre for Fetal Medicine, in the South East of England with a work load of over 40,000 patient episodes a year. The unit is also responsible for the routine obstetric ultrasound care of 4,000 women booked for delivery at KCH. During my period over two years of research fellow I have considerable exposure to a variety of obstetric and fetal medicine ultrasound problems. I performed routine lists the included first trimester NT assessment, 20/23 week anomaly scans, together with screening for preterm delivery

and PET, and third trimester scans for fetal wellbeing. Tertiary scans include risk assessment for chromosomal abnormalities, assessment of fetal anomalies, ongoing management of fetal anomalies requiring surgical repair after delivery and invasive procedures such as CVS, amniocentesis, cordocentesis, intrauterine transfusion, shunts and laser ablation in TTTS. As research fellow with a lot of experience in fetal heart I carried out most of the fetal heart evaluation in the low risk population. During my fellowship I performed CVS and amniocentesis. My special interest is in fetal heart abnormalities and I worked with Professor L Allan in the Fetal Cardiology Unit at HBRC. During my fellowship I developed my fetal heart scanning skills studying and participating in the diagnosis, assessment and counselling of a wide spectrum of congenital heart defects. Professor Allan gave me total responsibility to run the Fetal Heart Unit when she was not in the department.

Maternal Medicine

I was requested to return to Spain by the head of obstetrics and gynaecology at HCB to work as a senior consultant and cover study leave for the head of the prenatal diagnosis unit. But then I returned to London because it is my decision to establish my career in the UK, where foetal and obstetric medicine to me, is the most stimulating. I therefore attended the Obstetric Units of KCH and St Thomas' Hospital as a clinical attachment.

At KCH I assisted in the labour round every day, in HDU, in the maternal assessment unit and the high-risk Antenatal clinic (ANC) run by Ms L Penna. I also worked for a period of three weeks as an internal locum SHO, with in and out patients I attended labour ward and carried out caesarean sections and repaired perineal lacerations and D&G. I observed at meetings and teaching of cCTG and skill & drills in shoulder dystocia, breech delivery and massive obstetric haemorrhage, miscarriage, etc.

In St Thomas' Hospital as clinical attachment in maternal medicine, I was able to review UK management of pregnancies complicated by maternal conditions because it is a referral centre for high-risk maternal conditions and there is a high prevalence of cardiac disease secondary to rheumatic fever and HIV and SLE. They serve one of the

most socio-economically deprived populations in Europe and this is reflected in the problems faced in Obstetric care.

I had the opportunity to work in the ANC with C Nelson-Piercy, Ms Langford and K Head, with maternal cardiac disease. Also in preterm delivery, renal, HIV, PET with Prof Sheenan and Ms Harding, I worked with C Nelson-Piercy again and Dr S Bewley in Lupus clinic, including HIV and vaginal birth after caesarean delivery. At the Diabetic clinic run by Mr Ask. I observed the labour ward and the HDU, where Pre-Eclampsia and abruption and postpartum haemorrhage are common complications. There is a high incidence of these conditions in both south London hospitals.

These attachments gave me further experience in NHS clinical management, a wider spectrum of obstetric high-risk management, and a wide variety of clinical situations that only this complex population can present. I found the experience thought provoking and rewarding.

Research Experience

In the UK, I worked on fetal monitoring in growth restricted fetuses, relating biophysical parameters and Doppler evaluation and participating in their clinical management. During my training in Spain and at the HBRC I developed two areas of special interest within fetal medicine. Firstly, I have been closely involved in the Fetal Growth Restriction clinic run by Dr S Bower at HBRC, offering a clinical service and collecting research data. This has included developing research protocols and gaining ethics approval for an international multicentre study being coordinated by Dr A Baschat. The results of the study is a paper in review. Secondly, I spent part of my research fellowship working directly with Professor L Allan in the Fetal Heart Unit, reviewing all the ecocardiography tapes of trisomy 18 diagnosed during the last 5 years. The data was presented in an international congress (ISUOG 2004) and a paper published. It is the largest series of cardiac abnormalities in trisomy 18 to date.

I have participated in research groups related to Maternal-fetal Medicine in HCB collecting data, such as uterine artery Doppler in first and second trimester, fetal heart and screening for Down’s syndrome, threatening preterm delivery.

During my period in Biochemistry I worked in the fields of paediatrics and obstetrics with the maternal serum screening for Down's syndrome and with inborn errors of intermediary metabolism in infants, also amniotic fluid markers in fetuses affected by growth retarded intrauterine restriction. I developed my PhD thesis in anorexia nervosa's nutritional state.

Grants (Spain)

1994 – 1995 Collaborator on:
'Biochemical markers in amniotic fluid for antenatal outcome in fetuses affected of growth retarded intrauterine restriction.'
Spanish Public Health System – FISss 94/1365

1996 'Evaluation of nutritional state in Anorexia Nervosa.'
Hospital Universitari Sant Joan de Déu, Barcelona
Special award given to the 15 best projects

1996 – 1997 Salary as research Fellow (award)
Department of Biochemistry, Hospital Universitari Sant Joan de Déu, Barcelona

Prizes

1998 Antioxidant state in Anorexia Nervosa.
Prize Alexandre Frias y Riog
Catalonia Society of Paediatrics, Spain

Ethics Committee Applications

1996 Evaluation of nutritional state in Anorexia Nervosa
Hospital Universitari Sant Joan de Déu, Barcelona, Spain

2004 Fetal monitoring in growth restricted fetuses: relating biophysical parameters and Doppler evaluation to perinatal outcome: a multicentre observational cohort study.
Harris Birthright Research Centre for Fetal Medicine, King's College Hospital Ref 04/Q0703/88

Teaching experience

When I was consultant in Fetal Medicine in HCB I was closely involved in teaching and supervising colleagues carrying out CVS and amniocentesis. I gave tutorials to final year SpR's in fetal ultrasound. The Prenatal Diagnosis Department is a reference teaching school for transvaginal CVS.

As a final year SpR the hospital required me to be responsible for the training of two junior registrars and GP trainees every day for a period of 4 months in the labour ward, in HDU and in Obstetric and Gynaecology emergency. I supervised them to carry out all the procedures and assessments required. I was expected to report to my consultants when I considered it necessary.

As a senior doctor at the HBRC, I was involved in the supervision of the junior fellows, teaching fetal and maternal ultrasounds skills, fetal echocardiography skills and checking their scans. I supervised their training for counselling patients on the risk assessment for Down's syndrome.

I was also involved in the ongoing nuchal translucency audit that is used to assess the clinical service at King´s College Hospital. My personal data met the audit standard.

I worked closely with Mr J Hyett in the Placental and Fetal Doppler Assessment Audit for the Accreditation of the Doppler Certification of the Fetal Medicine Foundation during 2004 and 2005.

Other teaching commitments have included lectures in Spain and in the monthly meetings at the HBRC. I presented at sessions in the Perinatal Meeting at King´s College Hospital during my period working in the Obstetrics Department.

Management Experience

I was involved in committee work for the Fetal Malformations committee and the Perinatal Mortality Committee. This involved evaluating the management of the care with a multidisciplinary team in order to rectify and improve standards on a continual basis, implementing or updating protocols when needed. I participated in the development of clinical protocols such as Rhesus alloimmunization management and the review of old protocols at the HCB.

As a Dr John at HBRC, KCH, I was responsible for the junior fellows team and running the day clinic.

Postgraduate training

Advance Life Support Obstetrics Certification, North Tees, UK 22-23 July 2006

Fetal echocardiography and Theoretical course in Fetal Medicine FMF, London, 3-4 Nov 2005

Certificate of Competence in invasive procedures, FMF, London, June 2005

Intensive Advance practical course for certificate of competence in Fetal Cardiology, FMF, London, 14-18 June 2004

II Advanced Course in Fetal Medicine, FMF, Limassol, Cyprus,23-26 June 2004

Certificate of Competence in Fetal echocardiography, FMF, London, 2003

Fetal echocardiography course, FMF, London 2003

Certificates of Competence in ultrasound in 11-14 week, 18-23 week, Doppler Placenta-Fetus, Cervical assessment, Nasal bone. FMF London, 2003, 2004, 2005

First trimester ultrasound course, 18-23 week ultrasound course, Doppler Placenta-Fetus course and cervical assessment. FMF, London, 2003, 2004, 2005

Subspecialist Qualification in Obstetric and Gynaecological Ultrasound, Level III (high level ultrasound and Doppler studies), Spanish Society Ultrasound, 2003

Diploma in Fetal Medicine, Fetal Medicine Foundation, 2002

I Advanced Course in Fetal Medicine, FMF, Kalamata, Greece,1-5 July 2002

Certificates of Competence in First trimester ultrasound, FMF of America, NY 2002

Fetal Medicine Course, Clinical Hospital, Barcelona, Spain 23-25 May 2002

IX Intensive Course in Gynaecology and Breast Oncology , 10-15 November 2001. Lloret de Mar, Barcelona, Spain

III Echography Course in Obstetrics and Gynaecology, H. Clínic. Barcelona, 2-4 May 2001

Cervical and vulvar pathology course, Barcelona 2000

II-IV Doppler Course in Gynaecology, Obstetrics and Fetal Echocardiography, H. Clínic. Barcelona, Spain, 2-4 May 2000 and May 2002

Postgraduate Course of Sciences of Human Physiology and Nutrition, University of Barcelona, 1993-1995

Diabetic management course, Hospital Cruz Roja de Hospitalet. Barcelona,1987

Cardiac resuscitation course, Hospital Cruz Roja de Hospitalet, Barcelona1986

Publications

1. Baschat A, Cosmi E, Bilardo K, Wolf H, Berg C, Rigano S, Germer U, Moyano D, Bower S, Nicolaides K, et al. Intervention thresholds for early onset placental dysfunction (in review)

2. Moyano D, Huggon IC, Allan LD. Fetal echocardiography in trisomy 18. Arch Chilhood Disease. 2005; Nov;90(6):F520-2

3. Moyano D, Sierra C, Brandi N, Artuch R, Mira A, García-Tornel S, Vilaseca MA. Antioxidant status in anorexia nervosa. Int J Eat Disord 1999; Jan; 25(1):99-103

4. Moyano D, Vilaseca MA, Artuch R, Lambruschini N. Plasma amino acids in anorexia nervosa. Eur J Clin Nutr. 1998 Sep;52(9):684-9

5. Moyano D, Vilaseca MA Artuch R, Valls C, Lambruschini N. Plasma total-homocysteine in anorexia nervosa. Eur J Clin Nutr. 1998; Mar 52(3): 172-5

6. Moyano D, Vilaseca MA, Pineda M, Campistol J, Vernet A, Poo P, Sierra C. Tocopherol in inborn errors of intermediary metabolism. Clin Chim Acta 1997; Jul 25; 263(2): 147-55

7. Vilaseca MA, Moyano D, Artuch R, Ferrer I, Pineda M, Cardo E, Campistol J, Pavia C, Camacho JA. Selective screening for hyperhomocysteinemia in pediatric patients. Clin Chem. 1998;Mar; 44(3): 662-4

8. Sierra C, Vilaseca MA, Moyano D, Brandi N, Campistol J, Lambruschini N, Cambra FJ, Deuflofeu R, Mira A. Antioxidant status in hyperphenylalaninemia. Clin Chim Acta. 1998; Aug 10;276 (1):1-9

9. Vilaseca MA, Moyano D, Ferrer I, Artuch R. Total-Homocysteine in a pediatric population. Clin Chem 1997; Apr 43(4):690-2

Spanish Journals

10. Llopart R, Ferrer I, Artuch R, Moyano D, Pavía C, Ordóñez J. Relación de la lipopro teína (a) con el control metabólico en la diabetes mellitus infanto-juvenil. J An Esp Pediatr 1996; 44: 7-10

11. Moyano D, Valls C, Pavía C, Ramón F. Valores de referencia de diversas magnitudes hormonales en niños clasificados por estudios puberales. Quím Clín 1996; 15: 72-6

12. Moyano D, Vilaseca MA, Pineda J, Ramón F. Red blood cell tocopherol in a normal pediatric population. Quím Clín 1995; 14: 226

13. Moyano D, Vilaseca MA, Sierra C, Artuch R, Brandi N, Pineda M, Campistol J, Ramón F. Evaluation of oxidative stress in inborn errors of intermediary methabolism by determination of red blood cell tocopherol. Quím Clín 1995; 14: 271

14. Sierra C, Brandi N, Vilaseca MA, Moyano D, Artuch R, Mira A, Pineda M. Antioxidant enzyme activities in inborn errors of intermediary metabolism. Quím Clín 1995; 14: 271

15. Ferrer I, Llopart R, Moyano D, Pavía C, Farré C, Ordóñez J.Lipoproteína (a) [Lp (a)]: Concentraciones en niños con diabetes mellitus insulino dependiente. Medi Clín 1995; 104: 564-67

16. Toro H, Gonzalez P, Moyano D, Villanueva C, Enriquez J. [Splenic rupture in the course of pancreatitis. Rev Esp Enferm Dig. 1993 Jan;83(1):51-2

Poster Presentation

International Meetings

Integrating Doppler and biophysical parameters in management of intrauterine growth restriction:MCA Doppler is irrelevant. A Baschat, M Kush, A Manogura, D Moyano, STuran, S Bower, K Nicolaides, U Gembruch, et al. SMFM 26th, Miami, January 2006

Relationship between low growth potential and perinatal outcome. A Baschat, M Kush, S Turan, D Moyano, C Berg, T Mueller, U Gembruch, S Bower, K Nicolaides, et al. SMFM 26th, Miami, January 2006

Integrated fetal testing is the most accurate predictor of perinatal outcome in intrauterine growth restriction .A Baschat, M Kush, A Manogura, D Moyano, S Turan, S Bower, K Nicolaides, et al. SMFM 26th, Miami, January 2006

Predictors Of Necrotizing Entercolitis In Fetal Growth Restriction. A Manogura, M Kush, D Moyano, S Bower, K Nicolaides, C Harman, U Gembruch, A Baschat, et al., SMFM 26th, Miami, January 2006

cCTG in of intrauterine growth restriction. A Baschat, M Kush, STuran, D Moyano, U Gembruch, S Bower, K Nicolaides, et al.SMFM 26th, Miami, January 2006

Fetal echocardiography in trisomy 18 fetuses, Moyano D, Huggon I, Allan L, Kings College Hospital, 14th World Congress UOG, Stockholm, Sweden, 31-August-5-September 2004

Prospective uterine artery Doppler evaluation at first and second trimester in 54 pregnancies complicated by preeclampsia and IUGR. D Moyano, O Gómez, M Del Río, JM Martínez, M Palacio, B Puerto, V Cararach. 12th World Congress UOG NY, 2-7 November 2002

Echocardiography should be also performed during the third trimester in fetuses of pregestational diabetic mothers. B Puerto, JM Martínez, O Gómez, D Moyano, M

Palacio, S Martínez, A Borrell, V Cararach. 11th Wold congress on UOG. Melbourne, Australia, 23-28 October 2001

Fetal echocardiography in fetuses of pregestacional diabetic mothers. Moyano D, Martínez JM, Gómez O, Martínez S, Puerto B, Borrell A, Palacio M, Cararach V. 5th World Congress of Perinatal Medicine. Barcelona, Spain, 23-27 September 2001

Screening for total-Homocysteine in a pediatric patients. Vilaseca MA, Moyano D, Artuch R, Ferrer I, Pineda M, Cardo E, Campistol J, Pavía C, Camacho JA. 7th International Congress of Inborn Errors of Metabolism. Vienna, Austria 21-25 May 1997

Antioxidant status in Anorexia Nervosa. Moyano D, Sierra C, Brandi N, Vilaseca MA, Mira A, Lambruschini N, García-Tornel S. VIII Biennial Meeting International Society for Free Radical Research. Barcelona, Spain 1-5 October 1996

Antioxidant status in inborn errors of intermediary metabolism. Moyano D, Vilaseca MA, Pineda M, Campistol J, Vernet A, Poo P, Sierra C. Journal of Inherited Metabolic Disease. SSIEM 34 th Annual symposium. Cardiff, UK. 10-13 September 1996

Antioxidant status in Phenylketonuria. Sierra C, Mira A, Vilaseca MA, Moyano D, Brandi N, Artuch R, 12Th IFCC European Congress on Automation and New Technology in Clinical Chemistry. London, UK. July 1996

Reference values of different hormonal parameters in normal children classified according to puberal stages. Moyano D, Valls C, Pavía C, Ramón F. 11Th IFCC European Congress on Automation and New Technology in Clinical Chemistry, Tamper. Finland June 1995

Antioxidant damage in mitochondrial diseases. Vilaseca MA, Moyano D, Sierra C, Brandi N, Mira A, Artuch R, Campistol J, Pineda M. 3rd International Meeting on Human Mitochondiral Pathology. Chantilly, France. September 1995

Antioxidant enzyme activities in inborn errors of intermediary metabolism. Sierra C, Brandi N, Vilaseca MA, Moyano D, Artuch R, Mira A, Pineda M. VI International Congress on Automation and New Technology in Clinical Laboratory. Sitges, Spain November 1995

Red blood cell tocopherol in a normal pediatric population. Moyano D, Vilaseca MA, Pineda J, Ramón F. VI International Congress on Automation and New Technology in Clinical Laboratory. Sitges, Spain November 1995

Evaluation of oxidative stress in inborn errors of intermediary methabolism by determination of red blood cell tocopherol. Moyano D, Vilaseca MA, Sierra C, Artuch R, Brandi N, Pineda M, et al. VI International Congress on Automation and New Technology in Clinical Laboratory. Sitges, Spain November 1995

Poster in National Meetings

FIV. Doble gestación ectópica y tratamiento con methotrexate. D Moyano, JM Martínez, O Gómez, B Puerto, J Balasch. XXI Congreso USS SEGO. Barcelona, 2-3 Noviembre 2000

Aminoácidos plasmáticos relaciones como expresión del estado nutricional en la Anorexia Nerviosa. Moyano D, Vilaseca MA, Puig R, Moreno J, Artuch R, Ramón F. XV Congreso Nacional SEQCPM Madrid, Spain 31 October-2 November 1996

La Homocisteína total marcador deficiencia folato en la Anorexia Nerviosa. Moyano D, Vilaseca C, et al. XV Congreso Nacional SEQCPM. Madrid, 31 October-2 Novembre 1996

Estudio de la Osteocalcina y Fosfatasa Alcalina Ósea en la Anorexia Nerviosa. Moyano D, Valls C, et al. XV Congreso Nacional SEQCPM. Madrid, 31 October-2 November 1996

Determinación de Homocisteina total por HPLC con detección fluorimétrica: Valores de referencia en la edad pediátrica. Vilaseca MA, Moyano D, Artuch R, Ferrer I, Ramón F. XV Congreso Nacional SEQCPM. Madrid, Spain. 31 October-2 November 1996

Determinación glucosaminoglicanos orina espectrometría. Valores referencia pediatría. Artuch R, Quintana M, Vilaseca MA, Moyano D, XV CN SEQCPM. Madrid, 31 Oct-2 Nov 1996

Estrés oxidativo en el Síndrome de Rett. Sierra C, Brandi N, Mira A, Vilaseca MA, Artuch R Moyano D, et al. XV Congreso Nacional SEQCPM Madrid, 31 October-2 November 1996

Inmunoglobulina E y ferritina: comparación de tres métodos analíticos. Artuch R, Ferrer I, Moyano D, Ramón F. XIII Congreso Nacional SEQC. Salamanca, October 1994

Valores referencia de diversas magnitudes hormonales en niños clasificados por estadios puberales. Moyano D, Valls C, Pavía C, Ramón F. XIII C N SEQC Salamanca, October 1994

Anticuerpos antigliadina: comparación de dos técnicas por enzima inmunoensayo. Artuch R, Hernández A, Farré C, Ferrer I, Moyano D, et al. XII C N SEQC Murcia, 29-31 October 1993

Estudio Comparativo de deferentes métodos para la derminación de Glicohemoglobina. Moyano D, Ferrer I, Artuch R, Farré C, Ramón F. XII C N SEQC Murcia 29-31 October 1993

Actividad Alanina aminotransferasa y perfil analítico preoperatorio. Artuch R, Farré C, Moyano D, Ferrer I, García-Tornel S, Lázaro J, Ramón F. XII C N SEQC Murcia, 29-31 October 1993

Assistance at meetings and congress

14th World Congress on UOG, Stockholm, Sweden, 31 August-5 September 2004

First, Second and Third World Congress in Fetal Medicine Athens, Greece, 28-30 June 2002 and Lisbon, Portugal 23-26 June 2003, and Limassol, Cyprus, 20-22 June 2004

Lecture: *Diagnostic and screening of Down´s syndrome from the FMF* at the IV Curso teórico práctico sobre Ecografía en Obstetricia y Ginecología, H. Clínic of Barcelona, 13 Sept 2003

12th World Congress on Ultrasound in Obstetrics and Gynaecology, NY, 2-7 November 2002

5th World congress of perinatal medicine. Barcelona, Barcelona, 23-27 September, 2001

XXI Congress of Echography of the SESGO, Barcelona. Spain, 2-3 November 2000

XV National Congress of the Spanish SCCMP. Madrid, Spain, 31 Octuber-2 November 1996

34th Annual symposium SSIEM. Cardiff, UK, 10-13 September 1996

VI International Congress Automation New Technology CL. Sitges, Spain. November 1995

XVI National Congress of the SS Endocrinology Paediatric.Toledo, Spain, 30 May -1 June 1994

I Catalonya Congress Sciences C Laboratory, H Bellvitge Barcelona, Spain, 16-18 June 1994

XII National Congress of the Spanish Society of CC, Murcia, Spain, 29-31 October 1993

Career intentions

I am looking for an appointment in Fetal Medicine and Obstetrics in the UK rather than in Spain because I consider the UK medical system to have the best standard of care and to be the best example of modern medicine in the world. After my experience at Harris Birthright Centre I am most interested in the diversity of the population and the variety of pathology it presents. I find the wide range of ethnic, cultural and socio-economic groups and the problems faced in their obstetric and fetal care most challenging and rewarding.

I am particularly interested in the provision of high quality services for prenatal diagnosis of chromosomal abnormalities, to screen for obstetric complications and in the management of fetal structural anomalies.

I am keen to continue my skills in the diagnosis of fetal heart defects.

Referees

Dr Sarah Bower
Consultant in Fetal Medicine
Harris Birthright Research Centre for Fetal Medicine

Professor Lindsey Allan
Professor in Fetal Cardiology
Harris Birthright Research Centre for Fetal Medicine

Dr Oriol Coll
Head High Risk Unit Maternal-Fetal Medicine
Hospital Clinic Casa de la Maternitad of Barcelona

Ms Leonie Penna
Consultant Obstetrics & Fetal Medicine,
Department of Obstetrics, King's College Hospital

References

Karina Leed

From: Bower, Sarah
Sent: 08 August 2006 17:52
To: Karina Leed
Subject: RE: URGENT - reference request on Dr Dolores Moyano

This e-mail has been received directly from the Internet: you should exercise a degree of caution since there can be no guarantee that the source or content of the message is authentic.

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I enclose your form completed as far as possible. My comments are limited as you will see from the reference that I only worked with Dolores in a fetal medicine capacity and cannot comment on her general Obstetric and Gynaecology skills.

Sarah Bower

From: Karina Leed [mailto:K.Leed@health.gov.je]
Sent: Tue 08/08/2006 11:25
To: Bower, Sarah
Subject: URGENT - reference request on Dr Dolores Moyano

<<Reference request.3.doc>>

Due to start in post on Monday 14th August 2006 if satisfactory references received.

Many thanks

Karina Leed | Medical Staffing Assistant
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T: +44(0)1534 622775 | F: +44(0)1534 622198

09/08/2006

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Strictly Private & Confidential

By Email

Dr Sarah Bower
Consultant in Fetal Medicine
Harris Birthright Research Centre for Fetal Medicine

8 August 2006

URGENT – DUE TO START IN POST ON MONDAY 14TH AUGUST 2006, SUBJECT TO SATISFACTORY REFERENCES

Dear Dr Bower

Applicant's name: Dr Dolores Moyano **DOB: 20.04.1960**

Post applied for: Locum Consultant, Obstetrics & Gynaecology

Does the applicant work in your firm - YES/NO?

Please give the following information regarding applicant's employment with you:

Position:......Research Fellow in fetal medicine..

Dates employed:...

PLEASE TICK THE APPROPRIATE BOX

	Excellent	Good	Satisfactory	Poor
Timekeeping	yes			
Clinical Ability	yes			
Suitability for the post applied for	Yes *			
Sickness Record	yes			
Relationship with colleagues/nursing staff	yes			
Interpersonal skills	yes			

Please indicate practical procedures in which the applicant is competent:
....
......see attached reference..
......* I cannot comment on general O and G skills......

General opinion of the applicant:

......see attached reference..

Would you recommend the applicant for this post?

Strongly	
Support	yes
Reservations	
Not recommend	

Would you re-employ the applicant

Yes...

Your name: Sarah Bower................................

Your post:...Fetal Medicine Consultant.......................................

Signature:..

Date:...

Many thanks for your help.

Yours sincerely

Karina Leed
Medical Staffing Assistant

20.7.2006

re: Dolores Moyano

To whom it may concern:

Dolores worked as a Research Fellow at the Harris Birthright Research Centre for Fetal Medicine for over two years. During that time she improved her ultrasound skills and she has become a highly skilled sonographer. She is able to perform first and second trimester scans, including cervical length assessment and fetal echocardiography, at a highly competent level. She is also competent at performing CVS and amniocentesis.

She is a punctual and reliable member of the team and is a popular with colleagues and patients alike. She is a very good communicator and is kind and sympathetic to patients. To my knowledge Dolores is not under investigation for any disciplinary matters.

She is interested in research and I have worked with her in a dedicated Fetal Growth restriction clinic. She is highly skilled at fetal Doppler ultrasound assessment. She has evaluated numerous fetal anomalies and is conversant with their management.

She has worked extremely hard and has been a valuable member of the department. I will miss working with Dolores and wish her every success in the future.

Sarah Bower MD MRCOG
Fetal Medicine Consultant
Harris Birthright Research Centre for Fetal Medicine

Health and Social Services Department
Human Resources
General Hospital, Gloucester Street
St Helier, Jersey, JE1 3QS
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Email: K.Leed@health.gov.je

HEALTH & SOCIAL SERVICES
14 AUG 2006
HUMAN RESOURCES

Strictly Private & Confidential

By Email

Ms Leonie Penna
Consultant Obstetrics & Fetal Medicine
Department of Obstetrics, Kings College Hospital

8 August 2006

URGENT – DUE TO START IN POST ON MONDAY 14TH AUGUST 2006, SUBJECT TO SATISFACTORY REFERENCES

Dear Ms Penna

Applicant's name: Dr Dolores Moyano **DOB: 20.04.1960**

Post applied for: Locum Consultant, Obstetrics & Gynaecology

Does the applicant work in your firm YES/NO? (NO circled)

Please give the following information regarding applicant's employment with you:

Position: LOCUM SENIOR HOUSE OFFICER / RESEARCH FELLOW

Dates employed: 2 WEEKS 2001 ↑ ... 2003-2005 ↑

PLEASE TICK THE APPROPRIATE BOX

	Excellent	Good	Satisfactory	Poor
Timekeeping	✓			
Clinical Ability		✓ (as SPR)		
Suitability for the post applied for				I have not worked with [illegible] capacity
Sickness Record	✓			
Relationship with colleagues/nursing staff		✓		
Interpersonal skills		✓		

Please indicate practical procedures in which the applicant is competent:
General labour ward management
General fetal medicine skills
She has not worked in Gynaecology
to any significant degree in this trust

General opinion of the applicant:

Dalones is an extremely good doctor. English is not her first language and she works hard to ensure she communicates effectively

Would you recommend the applicant for this post?

Strongly	
Support	
Reservations	✓
Not recommend	

I have not worked with her in a senior capacity & so cannot comment adequately on her skills although she has worked in Spain as a consultant

Would you re-employ the applicant

Yes – At Registrar level

Your name: LEONIE PENNA

Your post: CONSULTANT

Signature: Leonie P

Date: 8/8/06

Many thanks for your help.

Yours sincerely

Karina Leed
Medical Staffing Assistant

Appendix G

Surgical procedures involving Dr Moyano (excluding 17 October 2006)

Patient ID	Date-06	Operation	Surgeon	Anaesthetist	Others present	Outcome	Comment
196231	22/8	Hysteroscopy	Roy (locum)	Unknown			Notes written by Dr M
104449	25/8	Sacrocolpopexy	NM	Unknown	Dr M	Uneventful	Dr M assisting
156117	25/8	Laparoscopic ovarian cystectomy	NM	Unknown	Unknown	Unknown	No mention of Dr M
041380	12/9	Hysteroscopy	Dr M	Unknown	Unknown	Uneventful	
210848	12/9	Colposcopy, Hysteroscopy, Laparoscopy	Dr E-F			False passage formed	Dr M not involved in the operation: only attended patient to discharge her home
294125	2/10	Hysterectomy BSO	Dr D	Unknown	Dr M	Uneventful	Dr M assisting
110555	2/10	EUA and smear	Dr M	Thomsen	Dr D	Uneventful	Dr D assisting
011293	2/10	EUA, Hysteroscopy, curettage	Dr M	Unknown	Dr D Dnes	Uneventful	Dr D, Dr Dnes assisting/present
243268	2/10	Episiotomy repair	Dr M	Unknown	Unknown	Uneventful	
137849	2/10	Hysteroscopy	Dr D	Unknown	Dr M		Dr M assisting
431380	3/10	Laparoscopy, Hysteroscopy, Dye studies	Dr D (L) Dr M (H)	Dr I	Unknown	Uneventful	
120824	3/10	Hysteroscopy	Dr D supervising Dr M	Dr I	Unknown	Uneventful	
042302	3/10	Laparoscopy, hysteroscopy	Dr D supervising	Unknown	Dr M	Uneventful	

			Dr M				
092636	4/10	Laparoscopy, hysteroscopy	Dr D (L) Dr M (H)	Unknown	Dnes	Infected scars	
189803	8/09	Laparoscopy, laparotomy	NM	Unknown	Dr M assisting.		No notes (PP)
286524	9/10	ERPC	Antaskiris	Thillai	Dr M	Uneventful	Dr M assisting
121465	13/10	Caesarean section	Dr M	Fenwick	Dr Cooper	Uneventful	
441578	13/10	Third degree tear repair	Dr M	None	Unknown	Uneventful procedure and recovery	Normal vaginal delivery, conducted by midwife
960618	13/10	Caesarean section	Dr M	Unknown	Dr Dnes, JD, Dr A	Tear in Caesarean section incision	Repaired by Dr A and JD
026154	16/10	Revision of scar	JD	Unknown	Dr M	Uneventful	
031805	16/10	Vaginal repair	Dr M	Unknown	JD	Uneventful	

Key:

PP – private patient; NM – Neil MacLachlan; Dr M – Dr Moyano; JD – John Day; Dr A – Dr Ahmed; Dr E-F – Dr El-Farra; Dr I – Dr Ilangovan

Appendix H

Operation list of 17 October

Patient no.	Operation	Surgeon	Anaesthetist	Others present
820066 (PP)	Hysteroscopy/removal IUCD, I:? O:?	JD	GP	Unknown
981369	Hysteroscopy/Laparoscopy I: 10.00, O: 10.25	JD/Dr M	Dr I	Unknown
831123	Laparoscopy I:10.30, O:10.45	JD	Dr I	Sullivan
050007	Hysteroscopy I: 11.00, O:11.15	JD and Dr M	Dr I	Sullivan
770552 (PP)	Colposcopy/Loop excision I:?, O:?	JD	Dr I	Unknown
Unknown (PP)	Hysteroscopy I: ?, O: ?	JD	Dr I	
181035	Hysteroscopy/ polypectomy I: 11.45, O: 12.00	JD	Dr I	Sullivan
470759	Hysteroscopy I: 12.15, O: 12.30	JD/Dr M	Dr I	Sullivan
231599	Hysteroscopy/Laparotomy I: 12.36, O: 13.05 I^2: 13.50, O^2: 17.45	Dr M/NM/Dr A/JD/NI/JA	Dr I /RT/Dr L	

Notes

Dr Ilangovan was the duty anaesthetist for the day. Dr Sullivan did not participate in the operations: she wrote up the ops and dictated the letters.

Key

PP – private patient; NM – Neil MacLachlan; Dr M – Dr Moyano; JD – John Day; Dr A – Dr Ahmed; NI – Nicholas Ingram; JA – James Allardice; GP – Graham Prince; Dr I – Dr Ilangovan; RT – Regina Thomsen; Dr L – Dr Lane

Appendix I

Letter from Graham Prince to Rose Naylor (sent by email on 19 February)

Critical Care Unit
General Hospital, The Parade,
St Helier, Jersey, JE1 3QS
Tel: (01534) 622492
Fax: (01534) 624044
Email: g.prince@health.gov.je
Website: www.health.gov.je

Rose Naylor
Director of Nursing and Governance
Health and Social Services Department

Our ref:
Your ref:

Sunday, 17 February 2008

Dear Rose

Re: Interim SUI report into the death of Mrs Elizabeth Rourke

The SUI team absolutely understand and support the decision to restrict access to sensitive information which may have an impact in forthcoming court proceedings. It does remain the responsibility of the team to ensure that the SUI process moves forward as best as is possible even under these delicate circumstances. We thought it sensible to clarify in writing where we felt early efforts should be made to improve standards. Hopefully this document can clarify the thinking behind the interim report and may be of assistance to those attending the meeting on Friday 22nd February.

Theatre Equipment

The most important recommendation in this section is (1). Though there is clearly management going on relating to theatres, communication between groups involved in theatres is poor and little is written down. The surgical division section of the policy publishing centre is completely empty.

The team felt that it was difficult to maintain good practice under such circumstances. If there are no written policies, procedures or guidelines - audit cannot take place. This adds up to a significant risk to HSSD when a sensitive area like surgical activity is involved.

A new surgeon arriving in Jersey would have to find out for himself how to use theatres, how lists are booked and published, what the rules are for consent and marking of patients, when patients should be consented and what equipment is available. This problem is particularly marked for locums, who currently receive no induction. A locum

who has not previously worked at a consultant level in a UK hospital would be at greatest risk.

Equipment management is another area where a theatre management group should give strong leadership. Steps are being taken to rectify deficiencies in this area with the introduction of Scantrack. This will not deal with the issue of stock control which is a cause of concern with the imminent closure of the TSSU. It is difficult to tell whether we are maintaining adequate stocks of equipment or whether we are replacing equipment on time because there is no register of assets.

A Theatre Management Team receiving reports from a Theatre user group was step 1 in the NHS modernisation agency 'Step Guide to Improving Theatre Performance, 2002'. Responsibilities set out for this group included:

- Agree the terms of reference for sub-groups as appropriate eg the Theatre Users Group.
- Ensure that theatre policy documents are agreed and that policies are adhered to.
- Agree and monitor education and training strategy.

The team believe that the current management process in theatres is deficient in these areas and this could be a cause for criticism. Significant changes have already taken place in theatres with the opening of DSU2 and further major changes are proposed in the next year including:

- Closure of TSSU
- Introduction of Scantrack
- Changes to roles and responsibility of theatre porters
- New theatre information system
- Introduction of PACS

Without more robust management processes and clearer policy development HSSD risks criticism if these changes result in increased risk or actual harm.

Vascular Services

The recommendation for Mr Butcher to review our policy for the management of vascular emergencies is absolutely key and should be actioned immediately. Serious on table vascular emergencies happen about once a year on average.

Nursing staff in theatres are concerned that our vascular equipment may be sub-standard and there is no in-house system for reviewing the stock held of equipment or prostheses.

Our emergency vascular response has performed well on most occasions but new surgeons are unlikely to have the skills in vascular surgery that our current group have. We need to be able to robustly defend our strategy which will come under scrutiny during the legal process.

Mr Butcher's review needs to cover each of the issues raised in section 5.2 of the SUI interim review document. He may be unable to give much insight into the 6th point about air transfer. HSSD may need to take separate advice on that issue.

Standards for Locum Appointments
The SUI group had serious concerns about this area because clear and sensible guidance on locum appointments has been available from the DoH for a decade and Jersey is not complying with these recommendations. HSSD is the employer of locums and ultimately must take responsibility if an unsafe locum is appointed and causes harm.

The first recommendation of the UK locum code is:

Trusts (and DMUs in Scotland) should consider carefully the relative cost effectiveness of engaging permanent and locum staff. Ideally, there should be sufficient substantive posts within the unit to meet foreseen service demands, including planned absences.

HSSD cannot plan manpower effectively because they have not completed job plans for existing consultant staff. There are several areas including obstetrics where appointment of an extra consultant, though unpopular with incumbents, could avoid the use of locums altogether.

HSSD policy on locums is driven by cost containment rather than good governance. Non-agency locums are preferred because they are cheaper, but they do not necessarily come with provenance or references. HR are often unable to complete the basic searches for health, criminal records and qualifications on non-agency locums within the available timescale – this represents a significant risk. Agency locums should provide this information as part of their service. Other recommendations of the locum code of practice include:

- Locums should undergo an interview process. *This can be achieved using teleconferencing but is not currently done*.
- It should be clear what the responsibilities of the locum post will be and what the basic requirements for the post are. This would require the job plan of the incumbent consultant and a person specification as provided when appointing a consultant
- If the locum appointed falls short of the required specification in any way relevant consultant colleagues (*including anaesthetists*) must be aware of these limitations.
- It is the duty of the medical director and the departmental clinical director to ensure that such an individual is adequately supervised.
- When locums leave, the organisation should complete an assessment form which should be fed back to the individual and kept on record in case future employers ask for information.
- If there are shortcomings in performance HSSD has a duty to inform the GMC.
- All locums should receive induction training.

The SUI team felt HSSD falls below existing standards in all of these areas. These shortcomings need to be urgently rectified.

Policy Management
All of the recommendations in this section need urgent attention. If we are to take governance seriously, there is a lot of work to do.

Management of Conflicting Demands
All recommendations in this section need urgent consideration. Recommendations 21-23 relate to leave management. Our investigation revealed that there was no communication between the individual consultants within the O&G department on leave issues. This means that there is great pressure on HR to find locums for this area and on occasions the department is largely staffed by locums. Similar problems have occurred in the Department of Medicine. This lack of communication will inevitably increase the requirement for locums and particularly for short term locums and short notice locums. This type of locum carries a high degree of risk. Consultant colleagues within O&G did not feel they had any responsibility to supervise Dr Moyano as she was employed as a consultant. Other areas have managed locums successfully by having a more hands on approach and by planning leave at a departmental level (eg Orthopaedics, anaesthesia).

- HR are not in a position to query leave requests with consultants and when they have done so this has lead to altercations.
- HR do not seem to be able to recognise situations where a dangerous combination of consultants and their middle grade staff are on leave at the same time.
- HR cannot keep a tally of on call work. They are therefore unable to assess if 'days of in lieu' are owed.

The solution to this weakness is to give responsibility for organising leave (and maintaining a safe level of service) to the departmental chairman. The departmental chairman is paid by HSSD for that type of responsibility. He will delegate responsibility where appropriate to his secretary. HR can put all the energy they currently put into leave management into auditing the leave management performance of the departments.

Recommendation 24 comes from the query raised by Forbes in his review. Forbes believed that JBD should not have arranged to see private patients at a time when he 'should have been in theatre'. With no job plan it would be difficult to sustain this argument. Absence of job plans makes it difficult to reach agreement on locum requirements as stated earlier and means that it is difficult for HSSD to plan workload in any meaningful kind of way.

Recommendations 25-27 relate to better governance and clearer policies within the surgical division. These may need clarifying but the team would expect most consultants to be fully aware of these responsibilities for most lists but there needs to be some thought about lists where locums are involved as the Consultant.

Record Keeping and IT
Recommendations 28 to 35 relate to information policy throughout the hospital. Writing policy in these areas sets standards and promulgates audit. These areas are therefore at the heart of good practice and governance in the hospital.

The organisation is weakened by the lack of an adequate induction process and this will be criticised during the Moyano case. Obviously as we have little written policy there is not a lot to tell people at induction. If the organisation decides to strengthen its policy management it will have an increasing need for a robust induction for medical and nursing staff.

Hopefully this explanatory letter will clarify some of the issues raised in the SUI report.

Yours sincerely

Dr G D Prince FRCA
Consultant in Anaesthesia and Intensive Care on behalf of the SUI team

Appendix J

This table shows the HSSD management team's assessment of progress implementing the recommendations of the July 2008 version of the serious untoward investigation report

Recommendation	**Completed**	**Partially Completed**	**Timeframe for LEAD OFFICER**	**Comment**
Section 5 5.1.1 Theatre Equipment Specific Recommendations relating directly to this case 1) Surgeons should ensure they are familiar with equipment before using it.	Completed		AB	Individual practitioners have a responsibility to their relevant Codes of Practice and work within the limits of their competence. There is a system in place for the evaluation and roll out of new/trial equipment to DSU and main theatre In addition to this there is a checklist in place for new doctors and locums, that includes equipment to be used on operating lists.
2a Theatre Equipment – broad recommendations and learning 2) The Surgical Directorate Manager must re-activate a theatre users group with management, nursing, surgical, anaesthetic and CSSD representatives to ensure : a) Robust policy development b) Policies are communicated to all users. c) An accurate asset register of surgical	Completed Completed Completed		AB AB AB	There are asset registers in place in Theatre, DSU and CSSD

equipment d) A system of planned replacement of surgical equipment		In progress	RN - June 2010	There is a replacement system for equipment in operation in theatres. Work around a planned replacement programme is part of HSSD's work on Medical Devices and Equipment Management.
3. Closure of TSSU must not take place before effective systems are in place to ensure continuity of the theatre service. A grade 4 manual worker is to be appointed with responsibility for ensuring transport between 5 Oaks and the hospital works smoothly.	Completed		AB	
4. Scantrack should be implemented as soon as possible	Completed - see comment		AB - December 2009	Scan Trak has been implemented - some technical difficulties that will be resolved by December 2009
5 HSSD should consider implementation of individual instrument bar-coding	*Completed		AB	*This has been considered, however we do not intend to bring in individual bar coding on single instruments at this time
6 HSSD develop a policy for the Management of Medical Devices and Equipment that promotes standardisation of equipment where practical, staffed to be trained and deemed competent on use prior to using and that stipulates equipment should be retained for checking	Completed in theatres	HSSD wide work ongoing	RN - HSSD wide February 2010 AB - theatre specific	Theatre work undertaken - competencies for specific equipment developed and in place. Orientation packs for theatre in place.

and potential use in an investigation				
7.HSSD develops an Incident Reporting policy that reinforces the above with regards to retention of equipment post incident.	Completed		RN – HSSD wide AB - theatre specific	At the time of the incident there was a system in place regarding retention of equipment in the event it was in use at the time an incident occurred. Since then HSSD has developed and ratified an organisational wide incident reporting policy which reinforces the management of equipment.
8.HSSD should ask Mr Will Butcher (visiting vascular surgeon) to review arrangements in Jersey for the provision of emergency vascular surgery.	Completed		RL/AB	Review undertaken following the incident Much work undertaken to implement the recommendations from his review in particular work around management of vascular emergencies.
5.3 12 HSSD should develop a locum policy based on NHS best practice and ensure all locum appointments are made in accordance with this policy.	Completed		MC/RL	Additional work undertaken to reduce the reliance on locums, policy developed and ratified – Sept 09
13 HSSD must clarify the procedures for registration with the Royal Court.	Completed		RL	This was reviewed, this sits outside of the control of HSSD
14 As part of their induction process non-consultants should be reminded of their duty to work within the standards set out by the GMC in their document 'Good Medical Practice' (2006) which states:	Completed		AB/MC	Implemented for locums. Information included in welcome pack on appointment, sent out by HR

e) Recognise and work within the limits of your competence f) Work with colleagues in the ways that best serve patients' interests				
15 The Consent Policy should be revised in line with current UK best practice guidance		Under revision	Jan 2010 RN	Policy developed in 2004, currently being revised.
The Policy Publishing Centre should be redesigned to simplify navigation and facilitate 'search' functionality.	Completed		RJ	
16 There should be a system for the management and standards for development of guidelines and policies	Completed		RN	
17 SMT should develop a policy management sub-group to set standards for policy development and to manage the process.	See comment		RN	This was considered not necessary, to set up an additional group for this at this time - standard format for policy development and guidelines (currently being updated) are in place, as is a system for ratification, via Governance Board SMT.
18 Local policy issues should be a part of the induction process for all	Completed		RN/AB	HSSD Corporate Induction in place which includes policy issues, such as Infection Prevention and Control, Child Protection etc..

staff				Local induction developed specific to speciality.
19. Leave Management - HSSD wide recommendations and learning	Completed		MC	Current system – standard proforma for leave requests – 8 weeks notice, management of this will be further strengthened by the development of a policy
20 Responsibility for leave management should lie with the clinical lead for each department rather than the HR department. (Leave management includes annual, study, sickness and special leave and lieu days).	Completed		MC	Responsibility for leave management lies with the Consultant. At this stage it is not operationally practical to move this responsibility to the Clinical Leads because of current work demands.
21 HR should produce standards and policy for leave management for departmental clinical leads in understanding their duties.	Completed		MC	As above
22 HR should robustly audit leave management within departments.	Completed		MC	HR monitor leave across HSSD. It is not envisaged that leave will be audited at this time nor in the future, there is not the resource to do this.
23 Job Planning – HSSD wide recommendations and learning		Ongoing	RL	Part of appraisal process Organisation wish to purchase softwear package to support job planning and rotas – current financial constraints have prohibited this,
24 Job planning and appraisal processes must		Ongoing	RL	84/94 have completed 360 appraisal. The 10 outstanding include some medical staff currently not working and staff

ensure that doctors meet the professional requirements of HSSD and the GMC.			Aim for 90% of medical staff to have completed appraisals by end of 2009	new to the organisation. 11 appraisals have been signed off and completed
25 Theatre list Management - HSSD recommendations and learning	Completed		AB/RP	Work undertaken and system improved, Monitoring continues on the system
25 5.6 Record Keeping and IT	Completed		AB/RP	Training programme developed and in place. All new surgeons are given an identification code which flags them on the system prior to commencement of their duties. Further improvements will be made to system through the ICR programme. Will continue to audit the system.
26 HSSD should develop standards for medical record keeping to include filing, archiving, approved abbreviations, retention and disposal.		Completed in part	RN/RL June 2010	Health and Social Care Records Policy revised Retention schedule in line with NHS Abbreviation policy Work to improve documentation during clerking Much work undertaken in this area.
27 Standards for medical record keeping should be covered in the induction process and should be audited by HSSD.		Completed in part	RN/RL June 2010	Included in HSSD Corporate Induction Regular audits of documentation undertaken, across HSSD, not just General Hospital, but process needs to be ongoing
28 The theatre management group must establish standards for data	Completed		AB	Training documentation identifies the standard required and improves skills on inputting. Will continue to monitor through audit.

collection into the IHS system				
29 The standards must identify a method for capturing details of the surgeon completing surgery	Completed		AB	As above
30 The standards must identify a method for capturing the level of supervision of non-consultant surgeons.	Completed		AB	As above
31 Standards for locum registration onto the IHS system must be developed - this should include target times for completion.	Completed		AB/RP	All locums are trained and access the IHS.
32 Theatre records must allow retrospective identification of those present in the operating theatre during an operation.	Completed		AB	
33 HSSD should risk assess the benefits and risks of introducing CCTV in theatres. This would potentially enable regular proactive		Ongoing work to minimise risk and improve safety	RN	Much work undertaken to develop risk management skills across HSSD – for example Obs and Gynea have a risk management group – MDT, meets on regular basis and discuss incidents, near misses, cases of concern. Other examples to reduce risk include the roll out of the WHO Safety Checklist earlier this year.

Appendix K

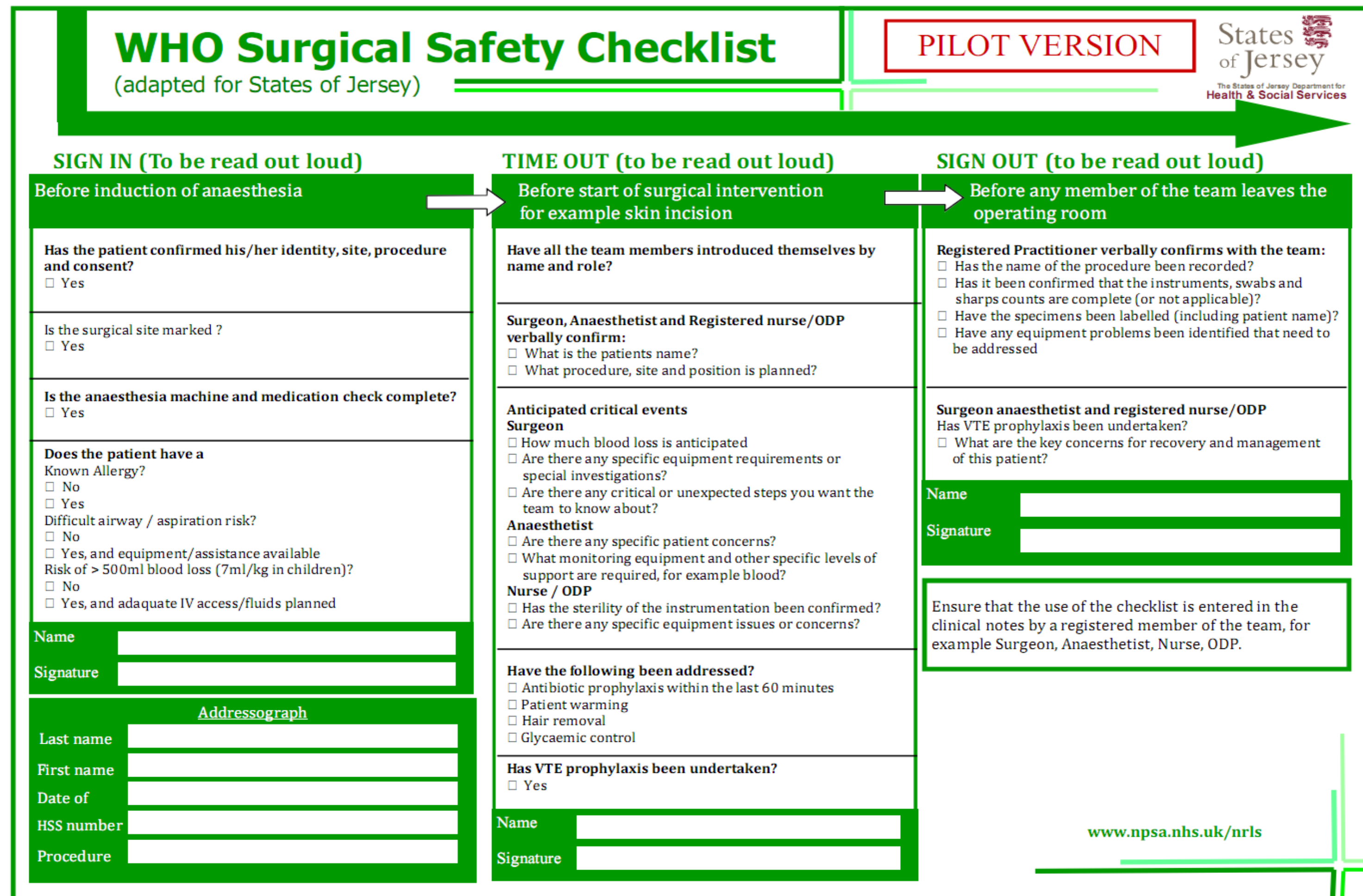
UK approved service providers (as at July 2009)

Provider	Service/specialty
Barnet and Chase Farm	ERCPs
Great Ormond Street	Pediatrics
Guys and St Thomas'	GU medicine, renal, pediatric, nephrology, pediatric dialysis, rheumatology, maternity and neo-natal
Leicester	Sports medicine
Moorfields	Specialist eye treatments
Portsmouth	Urology
Royal Bournemouth	Vascular
Royal Brompton	Respiratory, cardiothoracic
Royal Free	Plastic surgery, general medicine, cardiology, general surgery and haematology
Royal Marsden	Gynaecology, clinical oncology, medical oncology and general surgery
Royal National Orthopaedic Hospital	Trauma and orthopaedics
South England Cochlear Implant Centre	Cochlear implants
South London and the Maudsley	Mental health

St George's	Cardiology, cardiothoracic
Southampton University Hospital Trust	Clinical and medical oncology, general surgery, general medicine, neurosurgery, paediatrics, ophthalmology, trauma and orthopaedics, cardiac surgery, cardiology, ENT, neurology, gynaecology, oral surgery, thoracic surgery, interventional, neonatology and obstetrics
University College London Hospital	Hepatology, neurosurgery, neurology, ENT, dermatology, clinical heamatology, tropical medicine and BMT
Royal Surrey	Brachytherapy
Winchester	Breast reconstruction
Nuffield – Taunton	Spinal

Appendix L

This is a copy of the pilot version of the WHO pre-operative/surgical safety checklist in use in theatres at Jersey General Hospital during 2009



WHO Surgical Safety Checklist
(adapted for States of Jersey)

PILOT VERSION

States of Jersey
The States of Jersey Department for Health & Social Services

SIGN IN (To be read out loud)
Before induction of anaesthesia

Has the patient confirmed his/her identity, site, procedure and consent?
☐ Yes

Is the surgical site marked ?
☐ Yes

Is the anaesthesia machine and medication check complete?
☐ Yes

Does the patient have a
Known Allergy?
☐ No
☐ Yes
Difficult airway / aspiration risk?
☐ No
☐ Yes, and equipment/assistance available
Risk of > 500ml blood loss (7ml/kg in children)?
☐ No
☐ Yes, and adaquate IV access/fluids planned

Name

Signature

Addressograph

Last name

First name

Date of

HSS number

Procedure

TIME OUT (to be read out loud)
Before start of surgical intervention for example skin incision

Have all the team members introduced themselves by name and role?

Surgeon, Anaesthetist and Registered nurse/ODP verbally confirm:
☐ What is the patients name?
☐ What procedure, site and position is planned?

Anticipated critical events
Surgeon
☐ How much blood loss is anticipated
☐ Are there any specific equipment requirements or special investigations?
☐ Are there any critical or unexpected steps you want the team to know about?
Anaesthetist
☐ Are there any specific patient concerns?
☐ What monitoring equipment and other specific levels of support are required, for example blood?
Nurse / ODP
☐ Has the sterility of the instrumentation been confirmed?
☐ Are there any specific equipment issues or concerns?

Have the following been addressed?
☐ Antibiotic prophylaxis within the last 60 minutes
☐ Patient warming
☐ Hair removal
☐ Glycaemic control

Has VTE prophylaxis been undertaken?
☐ Yes

Name

Signature

SIGN OUT (to be read out loud)
Before any member of the team leaves the operating room

Registered Practitioner verbally confirms with the team:
☐ Has the name of the procedure been recorded?
☐ Has it been confirmed that the instruments, swabs and sharps counts are complete (or not applicable)?
☐ Have the specimens been labelled (including patient name)?
☐ Have any equipment problems been identified that need to be addressed

Surgeon anaesthetist and registered nurse/ODP
Has VTE prophylaxis been undertaken?
☐ What are the key concerns for recovery and management of this patient?

Name

Signature

Ensure that the use of the checklist is entered in the clinical notes by a registered member of the team, for example Surgeon, Anaesthetist, Nurse, ODP.

www.npsa.nhs.uk/nrls

Appendix M

Notes on the creation of an operating list

Our witness told us that when she was organising lists she had a sheet of paper with details of all the various operations that her surgeons undertook, against which she had put the times that it would take each one to do these operations. These times were established through conversations with consultants and also conversations with the theatre staff. The surgeons estimated the time it took them from the time they started the procedure until the time they finished it, and the theatre staff were able to say how much long it would take for one patient to leave the theatre and for the next one to be brought in, which would include, for instance, the time it took for any dressings to be applied, and the time needed to clean the theatre and prepare it for the next patient.

Our witness told us that the pre-admission nurses, and indeed the TCI clerks, are all very experienced as to what a normal list looks like, and would have no fear in raising an issue if they think that somebody's list is too heavy. She said that there is no management pressure now and as far as she can recall there was none in 2006, to add extra people to a full list. There is no real waiting list problem in Jersey.

The creation of a list is slightly complicated by the custom of dealing with private and public patients on the same list.

Many residents of Jersey are covered by health insurance, and as there are no private hospitals on the island with operating facilities or surgical consultants, most of the consultants employed at the Jersey General Hospital also have private patients. These patients will be seen in outpatient clinics away from the hospital, but if a private patient needs surgery or inpatient care, he or she will be treated at the district hospital or will have the treatment off island.

Private patients are booked onto the list by the consultants' private secretary, working in the consultant's private consulting rooms.

The rule is that consultants can use about 30 per cent of their operating list time for private patients, so long as their public patients do not have to spend more than three months on the waiting list after their outpatient appointment. If the public patient waiting list starts to lengthen beyond this time, the consultant will have to cut back on private patient procedures until the waiting time for public patients is below three months again.

A day surgery theatre will be booked from 9am to 12.30pm for a morning list. Thirty minutes is allowed for anaesthetising the patients etc, so the private secretaries (who have a copy of the paper with the estimated times for the various procedures that their consultants carry out) know that they can book patients for an hour of the surgeon's time, and the pre-admission nurse knows that she has about two hours for the public patients.

Once the private secretary has given a private patient an appointment on a theatre list, she will fax the information through to the secretary on the day surgery unit, and also to the TCI clerk. The TCI clerk will enter the details in the theatre list on the computer and also put it in the diary. Different coloured inks are used for the public and private patients to avoid confusion. The day surgery unit secretary will make a note of the appointment to make sure that she gets the patients notes by the date of the operation (private patients notes are kept in the private rooms, not at the hospital). Private patients also have to be assessed as suitable for day surgery and it is their responsibility to phone the day surgery unit secretary to be booked in for an appointment with the pre-admission nurse.

Sometimes it will happen that the private secretary will have an urgent case and no "private" space on any of the lists for the next few weeks. Equally it might happen that a public patient needs an urgent procedure, and there are no public spaces on the list for the next few weeks. In these circumstances, the day surgery secretary and the private secretary will talk to each other and sort something out. Clinical need always comes first. One thing that does not happen is that a list is made bigger by adding private patients or indeed public patients on to a full list, just to suit somebody's convenience.

Appendix N

Notes on the pre-admission assessment

Ms Pycraft has retired, but we were able to talk to a senior nurse on the day surgery init who has herself been responsible for pre-admission appointments and organising operating lists, and we have no reason to think that Ms Pycraft's practice would have been any different.

Our witness told us that when a patient is seen in outpatients, and listed for surgery (that is that it has been agreed that they will have the surgery but no date has yet been fixed) the patient will be given leaflets relating to the procedure that will be taking place. There is a leaflet relating to hysteroscopy, which was updated by Dr Nelson when she arrived, and which talked about the risks, including the risk of perforation being 1 in 200. There is also a leaflet about the Mirena coil, produced by its manufacturers, and a leaflet about the pre-admission appointment and how important it was to turn up for it and why. The leaflets are given to the patient at this early stage so that they can think about what is going to be happening and make a note of any questions that they will wish to discuss at the pre-admission appointment.

The pre-admission nurse has the patient's medical records at the meeting as it is good practice for her to check them in case there is something there that the patient does not mention – patients are inclined to say that they are fine when in fact they have a considerable history of difficulties in one area of another, and the pre-admission nurse needs to read the notes beforehand, to make sure that nothing is overlooked.

If the patient describes symptoms or problems that do not seem to be covered by the proposed procedure, or if there is a discrepancy between the patient's expectations and what is shown in the notes, the pre-admission nurse will seek the advice of the consultant to try and make sure that when the patient does come into hospital everything that needs to be done is done.

This is done to make sure that the patient is satisfied, but also to make sure that the list does not get disrupted. If the patient is being seen by a registrar in outpatients, who suggests a hysteroscopy and then the consultant discovers on the morning of the

day that a laparoscopy is also advisable, this could take an extra 40 minutes, which means that other operations might end up being cancelled. The nurse will therefore do everything reasonably possible to make sure that there are no misunderstandings and that there will be no avoidable problems on the day.

Appendix O

Notes on the day surgery procedure

It has been designed to allow a rapid through-put of patients, whilst at the same time ensuring that the patients do not feel that there is anything hurried or worrying about the process.

We were told by a number of people that Mr Day always went through to the anaesthetic room to have a few words with the patient and put her at her ease before the operation.

While the second patient is having her procedure, the first scrub nurse is preparing the trolley of instruments etc for patient number three.

Appendix P

Notes on medical training and qualifications

Doctors receive a mixture of academic and on the job training, and provide evidence of their increasing knowledge and skill through passing exams set for each level. Whatever her skill and experience, a doctor remains a junior doctor until she passes the exams that results in being admitted to the specialist register of the General Medical Council. A junior doctor is always supervised (the level of supervision will depend on her abilities and experience). Once a doctor has been admitted to the specialist register she is considered to be sufficiently skilled to act as an independent practitioner, not requiring supervision. Doctors on the specialist register will continue training throughout their careers, and will take further exams set by their Royal College to mark their increased knowledge and ability, so the life of a senior doctor involves very significant amount of continued education and training, but generally speaking it does not involve supervision on a day to day basis.

Specialist registrars in hospitals are doctors who are training to get on the Specialist Register. They will have been working and training in hospitals for at least seven years, having worked up from house officer to senior house officer and then to specialist registrar.

Getting on the specialist register does not automatically result in a doctor becoming a consultant. A consultant position is a job, not a qualification. If a doctor does get a job as a consultant, he or she will then be termed a senior doctor, and will have significant responsibilities in addition to clinical practice, including the teaching and supervision of junior doctors.

Some doctors finish the specialist registrar training, but either do not complete the necessary exams to get on the register or, having completed the exams and got on the register, do not become consultants. Those who have not completed the exams are designated as staff grade doctors, and those who are on the register but do not have consultant jobs are designated as associate specialists. The fact that these doctors are not on the register or are not consultants, may say very little about their skill and ability – doctors who qualify other than in the EU have to re-qualify if they wish to

work within the EU, and some very experienced doctors who are working in the EU prefer simply to remain as staff grades or associate specialists, rather than go through the whole training again to become a consultant. Others are on the register, but do not wish to become consultants because they do not wish to take on the added duties, and prefer to stick to clinical work.

Staff grades and associates specialists are known as middle grade doctors. Middle grade doctors will often provide experienced continuity in a hospital where the junior grades move through and out as part of their training and consultants have to devote considerable time to non-clinical duties. Although they have no formal teaching responsibilities, they are often the most senior doctors on the ward, and, through their experience and expertise, they play a major part in maintaining the standards and culture of the hospital.

Dr Moyano trained and qualified in Spain, and as Spain is part of the EU, her certificate of qualification is recognised as equivalent to the certificate of completion of specialist training that is necessary to get on the specialist register of the GMC, and therefore Dr Moyano was entitled to be admitted to the register. Having been admitted to the register, she was entitled to apply for consultant posts, but could also cover for a specialist registrar, a staff grade or an associate specialist. After obtaining her certificate she had worked as a junior and as a senior consultant in Spain, but had not worked as a consultant in the UK.

Dr Elfara was a specialist registrar in training – that is to say he was not yet on the specialist register and had not yet taken his final exams. However, he had reached the point where he was able to be the on-call specialist registrar who would be first on the scene in the event of an emergency.

Appendix Q

Team biographies

Ed Marsden

Ed is a former NHS manager with many years' experience of leading complex organisations and managing sensitive political issues. He has worked for the National Audit Office and the Department of Health, and before founding Verita, he was director of performance management for West Kent Health Authority. Ed has a clinical background in general and psychiatric nursing.

Now the managing director of Verita, a management consultancy specialising in the conduct of investigations and inquiries in health and other public organisations, Ed has handled the political repercussions of high-profile mental health inquiries, including the Michael Stone case. Along with Professor Robert Tinston, Ed carried out the corporate governance review of the Royal United Hospitals Bath NHS Trust. He has also worked with Ruth Carnall on a financial management and governance review of Worthing and Southlands Hospitals NHS Trust. Ed co-wrote the board leadership review of the Maidstone and Tunbridge Wells NHS Trust. This followed the Healthcare Commission's report on the deaths of patients as a result of *clostridium difficile*. Ed is an associate of the Prime Minister's Delivery Unit and has carried out three assignments on immigration.

Derek Mechen

Derek is director of client work at Verita and has been involved in healthcare in a variety of settings for over 30 years. He has held senior positions in operational management in both the NHS and the independent sector, and has also worked at the National Audit Office, where he led several value-for-money studies and spent a year on exchange at a teaching hospital in Chicago. For Verita he has worked alongside Professor Robert Tinston on a focused review of orthopaedic services and an investigation into serious waiting list breaches. He is currently managing three independent homicide inquiries, one at Broadmoor and two in London.

Lucy Scott-Moncrieff

Lucy qualified as a solicitor in 1978, and has worked in the fields of mental health and human rights law ever since. She is a member of the Law Society's Mental Health & Disability Committee and its Access to Justice Committee, having previously chaired both committees. In 2005 Lucy was awarded the Mental Health Legal Aid Lawyer of the Year award, and two years later her firm was short listed for the Law Society's award for Excellence in Innovation. Lucy is a director of Edge Training Limited, a company that offers training on the law to the purchasers and providers of health and social care, and a member of the QC Appointments Panel. She is also a commissioner with the Royal Mail regulator Postcomm. Lucy is on the editorial boards of the *Community care law reports* and the *Mental health law journal* and has written and broadcast regularly on legal issues over the years.

Julian Woolfson, OBE, MB ChB, LLM, FRCOG

With over 35 years' experience in private practice and the NHS, Julian Woolfson is a leading authority on obstetrics and gynaecology. Until 2007 he worked for Queen Mary's Hospital Sidcup NHS Trust, where he combined his clinical role as a consultant with that of associate medical director responsible for all aspects of clinical governance and for devolving and supervising best practice. He was also the trust's clinical risk manager. He is a member of numerous regional and national committees and has only recently stepped down as the chair of the Royal College of Obstetricians and Gynaecologists' Professional Standards Committee, and a member of the college's Ethics Committee and its Specialty Training Committee. Julian is also a lead examiner and hospital visitor for the college, and has published numerous books and articles on obstetrics and gynaecology. Over the last 20 years, he has written 1000 expert reports for claimants and defendants attending court and has given oral evidence in 22 High Court trials. He is a trustee of The Sudborough Foundation (an educational support trust) and Wellbeing of Women (research funding trust), and chair of governors of Ravensbourne College of Design and Communication. He was awarded an OBE for voluntary services to higher education in 2008.