STATES OF JERSEY

COMMITTEE OF INQUIRY INTO THE DEATH OF MRS. ELIZABETH ROURKE

Lodged au Greffe on 29th May 2009
by Senator S. Syvret

STATES GREFFE

2009 Price code: C P.76

PROPOSITION

THE STATES are asked to decide whether they are of opinion –

(a) to agree that a Committee of Inquiry should be established in accordance with Standing Order 146 to inquire into a definite matter of public importance, namely the circumstances surrounding the death of Mrs. Elizabeth Rourke in October 2006;

(b) to agree that a nationally recognised healthcare investigatory organisation be invited to undertake the investigation and to nominate investigators for approval by the States as Chairman and members of the Committee of Inquiry;

(c) to agree that the detailed terms of reference of the Committee of Inquiry should be agreed with the commissioned organisation and submitted to the States for approval alongside the names of the Chairman and members;

(d) to agree that the Greffier of the States be asked to identify a suitable investigatory organisation, negotiate terms of reference based upon the accompanying report, and, following approval of the membership and terms of reference by the States, sign the relevant contract on behalf of the Assembly;

(e) to agree that the proposed investigation by Verita into the death of Mrs. Elizabeth Rourke should not proceed and to request the Minister for Health and Social Services to take the necessary steps to discontinue that investigation.

SENATOR S. SYVRET

REPORT

Elizabeth Rourke, a patient of the States of Jersey's Health and Social Services Department, died – needlessly – in October 2006, following what should have been a routine surgical procedure.

The States of Jersey has a moral obligation to discover the true facts of this tragedy which has left a family bereaved.

It is fair to say that a great deal is already widely known concerning this incident.

Clinical governance is the term used to describe a systematic approach to maintaining and improving the quality of patient care within a health system. Sufficient facts are in the public domain to demonstrate that what took place represents a disastrous failing in the expected clinical governance standards.

And, as disturbingly, it is also the case that sufficient evidence is in the public domain to show – quite unambiguously – that the senior management of Health and Social Services (H&SS) have striven to divert culpability away from themselves, and on to innocent parties.

Effectively, what we see is a brazen attempt at a cover-up.

And for further evidence of that on-going cover-up, we need only observe the actions of H&SS in commissioning one of those companies widely known to be little more than a "trouble-shooting" organisation which specialises in rescuing authorities facing a scandal and which are in need of some "blame-free" gloss to brush over the festering chaos that caused the problems.

I will return to the subject of the company appointed by H&SS, "Verita", later in this report.

Let us be clear about the seriousness of this situation. A person has lost their life needlessly.

Yet – so far – every single aspect of public administration in Jersey has failed to take anything approaching the correct and appropriate actions.

Health and Social Services, the Council of Ministers, the Chief Executive to the States, the States of Jersey Police and what passes for a prosecution system in Jersey.

All have failed.

In fact, the one, single agency to successfully have carried out its duties in this matter was the Jury who acquitted the locum doctor who had been wrongly charged with the manslaughter of the patient.

Telling – is it not – that every single part of officialdom failed in this case – and the only people to get it right were members of the public – the men and women of the Jury?

Finally – as much as it may wish to – the States of Jersey cannot shirk its responsibility.

It would add insult to injury if H&SS were permitted to escape the necessary, rigorous, expert and independent scrutiny. Yet that is what will happen if the Assembly allows the Department to get away with the farrago of an "inquiry" they propose.

Some key facts already in the public domain

Following the death of Elizabeth Rourke, eventually, the locum doctor, Dr. Dolores Moyano, was charged with manslaughter.

She was, rightly, acquitted of this charge.

Whether Dr. Moyano's professional conduct was acceptable, remains a question for her professional regulatory body, the General Medical Council.

However, any professional errors of judgment which may have occurred, do not automatically justify something as serious as being prosecuted for manslaughter, in all but the most obvious of circumstances.

We know that insufficient care was taken in the recruitment, assessment and monitoring of Dr. Moyano.

We know that certain expressions of concern in respect of Dr. Moyano's surgical competencies had been made to the relevant mangers.

We know that the management structure failed to take action to halt, even temporarily, Dr. Moyano's practice – notwithstanding such expressions of concern.

We know that the relevant managers failed to communicate to all those other clinicians who would be working with Dr. Moyano, the fact that her surgical competencies had been called into doubt.

We know that the management of the hospital's reporting system failed disastrously.

We know that, for the final hours of her life, Elizabeth Rourke was under the care of a Consultant Anaesthetist.

We know the quite extraordinary and breathtaking fact that – notwithstanding his being a key actor in the SUI – he nevertheless was appointed – and accepted being appointed by the organisation – as the internal case manager for the SUI investigation.

We know that, notwithstanding the utterly extraordinary nature of a person being placed in charge of an investigation – of in incident they were involved in, H&SS management has seen fit to continue with the Consultant Anaesthetist as the internal Case Manager.

We know that activities were engaged in by certain senior managers following the Serious Untoward Incident that have every appearance of being a co-ordinated attempt to conceal the truth, using such methods as the post-event manufacture of 'file-notes', etc. (see Appendix 1).

We know that certain senior managers engaged in quite brazen attempts to mislead the media as to the true facts of the case, for example that fact that the Consultant Anaesthetist was both a key actor in the incident and the organisation's internal incident investigator. (See the Jersey Evening Post of 31st January 2009.)

Given that all the above are readily ascertainable facts – knowable to anyone who studies the evidence in the public domain – can it seriously be proposed that the self-same people responsible for the above, can pick and choose their own investigators?

Let us be clear about the key facts:

1: A person was unlawfully killed.

2: Health and Social Services is the culpable organisation.

3: A number of senior, key managers have responsibility for the clinical governance system which failed so disastrously – including the human resources management.

4: The soi disant "independent" investigation has been commissioned and designed by the same senior managers responsible for the system failure.

5: The terms of reference of the investigation have been drawn up by the self-same senior managers. And it shows.

If it is to redeem itself from its wholly wretched contrivance of corporate failure, Jersey's public administration must surrender this issue to *genuine*, external scrutiny.

Any other course would be an obvious betrayal of the public interest.

But sadly, we can be absolutely confident as to what the real purpose of the H&SS investigation is – namely, the exculpation of the senior managers in question.

That is the central and overarching objective of the investigation proposed by H&SS.

Should there be any doubt at all remaining as to that purpose – we need only turn to the full terms of reference – the very first paragraph of which says this –

> "The Minister for Health & 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 system and processes."** (Emphasis added.)

Let it be noted that this – crucial – opening paragraph from the terms of reference written by Health and Social Services, was, mysteriously, omitted from the terms of reference as issued to the media.

The Proposition

Part (a) of the proposition asks the Assembly to agree the principle of establishing a Committee of Inquiry in respect of this tragic incident.

Part (b) stipulates the type of organisation that should be commissioned to undertake the Inquiry, and that the organisation nominate a Chairman and members of the Committee. In agreeing the proposition, the Assembly needs to make it clear that an organisation of national high repute will be commissioned, and, to ensure the independence of the Inquiry it will choose who it wishes to be nominated as a Chairman and members.

Part (c), for similar reasons of independence, ensures that the organisation will be able to participate in the drafting of the terms of reference. The ability to help shape the terms of reference will be essential in recruiting any respectable health care standards organisation.

Part (d) asks that the Greffier of the States be asked to undertake the task of recruiting a suitable organisation, undertaking any negotiations with them, and following approval by the States of the membership and terms of reference, to sign the relevant contract on behalf of the Assembly.

I have discussed this matter with the Greffier, and, if so ordered by the Assembly, he is content to undertake these tasks.

It is custom and practice, the Assembly having agreed to establish a Committee of Inquiry into a particular matter, that the member who brought forward the proposition then returns to the Assembly shortly afterwards with a proposition which names the Chairman and members of the Committee, and, in some cases, the detailed terms of reference.

However, there are 2 reasons as to why some departure from the normal practice is required in this case. Firstly – no backbencher can negotiate and sign contracts which commit the States' and taxpayers' money.

Secondly – it would not be appropriate for me as the member bringing this proposition, to then play a role in identifying and selecting the investigatory organisation, nor negotiating the terms of reference.

As the Minister responsible for the organisation at the time of the SUI, I would have a conflict of interests in shaping and determining the Inquiry to the traditional extent.

Instead, these particular tasks will be undertaken on behalf of the Assembly by the Greffier, a man of impeccable objectivity and impartiality.

As the member moving this proposition, I commit to bringing forward – unaltered – for approval by the States the membership and terms of reference as settled by the Greffier. Thus the Assembly will be able to approve a Committee of Inquiry of complete impartiality.

It may be asked, 'why should this approach be necessary; why not just ask a Minister or the Council of Ministers to negotiate the contract, and bring forward the settled membership and terms of reference for approval?'

Obviously, the Health and Social Services Department is heavily conflicted from having any involvement in shaping and commissioning this investigation. But additionally, there are a variety of significant and very seriously overlapping conflicts of interest which cut across several executive departments and the senior reaches of the civil service.

This is an occasion – the tragic and avoidable death of a person – on which the States Assembly must exhibit the leadership expected by the public – and assert its authority over the executive – and hold publicly-funded departments to account.

It is almost a certainty that any respectable, professional investigatory organisation will wish to have a certain degree of independence and be empowered to conduct an investigation as they see fit – rather than working to artificial constraints imposed by those who are under investigation.

For that reason, it will be essential that whichever organisation is commissioned to undertake the investigation, will have been able to play a major role in defining and refining the terms of reference.

However, it is appropriate that members and potential investigators have a reasonably clear idea as to purposes of the inquiry. Therefore I include the following draft terms of reference simply as a general guide as to what may be expected of the investigation.

(i) to investigate the cause of, and the factors that contributed to, the death of Mrs. Elizabeth Rourke;

(ii) to investigate the actions of all individuals involved in the case on the day of the Serious Untoward Incident;

(iii) to investigate the actions of all individuals involved in the recruitment, management and monitoring of Dr. Dolores Moyano;

(iv) to investigate the actions of all individuals involved in the recruitment, assessment and supervision of locum staff in general;

(v) to investigate the recruitment, qualifications, performance and supervision of those individuals responsible for managing staff employment and performance, with particular regard, but not confined to, locum employment and performance;

(vi) to investigate the policies and processes employed by the Health and Social Services Department for managing patient safety, with particular regard to general safety management and the reporting processes and culture within the organisation;

(vii) to investigate the effectiveness and application of the policy in the General Hospital for dealing with Serious Untoward Incidents, with particular regard to the organisation's response to this particular incident;

(viii) to review the actions taken by the Health and Social Services Department in response to the patient's death, to include a review of the conduct of its own internal investigation, the conduct of its liaison with the police, and a review of the conduct of the suspension of the Consultant Gynaecologist;

(ix) to review any changes in practice and policy made subsequent to the patient's death and the progress made in their implementation;

(x) to make clear, sustainable and targeted recommendations, based upon and arising from, its investigations and review; such recommendations to ensure patient safety, management performance and accountability;

(xi) to make clear recommendations as how to most effectively ensure the lessons arising from the investigations are learned, acted upon and shared; such recommendations to include, as appropriate, the future provision, operation and management of medical services, and how such recommendations are to be implemented;

(xii) to agree that the Committee of Inquiry should be based and conducted in a location which is not under the control of the Health and Social Services Department and in a manner which does not involve any personnel from that Department supporting or assisting in the administration of the inquiry – thus enabling members of staff and other individuals to speak to investigators in complete confidentiality, and in a location away from any H&SS premises.

(xiii) to produce a detailed report following the investigation which will be published in full, with the sole omissions of patient data and the identities of whistle-blowers and non-management staff – with such publication to be undertaken with no editorial input, preview or control by any Department, employee or member of the States of Jersey.

The above draft terms of reference are put forward merely as a guide and indication as to the nature of the investigation required and its modus operandi. They are in no way binding.

In writing these draft terms of reference, I have taken advice and guidance from those with specialist knowledge in health care matters.

We can be quite certain that the suggested indicative terms of reference above will produce a vastly superior inquiry to the largely cosmetic, so-called investigation as proposed by Health and Social Services, who instead have advised the Minister to commission the organisation, "Verita".

Which is why part (e) of the proposition asks the Minister to abandon that non-independent, so-called investigation.

The motivations of the senior managers, who have designed the current "investigation" being largely obvious, let us consider the organisation carefully selected by those mangers to undertake their "investigation".

The first thing to be noted about Verita is the organisation's slogan:

"Verita: finding facts, not finding fault".

This is a quite unashamed proclamation of Verita's main selling-point – the delivery of "Blame-Free" escape routes for culpable organisations. By spending taxpayers' money on employing such organisations, senior civil servants can protect themselves, and be confident in the knowledge that the "investigation" will return a report which is not, specifically critical of themselves, and which will, at best, consist of a range of bland observations and recommendations that are little more than statements of the obvious.

It is true that the concept of "blame-free" investigation is often applied in health and social care environments. The thinking behind the blame-free approach is that by making staff feel secure from disciplinary actions, they will be more open, frank and forthcoming with the facts relating to any serious incident.

And it is true that this approach can, indeed, be effective in getting to the truth and learning lessons.

However, the approach itself has certain serious limitations, even when applied correctly. But, in fact, it is often misapplied.

If that approach is always adopted in an organisation, it can lead to serious levels of complacency amongst some staff, who may pay less attention to the quality of their work, secure in the knowledge that if something goes wrong, no real consequences will arise for them personally.

It can lead to defective, incompetent or dangerous staff remaining working in an environment in which they continue to pose a risk.

The "blame-free" approach should only be applied, where appropriate, to frontline staff and professions allied to medicine. Instead – it has been hijacked by senior management and misapplied in order to protect themselves.

Senior managers in an organisation must carry meaningful expectation and accountability, concomitant to their level of responsibility and remuneration.

When every person working within an organisation – up to and including the highest levels of management – becomes cloaked and shielded with the "blame-free" mantra – effectively, you have an organisation which, in its entirety, is "blame-free".

No matter what catastrophic deficiencies the organisation may suffer from – no one will ever be to blame for those deficiencies.

No one will ever be held to account – with the result that you have an organisation which is immune from accountability.

But, in this case, a person is dead.

She lost her life needlessly as a consequence of a cascade of management, clinical and clinical governance failings.

Some people are to blame for that fact; some people are accountable.

Yet if we allow the people who are culpable to employ Verita, we grant them immunity from accountability.

In considering Verita, it is useful to read the following selection of quotes taken from the organisation's 'sales-pitch', as found on its website. And as is ever the case with such things, to gain an understanding of the true meaning of what's being communicated, it is necessary to 'read between the lines'. Emphasis added throughout –

> "Verita is a specialist consultancy service with one aim: to help public sector organisations **when a crisis threatens**. Our experience in the management and conduct of investigations, reviews and inquiries is unrivalled in the UK.
>
> With our in-depth knowledge of the way that health and social care organisations work and the pressures they are under, we can help you pinpoint the cause of the problem – **and then help you deal with the consequences**. We always do this to the highest standards, on time, and within an agreed budget."
>
> "Public sector organisations work under constant scrutiny. **When things go wrong people want to know why and, increasingly, who is to blame**. Faced with allegations of falsifying hospital waiting lists, the death of a child on the child protection register or a case of staff bullying, an organisation will find itself having to commission an investigation, review or inquiry and **then communicate the findings to a sceptical public**. Few organisations are equipped to do this, and this is where Verita can help."
>
> "We provide advice and consultancy on every aspect of setting up and conducting an investigation or inquiry: agreeing the terms of reference, collecting and safeguarding the evidence, appointing the chair and panellists, managing the inquiry process, resolving the legal issues, writing and publishing the report, **and communicating the findings to the public."**
>
> "Commissioning and managing inquiries is a risky business that is beyond the experience of many managers. **All too often what starts off as a remedy and a desire to learn and improve becomes yet another problem for the organisation to manage**: the process becomes long and drawn out, findings fail to stand up to scrutiny, and costs soar. Verita helps public sector organisations to avoid these pitfalls."
>
> "**Where appropriate, we will devise a strategy for handling the media and, when the investigation is over, make sure that its conclusions and recommendations are communicated clearly and effectively to the public.**"
>
> **"The importance of planned communications**
> **By being proactive about communication, and establishing trust with key journalists early on, you take control over what is reported. At a minimum this should eliminate the inaccuracies and misconceptions that**

can creep into coverage. At best, you will be credited for an open and responsible process and reliable conclusions."

"Write the terms of reference. Having established a clear purpose, write it down and clear it with your lawyers. **Do not automatically commit the organisation to full and open publication of the final report."**

"Communicate. Whether or not the investigation report is published, you will need to communicate what went wrong, the lessons learned and the actions taken. **Decide who you need to tell, what you need to say, how you are going to say it, and when."**

The above-quotes are taken from the sales-pitch of Verita, as published on their website – and are clearly designed to instantly appeal to any management structure which finds itself under the microscope.

It is clear that Verita are health and social care investigatory agency second – and a firm of spin-doctors first.

This organisation – on which we propose to spend taxpayers' money – has as a true purpose, to assist failed senior managers spin themselves out of trouble.

Is that what the people of Jersey want?

Or do they expect a genuine, comprehensive, independent inquiry – which will get to the truth – and, if appropriate, apportion blame accordingly?

It is plain that the Minister for Health and Social Services must be told by the Assembly to abandon the farrago engineered by the senior managers, and that the States must employ an organisation with real experience of genuine health and social care investigations; for example, the Care Quality Commission.

The Care Quality Commission (CQC) is the statutory inspection and investigation authority for healthcare in England. Encompassing all aspects of health and social care, the organisation is able to engage in a holistic approach to all aspects of regulating and inspecting health and social care organisations.

The CQC is simply the most obvious body to commission. However, there are other organisations which could undertake this task with professionalism and objectivity. For example, the Royal College of Obstetricians and Gynaecologists.

The States of Jersey has a choice.

We can, effectively, endorse the farrago that is the proposed "independent" investigation, as preferred by H&SS managers.

Or we can seek the involvement of a reputable organisation of national stature to deliver a real investigation into this tragedy.

There can be no credible argument as to which of those 2 paths best serves the public interest.

Financial and manpower statement

I do not know what the cost of this investigation will be. What can be said with confidence is that it will certainly be no more than H&SS propose to spend on their preferred firm of spin-doctors. Once the Greffier has negotiated a contract, the management budget of Health and Social Services would seem the most appropriate source of funding.

Likewise, any manpower or staff time requirements that might be involved in servicing a professional, independent health investigatory organisation will be no more than those which would be incurred by the non-independent inquiry preferred by H&SS senior managers.

In any event – a person has lost their life – needlessly. Could the States seriously argue that properly investigating that tragedy would be "too expensive"?

APPENDIX 1

E-Mail exchange amongst certain H&SS Managers

"From: R
Sent: 21 March 2007 11.42
To: M; R
Subject: RE: Mr. D

Status: Confidential

Thanks M

I have left a message with S requesting permission to disclose to NCAS. As said, we keep Minister and deputy Minister informed of this case at each fortnightly meeting. I will suggest at the meeting this Friday that a ministerial decision will be required regarding next steps.

Regards

R.

R
Director of Corporate Planning
& Performance Management.

----Original Message----
From: M
Sent: 20th March 2007 19.01
To: R; R
Subject: Mr. D
Sensitivity: Confidential

Hi R

I've been working on a timeline to cross-reference how and when we have complied with the Docs Disciplinary Procedure as requested by Advocate D.

We're mostly OK (it's quite tricky given the level of detail in the procedure). I'll forward you copies when I've finished.

The bits where we have slipped a little (we can justify but need a couple of file notes) are:

Keeping the Minister updated in a formal manner. I know MP will be doing this regularly but technically we should be providing the Minister with a written report and the end of each exclusion period! I'll get MP to provide me with a file note to explain how and when he updates SS. Going forward could this be added as a quick agenda

item at the Ministerial meeting once a month so that we can prove we've complied? Seems a bit OTT but DC is being so pedantic Advocate D thinks we should make every effort to comply.

Once we reach 6 months of exclusion we are required to report to the Minister a situation report detailing reasons for continued exclusion, actual and anticipated final costs and anticipated timescale so I'll definitely make sure we do this.

Also we are obliged by this stage in the exclusion period to 'formally' refer the case to NCAS. Although we've registered the case and entered into correspondence we haven't formal referred it and asked NCAS to investigate. Dr. L – in the update letter you're about to send to NCAS could you point out that our disciplinary procedures states that we should be making a formal referral but we are minded to wait until the police have pronounced. Could they confirm in writing that this would be appropriate. What do you think?

Also I've had to allocate roles as per the procedure. Dr. L you're the Case Manager (as MD this is appropriate). The guidelines state you must consider all the issues around pay, exclusion from premises, keeping in contact, cpd etc which you've been doing.

RJ as the 'Designated Board Member' you are the person who oversees and maintains momentum of the process. Your responsibilities include:

- Receiving reports and reviewing the continued exclusion form wok of the practitioner;
- Considering any representation from the practitioner about their exclusion;
- Considering any representations about the investigation.

So you're doing all this too.

I'll try and catch you both tomorrow morning.

RJ – hope your plane spotting is going well!!!

Dr. L – hope you're feeling better X

Thanks

M".

APPENDIX 2

H&SS Managers' Preferred Terms of Reference as Issued to the Media

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

The Health and Social Services Minister has commissioned an independent investigation into the care, treatment and management of Mrs. Elizabeth Rourke who died during a routine gynaecological operation at the General Hospital on 17th October 2006. A subsequent police investigation led to the locum registrar who operated on Mrs. Rourke standing trial for manslaughter. At the trial, which concluded in January 2009, the defendant was found to be not guilty.

The purpose of the independent investigation is to:

> 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 her death including its own internal investigation
>
> 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 patient safety and quality of health services.

The independent investigation will be carried out by Verita, a management consultancy that specialises in reviews, investigations and inquiries in health and social care. Three of Verita's most experienced investigators will carry out the work: Managing Director Ed Marsden, Director of Client work, Derek Mechen and Senior Investigator Dr. Sally Adams.

The investigation team aims to conclude its work by September 2009 and will provide a written report with recommendations to the minister.

No further information about the investigation or its findings will be released until the investigative team has concluded its work.

Ends

For more information, please contact Rose Naylor on 01534 444196.