STATES OF JERSEY

VOTE OF NO CONFIDENCE: STATES EMPLOYMENT BOARD (P.137/2016) – COMMENTS

Presented to the States on 27th January 2017
by the States Employment Board

STATES GREFFE

SEB COMMENT P.137/2016

VOTE OF NO CONFIDENCE: STATES EMPLOYMENT BOARD

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SEB COMMENT – P.137/2016 VOTE OF NO CONFIDENCE: STATES EMPLOYMENT BOARD

1. Executive Summary

The States Employment Board (SEB) rejects P.137/2016 – 'Vote of No Confidence: States Employment Board' lodged by Deputy M.R. Higgins of St. Helier.

The functions and role of the SEB were highlighted and examples of the work undertaken by the Board are shown in Appendix 8.

The suggestion in P.137/2016 that the case of Power, Bellwood and Day are examples of similar cases that support a motion of no confidence in the SEB are considered and rejected.

- Mr. Power, as Chief of Police was not subject to the SEB. In law, he reported to the Home Affairs Minister of the day and was not a States employee. The circumstances surrounding this case have been fully explored in the Napier report at the time.
- Mr. Bellwood`s case was reviewed by the SEB of the day and an independent review (Upex Review) commissioned to examine his dismissal. The recommendations were implemented. It is noted that this is a case from 2007 that involved none of the members of the 2 SEBs involved in the Alwitry case.
- Mr. Day`s case had not been resolved when the current Chair of the SEB took office in 2011 but was resolved in short order afterwards. It had been subject to a detailed review as part of the wider Verita report, which led to an overhaul of the HSSD management and clinical leadership structure.

The proposition relies heavily on the case of Mr. A. Alwitry and the report of the States Complaint Board. The SEB report in response to the Complaint Board report clearly highlights both the serious and detailed concern it has applied to this case over 4 years and why it has maintained the consistent position that the decision to rescind was the correct albeit there were some procedural flaws that it has accepted. Process in the hospital have been both reviewed and improved subsequently (Appendix 7).

Mr. Alwitry had his contract of employment as an Ophthalmology Consultant at the Jersey General Hospital withdrawn on 22 November 2012 owing to:

- Attitude and behaviour displayed in relation to multiple aspects of the role.
- Demonstrable evidence of a dysfunctional relationship with the clinical director and other senior medical and management staff.
- Loss of trust and confidence between the respective parties resulting in any employment relationship being irreparably damaged.
- The decision of HSSD senior and clinical management, under delegated authority, to terminate the contract was supported by SEB when the then States of Jersey HR director informed them via email.

The SEB during 2013 commissioned 3 independent reports by external specialists to assure itself that the decision to terminate was both the right one and proportionate.

i. The Haste Report February 2013 (Appendix 3): the purpose of the report was to establish whether it was possible via mediation to resolve the dispute between Mr. Alwitry and senior managers and Clinicians. Nine interviews were conducted including Mr. Alwitry. The conclusion was that whilst mediation could take place:

> *"I have concerns about the feasibility of mediation as a dispute resolution mechanism per se given Mr. Alwitry`s reluctance to explore the issues except as a means to the end of achieving the reinstatement of the appointment; but also because the clear consensus from the decision makers that a reversal of the decision to withdraw is not tenable."*

ii. The Beal Report April 2013 (Appendix 4): the purpose of this report was to review the process of recruitment and the decision to rescind the offer of employment. Nineteen interviews were conducted including Mr. Alwitry. The outcome of the report was that recruitment process of the Consultant "was not robust and lacked objectivity and integrity." In reality, this criticism suggests that the decision to recruit Mr. Alwitry may have been the wrong one. With regard to the decision to rescind the contract of employment the report concluded;

> "*the team took a reasoned and well thought through approach, taking soundings on the matter form the law office, informed SEB of their view and took the appropriate action based on clinical need and service delivery. I believe they followed due process to try and resolve the issues with Mr. Alwitry on his start date and that they tried to seek agreement on the job plan with him. Clearly, the trust and confidence between the employer and Mr. Alwitry has broken down and this was a reasonable response to the situation at the time. Mr. Alwitry appears to lack insight into his part in this situation he now finds himself …."*

iii. The Sharp Report February 2014 (Appendix 5): the purpose of the report was to provide a definitive and final review of the Alwitry case. The Solicitor General Howard Sharp QC interviewed the key personnel including Mr. Alwitry. He concluded that whilst the procedural aspects of the case were unsatisfactory:

> "*it was reasonable for the hospital management to terminate the employment contract.*"

Indeed, he goes on to say:

> " *If an appropriate procedure had been followed, I have concluded that the outcome would have been the same in this case. A proper investigation of the 12th November 2012 email would have provided confirmation of the dysfunctional relationship and revealed allegations of bad faith. I have interviewed Mr. Alwitry over several hours. I have been unable to reconcile much of his testimony to the other evidence in the case. It was hard to detect any sign of an acceptance of responsibility for the events I describe below. Further allegations of bad faith have been made or raised for my consideration.*

This is not a case where it is appropriate to consider reinstatement. As I have already indicated, the merits of the decision cannot be criticised and the continued pursuit of allegations of bad faith is not conducive to rebuilding a broken relationship."

In the light of the consistent conclusions of all 3 reports the SEB conclude the decision to rescind the contract was the correct one.

Mr. Alwitry lodged an Employment Tribunal claim that he subsequently withdrew without proceeding to the Full Hearing.

A complaint was lodged with the States Complaint Board on 10 March 2014, which was eventually heard on 16 March 2016 after a number of postponements. The terms of reference in an email from the Greffe were quite specific:

"I wish to confirm that the basis upon which the case will be heard is unchanged –

The decision that the Panel will be considering involves the process resulting in the revocation of Mr. Alwitry's contract. It will not be looking at the grounds on which SEB withdrew the contract nor the merits of those grounds. They will also not be looking at matters relating to patient safety or whistle-blower protection.

The papers previously circulated are the only papers which will be under consideration and the Panel will disregard any elements which are not pertinent to the issue under consideration (as aforementioned)."

The SEB believes the conclusions of the Complaints Board which are extensively quoted in P.137/2016 are neither consistent with the terms of reference or with a balanced and considered response from a public body established by the States Assembly. The detailed response of the SEB is shown in Appendix 1.

In conclusion, in certain employment matters, a dismissal may be justified when the integrity or competence of the employee is not in issue but where the cause for concern is personality and the inability of the employee to build and maintain essential working relationships with others in the workplace. In Perkins v St. George's Healthcare NHS Trust [2005] EWCA Civ 1174, the English Court of Appeal considered the appeal of an employee who had been dismissed because they were unable to work harmoniously with other colleagues, which was an essential part of the role. The English Court of Appeal confirmed that such an issue in the workplace could justify dismissal. The employee's response to the criticism made of him by his employer was to launch a sustained and manifestly ill-founded attack upon the honesty and integrity of his colleagues. These allegations made it impossible for the employee to continue in his employment and due to their nature and persistence, they were found to corroborate the original concern; that the employee was near impossible to work with.

Employment Tribunals in both England and Jersey frequently hear unfair dismissal cases whereby an employer has good grounds to dismiss an employee but has failed to follow a fair

procedure before taking the decision to dismiss. In such circumstances, Tribunals are highly likely to make a finding of unfair dismissal, awarding a measure of compensation to the employee. However, if it is found that the decision to dismiss had merit, this may be a relevant factor in assessing the level of compensation awarded. In these circumstances, the employee's conduct would be a relevant consideration and Tribunals have been known to reduce an award to zero, based on the employee's conduct.

In the context of this case, it is also important to acknowledge that it is not uncommon for employers to decide that the situation with an employee is such that it would be better to terminate the contract and make a payment to the employee equal to the compensatory award that may be due. This is in order to draw a line under the matter and quickly move on, should that be in the best interests of the company or organisation and indeed the individual. Clearly, such a decision should only be taken only after very careful thought. The SEB does not regard such action as extraordinary or rare as the Complaints Board appears to suggest.

Mr. Alwitry has issued legal proceedings in the Royal Court.

2. Response to Proposition

The SEB, in its comment, strongly refutes that there is any need for a vote of no confidence on this or any other matter in relation to its accountabilities. The States Assembly is invited to reject the proposition.

3. The Role of the States Employment Board

The role and the accountabilities of the States Employment Board are contained in the Employment of States of Jersey Employees Law 2005, (see link below). The States Employment Board (SEB) has the power to delegate its functions to any of its members or to the Chief Executive. There is provision for the Chief Executive to further delegate this power.

https://www.jerseylaw.je/laws/revised/Pages/16.325.aspx

Such delegations are confirmed following the appointment of members to the States Employment Board after a public election has taken place. For ease of reference, the key features are shown in full below by Article number:

"8 Functions of States Employment Board

(1) The States Employment Board shall –

(a) employ persons on behalf of the States and administrations of the States;

(b) ensure that the public service conducts itself with economy, efficiency, probity and effectiveness;

(c) ensure the health, safety and well-being of States' employees;

(d) determine any other matter that may reasonably be considered necessary for the proper administration and management of States' employees; and

(e) discharge any other function conferred on it by or under any enactment.

(2) The States Employment Board shall, for the purpose of the discharge of the functions described in paragraph (1)(a) to (c) –

(a) give directions regarding consultation or negotiation with States' employees, or with representatives of States' employees, concerning the terms and conditions of employment of States' employees;

(b) issue codes of practice concerning –

(i) the training and development needs of States' employees,

(ii) the procedures for recruitment of States' employees,

(iii) the procedures for appraisal of the performance of States' employees,

(iv) the procedures for disciplining, suspending and terminating the employment of States' employees, and

(v) interventions by the Commission under Article 26A.

(3) The States Employment Board may issue codes of practice concerning any other matter relating to the employment of States' employees.

(4) In paragraph (2)(b)(ii), "States' employees" includes a person who is to be treated as a States employee by virtue of Article 15(2).

(5) The functions referred to in paragraph (1)(e) include the functions conferred by Article 8(1) of the Departments of the Judiciary and the Legislature (Jersey) Law 1965[1], Article 3 of the Loi (1864) concernant la charge de Juge d'Instruction[2] and Article 41(5) of the States of Jersey Law 2005[3]."

"5 Membership of States Employment Board

(1) The States Employment Board shall be constituted by –

(a) the Chief Minister, or another Minister who is nominated by the Chief Minister to be a member of the Board in his or her place;

(b) 2 other persons, each of whom –

(i) is a Minister or an Assistant Minister, and

(ii) is appointed in writing by the Chief Minister to be a member of the Board; and

(c) 2 elected members of the States, each of whom –

(i) is neither a Minister nor an Assistant Minister, and

(ii) is elected by the States to be a member of the Board.[4]

(2) The Chief Minister or, if the Chief Minister nominates a person under paragraph (1) to be a member of the Board in his or her place, that person, shall be the Chairman of the States Employment Board.

(3) A member of the States Employment Board shall hold office until a Chief Minister is appointed to office, under Article 19(7) of the States of Jersey Law 2005[5], following the

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[1] chapter 16.300
[2] chapter 07.525
[3] chapter 16.800
[4] Article 5(1)amended by R&O.44/2010
[5] chapter 16.800

next ordinary election, unless the member of the Board resigns or is removed from office earlier.[6]"

"9 Powers of States Employment Board

(1) The States Employment Board has the powers necessary to perform its functions.

(2) Without limiting the generality of paragraph (1), the States Employment Board has the power to enter into contracts of employment of persons and to enter into contracts for the provision of services, including by consultants."

"10 Delegation

(1) The States Employment Board may, by instrument in writing, delegate to any of its members, or to the Chief Executive Officer, any of its powers or functions under this Law.

(2) If a power or function has been delegated under paragraph (1) to a member of the States Employment Board, the member may, with the approval of the States Employment Board, delegate by instrument in writing the power or function to the Chief Executive Officer.

(3) If a power or function has been delegated under paragraph (1) or (2) to the Chief Executive Officer, he or she may, with the approval of the States Employment Board, delegate by instrument in writing the power or function to another person who is –

(a) a person approved by the States Employment Board; or

(b) a member of a class of persons approved by the States Employment Board."

At a practical level the role of SEB is to provide strategic policy to officers to discharge its responsibility as the employer in law. Its functions are fulfilled via reports, briefings, discussions and meetings presented by its officers and departments. It meets regularly once a month and on an ad hoc basis if needed. Its meetings are fully minuted by the States Greffe and experienced Committee clerks.

The members of the States Employment Board are highlighted above and it is of note that 2 of its members who are elected to the Board represent the States Assembly. This was implemented in an amendment to the Employment of States of Jersey Employees (Jersey) Law 2005 implemented by the Employment of States of Jersey Employees (Amendment No. 5) (Jersey) Regulations 2010. The debate at the time explained why such an amendment was made but, clearly, the 2 members elected by the States are there to ensure that the SEB functions effectively as the corporate employer and not acting purely as an agent of the Chief Minister or the Council of Ministers.

They provide a valuable assurance process for the Assembly that the Board is fulfilling its functions appropriately. In the event that they have a fundamental disagreement, they can bring their concerns back to the Assembly.

A typical year for the States Employment Board is shown in Appendix 8.

[6] Article 5(3)added by R&O.81/2015

4. Cases highlighted in the Proposition

Deputy Higgins refers to 3 cases: Mr. J. Day, Mr. G. Power, Mr. S. Bellwood, as well as Mr. Alwitry to justify his proposition.

- Mr. Power, as Chief of Police was not subject to the SEB. In law, he reported to the Home Affairs Minister of the day and was not a States employee. The circumstances surrounding this case have been fully explored in the Napier report at the time.
- Mr. Bellwood`s case was reviewed by the SEB of the day and an independent review (Upex Review) commissioned to examine his dismissal. The recommendations were implemented. It is noted that this is a case from 2007 that involved none of the members of the 2 SEBs involved in the Alwitry case.
- Mr. Day`s case had not been resolved when the current Chair of the SEB took office in 2011 but was resolved in short order afterwards.. It had been subject to a detailed review as part of the wider Verita report, which led to an overhaul of the HSSD management and clinical leadership structure.

All 3 cases have no relationship to the case of Mr. Alwitry.

It is difficult to see what relevance highlighting these cases has to the specific vote of no confidence proposed by Deputy Higgins.

5. Background

Mr. Amar Alwitry is a Consultant Ophthalmologist. He applied for a new Consultant post at Jersey General Hospital in June 2012, which stipulated a start date of winter 2012. He attended, with others, an interview process on 31 July and 01 August 2012. He was successful and the post was offered to him by the Clinical Director – Mr. Richard Downes on 01 August, which was followed up by an offer letter on 8 August 2012, which indicated a start of 3 days a week initially until going full-time c. 4 February 2013. On 8th August 2012, Human Resources sent Mr. Alwitry a letter that began *"Further to our recent conversation".* Mr. Alwitry initiated this conversation. The letter enclosed an employment contract not withstanding that negotiations about start date had not been resolved.

The Managing Director of the Hospital has stated that he became concerned about Mr. Alwitry's contact with Human Resources when he was told about it shortly after the event. The Managing Director says Human Resources told him that Mr. Alwitry had asked them for the employment contract on the basis that he, the Managing Director, had approved this request. He had not. This resulted in the letter from the Managing Director of the Hospital dated 10 August 2012. The letter highlighted what Mr. McLaughlin referred as "*remarkable*" and "*unique*" behaviour in his experience. It was at this stage that initial concerns grew leading him and others to doubt in August 2012 whether Mr. Alwitry should be engaged as an employee at all.

In parallel discussions were continuing about the job plan which is an integral part of the contract which again makes it surprising a contract had been issued and accepted by Mr. Alwitry. The process of Job Planning, which is integral to the contract of a Hospital consultant, is normal both here and in the NHS in the UK.

A job plan can be described in simple terms as a prospective, professional agreement that sets out the duties, responsibilities, accountabilities and objectives of the consultant and the support and resources provided by the employer for the coming year. However, in order to drive measurable and sustainable improvements in quality, an effective job plan needs to be more than a high-level timetable that sets out in general terms the range of a consultant's activity. It is vital that it articulates the relationship between the organisation and the consultant and the desired impact on patient care.

To make job planning a better instrument for consultants and managers to provide high quality care, the process should be:

- *undertaken in a spirit of collaboration and cooperation*
- *completed in good time*
- *reflective of the professionalism of being a doctor*
- *focused on measurable outcomes that benefit patients*
- *consistent with the objectives of the organisation, teams and individuals*
- *clear about the supporting resources the organisation will provide to ensure that objectives can be met*
- *transparent, fair and honest*
- *Flexible and responsive to changing service needs during each job plan year*
- *fully agreed and not imposed*
- *focused on enhancing outcomes for patients whilst maintaining service efficiency.*

It is during the process of job planning and start date negotiation that the hospital management and senior clinicians saw behaviours, which gave them cause for concern. For example:

Following Mr. Downes' email of 24 September 2012, which made very explicit the proposed job plan, Mr. Alwitry then proceeded to contact a number of staff in the Hospital seeking to go behind it and rearrange the timetable set out in Mr. Downes' email. This was unacceptable and resulted in Mr. Downes' letter of 9 October 2012, which clearly indicated the behaviour expected of Mr. Alwitry in the organisation. Mr. Downes expected to meet Mr. Alwitry to discuss his arrangements for starting work in December 2012 when he came to the Island on 22 and 23 October 2012 but Mr. Alwitry did not meet him or any other Hospital management. Following disclosure of documentation that was subsequently obtained from the BMA, it is understood that he had been in discussions with the BMA.

Discussions about job planning etc. and various email exchanges took place during early November. It is alleged by Mr. Alwitry that these were driven by patient safety concerns and not his own desire to have a job plan, which suited his domestic circumstances irrespective of

the impact on the Hospital and patient needs. A detailed refutation of the patient safety claim is shown in Appendix 6. The key issues are:

- Mr. Alwitry first stated in September 2012 that for safety reasons
  - He required a post-operative clinic to review his complex patients the day following surgery.
  - He stated that a new and unnecessary clinical risk would be introduced if he had to operate on his complex cases (or indeed any intraocular surgery cases) on a Friday as there would be no follow-up on the Saturday
  - He stated that it would be ideal to have consecutive theatre sessions in case he needed to return to theatre the following day if complications arose with one of his complex cases (Trabeculecomy cases).

The first 2 points are valid and broadly supported by his 'expert' submissions, the third is seen as 'ideal but not essential' by his 'experts', who also note that serious complications are 'very rare'.

However:

- The timetable the Clinical Director proposed on 24 September 2012 gave Mr. Alwitry access to a theatre session with a clinic the following day (on alternate weeks) – which is what he requested. This appears to meet his patient safety requirements and is not therefore a patient safety issue:
  - This would have been sufficient for scheduling the complex patients, as volumes are low. (1-2 per week)
  - If more capacity was required, he could have utilised colleague's sessions when they were away – a solution that Mr. Alwitry put forward himself.
  - Alternatively, he could have used his Tuesday operating list, seen his follow patients in his Admin time on Wednesday, and switched a later session to undertake admin.

- At no point was there *only* Friday operating lists proposed, meaning that there was always an opportunity to undertake his complex cases on another weekday – therefore Friday operating was not a patient safety issue.
  - There are high volumes of routine ophthalmology day case procedures that can perfectly safely be undertaken on a Friday, Mr. Alwitry would be expected to undertake his 'share' of this type of case – therefore this list could be utilised safely.
  - Simple cataracts operations are considered intraocular yet can safely be completed as very short procedures and discharged without next day follow-up (Mr. Alwitry undertakes this model of surgery currently). Cataracts are the highest volume procedures undertaken in Jersey and would be suitable for a Friday operating list.

- There is a staffed 24/7 emergency theatre available for urgent cases or returns to theatre. This would support any urgent complications that could not be accommodated in an ophthalmology list. As there have never been more than

8 trabeculecomies in any one year this event would be exceedingly rare – Therefore this was not a patient safety issue.

- The allegation that the timetable was altered to knowingly introduce further clinical risk is unfounded as the alternate week Friday operating list was in the originally proposed timetable advertised with the job and remained the same in the proposed final version on the 24/09/12.

- Mr. Alwitry proposed changing his weekday 'on call' to a Monday yet not planning to fly back to the island until Monday morning – this was rejected as this would have been a significant patient safety issue on each and every working week.

It became clear in late October /early November that Mr. Alwitry`s behaviours were leading to a breakdown in trust and confidence in him by both senior clinicians and senior management in the hospital. The importance of relationships and the wider culture is summarised in a quote from the then Hospital Managing Director:

> "*when I first arrived I was brought in specifically to deal with a number of issues, one of which was the relationship issue, which had broken down between the consultants in obs and gynae, and that related to the, to the tragic death of Mrs. Rourke during a routine procedure a number of years ago, which had led to police investigations and other investigations, GMC enquiries, the lot. There was a difficult relationship between the consultants in that department and it needed mediation to sort out, and part of what I was doing when I first came in was actually conducting that mediation between the consultants in that department. I can think of at least three other departments where there were multiple BMA complaints raised by consultants against their consultant colleagues, very poor relationships, and that potentially compromises patient care. Now there was, so there is a very clear link between behaviours of consultants and the relationships between consultants within the department and their ability to deliver safe care ultimately to patients.*"

This refers to the context in which the Verita Report was produced (Appendix 7) and the change in hospital leadership that took place in 2010. The new leadership was tasked with significantly improving the quality and performance of the hospital. As part of that task, it was vital to ensure high quality relationships between clinicians and clinicians and senior hospital management. A view emerged that Mr. Alwitry and his behaviours would set back significantly the progress achieved to that point.

A consensus within HSSD Clinical management and Hospital management concluded that the appropriate course of action was to withdraw the contract of employment before Mr. Alwitry commenced work on the 3 December 2012.

The Hospital Managing Director, HSSD HR Director and the Medical Directors provided briefings to the CEO and the Ministers. Authorisation to terminate the contract was agreed.

The SEB were informed by the then SOJ HR Director via email for information because of the HSSD concern of media/political involvement. They accepted the joint clinical and management advice of the Hospital, which had been endorsed by the Health Ministers.

The HSSD HR Director issued the letter rescinding the contract on 22 November 2012.

The SEB met on 18th December 2012 to discuss the matter as there had been significant correspondence from third parties such as family, friends and some politicians concerning the decision. The Minister attended for Health and Social Services together with colleagues from clinical and senior management as follows –

J. Garbutt, Chief Officer
A. McLaughlin, Hospital Managing Director
T. Riley, Human Resources Director
A. Luksza, Consultant Physician and Joint Medical Director
M. Siodlak, Consultant Surgeon and Joint Medical Director
R. Downes, Consultant Ophthalmologist and Clinical Director
A. Body, Director of Operations.

At this meeting, the Board reviewed the facts of the case as presented by HSSD clinical and senior management and determined the following, that the SoJ HRD should complete a review of the recruitment process assisted by the LOD.

On 8th January 2013, a further meeting took place that revised the approach. It was agreed that an independent mediator be sought to see if a mutual satisfactory outcome could be achieved (The Haste Report). Separately, an Independent report (as opposed to the internal report originally envisaged) was commissioned to review the HR recruitment process and the decision to rescind the contract (the Beal report). Finally, in September 2013 the Board commissioned the then SG to produce a definitive and further independent report (the Sharp report). HSSD clinical and senior management provided the SEB with a letter dated 14 January 2013 – shown in Appendix 2 which referred to their concerns.

Copies of these reports are found in Appendices 3, 4 and 5.

The overwhelming conclusion of all 3 reports, all of which included interviews with some or all of the parties including Mr. Alwitry, was that whilst the process of the decision to rescind the contract should have been better – the outcome was correct.

6. Employment Tribunal Claim

Mr. Alwitry submitted an employment tribunal claim on 8 July 2013 and is understood to have withdrawn from proceedings on 8 December 2014 prior to a Full Hearing.

In the context of this case, it is also important to acknowledge that it is not uncommon for employers to decide that the situation with an employee is such that it would be better to terminate the contract and make a payment to the employee equal to award that may be due. This is in order to draw a line under the matter and quickly move on, should that be in the best interests of the company or organisation. Despite the States Complaint Board`s assertion, this practice takes place both here and in the UK and in both the private and public sector.

7. States Complaints Board report

The complaint was first submitted in March 2014 and was subsequently heard on 16 March 2016, after a long deferral and postponements to allow an Employment tribunal and reflecting Mr. Alwitry`s requests. Following correspondence from the Complainant, the Deputy Greffier wrote a letter to him on 1 April 2015, explaining the limitations of the powers of the Board.

Following a letter from Messrs Sinels (the Complainant's Advocates) to the Deputy Greffier on 8 April 2015, the Deputy Greffier emailed the Complainant and his legal representative the following day and reiterated the basis upon which the Board would be considering the complaint. The email is written in clear terms and states –

> *"I must take this opportunity to remind you both that we are not an employment tribunal and will not consider whether the SEB had reasonable grounds for seeking to terminate the contract. The discussions over start date, job plan, etc., are not therefore critical to the Board's deliberations. I note that Mr. Alwitry has provided a list of people who will accompany him, but as the Board's deliberations will be confined to whether the SEB followed due process in terminating the contract, he may wish to rethink who he wishes to accompany him. The Board can only deal with the administration of the employment process and not drift into clinical considerations – this is not within its jurisdiction at all.*
>
> *The Board is keen for Mr. Alwitry to be given every opportunity to see the hearing of his own complaint, but has to respect its boundaries. The hearing is not a legal environment – it is an informal meeting at which both sides present their case and then the Board adjudicates."*

On 30 April 2015, the Deputy Greffier emailed the Complainant once more. The email confirmed a new date for the hearing and repeated the basis upon which the Board would be hearing the complaint. Once again, the email was written in clear and unambiguous terms and stated –

> *"I passed on your comments to the Chairman and members regarding the scope of the hearing and they are adamant that they will not be looking at the grounds on which SEB withdrew the contract, let alone the merits of those grounds. They will also not be looking at matters relating to patient safety or whistle-blower protection.*
>
> *The decision that the panel will be considering (on which the Solicitor General has already admitted was unsatisfactory) involves the process resulting in the revocation of your contract."*

The hearing did not take place in 2015, following various requests from the Complainant for the hearing to take place on alternative dates. During the various correspondence between

the parties during 2015, the Board's terms of reference were called into question and on 3 June 2015, the Deputy Greffier reiterated, once again, to both parties the basis upon which the Board would be considering the complaint. The following was stated –

> *"The decision that the Panel will be considering involves the process resulting in the revocation of Mr. Alwitry's contract. It will not be looking at the grounds on which SEB withdrew the contract nor the merits of those grounds. They will also not be looking at matters relating to patient safety or whistle-blower protection.*
>
> *The papers previously circulated for the hearing, which was deferred in April 2015, are the only papers which will be under consideration and the Panel will disregard any elements which are not pertinent to the issue under consideration (as aforementioned). No correspondence received subsequently has been forwarded to the Panel for consideration as part of the process."*

Following further postponements, the Deputy Greffier listed the complaint to be heard on 1 March 2016.

Upon receipt of confirmation from the Complainant that he would be unavailable to attend the listed hearing, the hearing was relisted to 16 March 2016. This was the second occasion upon which the Complainant had sought a relisting of the hearing in order to ensure that he would be available to attend.

On 24 February 2016 (following a suggestion that the Complainant had attempted to introduce additional papers to those that should be before the Board), the Deputy Greffier on behalf of the Chair of the Complaints Board confirmed the following –

> *"I wish to confirm that the basis upon which the case will be heard is unchanged –*
>
> *The decision that the Panel will be considering involves the process resulting in the revocation of Mr. Alwitry's contract. It will not be looking at the grounds on which SEB withdrew the contract nor the merits of those grounds. They will also not be looking at matters relating to patient safety or whistle-blower protection.*
>
> *The papers previously circulated are the only papers which will be under consideration and the Panel will disregard any elements which are not pertinent to the issue under consideration (as aforementioned).*"

On 2 March 2016, the Deputy Greffier received an email from Messrs Sinels seeking a further postponement of the hearing on the basis of the recently handed down Royal Court judgment concerning the Complainant's application before the Royal Court under the Data Protection legislation.

On the same day, the Deputy Greffier emailed Messrs Sinels confirming that the hearing would not be adjourned and will proceed on 16 March 2016, as previously listed. The email further stated the basis upon which the Board would hear the complaint as follows –

"The Chairman says –

We have informed the parties that we will limit our enquiry to the process by which the contract of employment was terminated/withdrawn, and not the ground upon which the decision was taken. I will expect any disclosure pursuant to the judgment would impact on the grounds rather than the process.

If, however, Mr. Alwitry (or indeed the Board) during the course of our hearing believes that the consideration of the process would be assisted by having available data produced following the Court Order, then the hearing could be adjourned to allow the Board and the parties that newly available data.

I hope that this is an acceptable way forward."

Given the correspondence concerning the complaint, the SEB understood that the hearing of the complaint would be restricted to examining the policies, procedures and process involved in the termination of Mr. Alwitry's contract of employment.

In the event, Mr. Alwitry did not appear nor did he present any witnesses. This would have allowed the Board to have access to first hand evidence about the events in question.

The Complaints Board acknowledges in its Report that the absence of the Complainant and his witnesses was unsatisfactory.

The response of the SEB is shown at Appendix 1.

Members are encouraged to read the SEB's response to the Complaints board for themselves. However, the SEB position is defined as follows:

The SEB considers that the Complaints Board did not conduct the hearing in accordance with its own directions and that it strayed into areas that it had specifically and repeatedly told the SEB and the Complainant that it would not deal with such as the reasonableness of the decision to withdraw Mr. Alwitry's contract of employment.

Whilst the SEB acknowledges that it is perhaps understandable, given the considerable delay there had been in arranging the hearing due to the objections raised by Mr. Alwitry which eventually took place two years after the complaint was first lodged, that the Board was reluctant to adjourn the hearing any further, nevertheless the Board did not hear sufficient witness evidence relevant to the enlarged scope of the Board's review. The findings and recommendations of the Board fall considerably outside those terms and are not supported by the necessary evidence. It only heard from one witness, whose evidence on behalf of the SEB largely only went to the procedure followed in relation to the decision to withdraw the offer of employment to Mr. Alwitry.

The SEB commissioned two reviews prior to the review of the Board, both of which concluded that the decision made was the correct one. Neither was cursory and both were independent. The SEB considers that the conclusions of Mr. Beal and the former Solicitor General are reliable and soundly based. Unlike the Board, Mr. Beal and the

former Solicitor General had interviewed 18 and 11 witnesses respectively, including lengthy interviews with Mr. Alwitry.

The SEB strongly disagrees that the decision to withdraw Mr. Alwitry's employment was not one that a reasonable body of persons could make.

Whilst it is accepted that there could be improvements in the way the decision was taken, the SEB and the Hospital remain convinced that it was the correct decision in the best interests of the Hospital and of the Island of Jersey. There were procedural failings that the SEB has previously acknowledged. However, the SEB invites the Board to reconsider the remainder of its findings. The SEB notes that the Board recognises that "there may be exceptional circumstances that would justify a breach of contract if it were clearly in the public interest to do so". It is submitted by the SEB that there were such exceptional circumstances here.

It is accepted that in future, if a particular start date is required, this should be specifically stated in the advert. In addition, in the event that there was a future need to withdraw an offer of employment from a consultant before their commencement date there will be a meeting with that consultant to provide him of her with the opportunity to explain their version of events.

The SEB disagrees with the conclusion in respect of the motivation of the Hospital's senior management team, which was driven not by financial cost but by the importance of ensuring a harmonious working relationship within a small team of three consultants and by a loss of trust and confidence in Mr. Alwitry. It accepts (and has accepted since November 2012) that a payment should be made to Mr. Alwitry to reflect the absence of a period of notice and the offer of a procedure. This was a difficult decision and the easy option for the Hospital's senior management would have been not to withdraw the contract. The senior management team rightly chose not to take the easy option for the benefit of the Hospital.

Verbal and written feedback has been received from successful and unsuccessful candidates and Royal College representatives complimenting the Hospital on its recruitment process. The SEB has seen emails from ten Consultants commenting on the positive experience of the recruitment process in Jersey, including positive comparisons with the NHS recruitment process.

Finally, the management structure at the Hospital has been further strengthened since the appointment of the current Managing Director, who was not in post in 2012. There is an appropriate focus on clinical governance that is in line with structures in the NHS. The SEB are assured that improvements in relation to recruitment, particularly in relation to start dates and hours worked have been implemented.

8. Status of Claim

An Order of Justice claim has been lodged in the Royal Court. It would be inappropriate to comment further.

9. Conclusion

The SEB is of the view that, far from there being a vote of no confidence in its handling of the Alwitry case, it has conducted in detail and over a considerable period of time, a detailed review of the HSSD decision to rescind the contract offered to Mr. Alwitry. It has assured itself that the outcome was the correct one. It has accepted that whilst there were procedural irregularities, Mr. Alwitry`s behaviours meant that there was irrevocable breakdown in the employment relationship such that HSSD had no alternative but to dismiss if they wished to maintain a positive and strong clinical leadership in the Hospital delivering high quality and safe patient care to the Island.

The SEB is of the view that there are no grounds for the Assembly to proceed to a Vote of No Confidence.

APPENDICES

Appendix 1 –	**Response by the States Employment Board to the findings of the Complaints Board regarding Mr. Alwitry – 04 October 2016**
Appendix 2 –	**Letter from Hospital Management Team – 14 January 2013**
Appendix 3 –	**Report on the Independent Conflict Analysis carried out for John Richardson, Chief Executive, States of Jersey (Haste report) (Haste Report) – 26 February 2013**
Appendix 4a –	**States of Jersey Independent Case Review (Beale Report) – 8 April 2013**
Appendix 4b –	**Updated actions from the Beal Report**
Appendix 5 –	**The Recruitment of Mr. Alwitry: The Solicitor General's Report – 17 February 2014**
Appendix 6 –	**Mr. Alwitry Safety Case – 5 January 2017**
Appendix 7 –	**Verita: An independent investigation into the care, treatment and management of Mrs. Elizabeth Rourke – January 2010**
Appendix 8 –	**A typical year's activities for the States Employment Board (2015)**

APPENDIX 1 to P.137/2016 Com.

RESPONSE OF THE STATES EMPLOYMENT BOARD TO THE FINDINGS OF THE COMPLAINTS BOARD REGARDING THE WITHDRAWAL OF AN OFFER OF EMPLOYMENT TO MR ALWITRY

Response by the States Employment Board to the findings of the Complaints Board (constituted under the Administrative Decisions (Review) (Jersey) Law 1982 (the "Law") to consider a complaint made by Mr A Alwitry regarding the offer of employment to the position of Consultant Ophthalmologist

Executive Summary

The SEB considers that the Complaints Board did not conduct the hearing in accordance with its own directions and that it strayed into areas that it had specifically and repeatedly told the SEB and the Complainant that it would not deal with such as the reasonableness of the decision to withdraw Mr Alwitry's contract of employment.

Whilst the SEB acknowledges that it is perhaps understandable, given the considerable delay there had been in arranging the hearing due to the objections raised by Mr Alwitry which eventually took place two years after the complaint was first lodged, that the Board was reluctant to adjourn the hearing any further, nevertheless the Board did not hear sufficient witness evidence relevant to the enlarged scope of the Board's review. The findings and recommendations of the Board fall considerably outside those terms and are not supported by the necessary evidence. It only heard from one witness, whose evidence on behalf of the SEB largely only went to the procedure followed in relation to the decision to withdraw the offer of employment to Mr Alwitry.

The SEB commissioned two reviews prior to the review of the Board, both of which concluded that the decision made was the correct one. Neither was cursory and both were independent. The SEB considers that the conclusions of Mr Beal and the former Solicitor General are reliable and soundly based. Unlike the Board, Mr Beal and the former Solicitor General had interviewed 18 and 11 witnesses respectively, including lengthy interviews with Mr Alwitry.

The SEB strongly disagrees that the decision to withdraw Mr Alwitry's employment was not one which a reasonable body of persons could make.

Whilst it is accepted that there could be improvements in the way the decision was taken, the SEB and the Hospital remain convinced that it was the correct decision in the best interests of the Hospital and of the Island of Jersey. There were procedural failings which the SEB has previously acknowledged. However, the SEB invites the Board to reconsider the remainder of its findings. The SEB notes that the Board recognises that "there may be exceptional circumstances that would justify a breach of contract if it were clearly in the public interest to do so". It is submitted by the SEB that there were such exceptional circumstances here.

It is accepted that in future, if a particular start date is required, this should be specifically stated in the advert. In addition, in the event that there was a future need to withdraw an offer of employment from a consultant before their commencement date there will be a

meeting with that consultant to provide him of her with the opportunity to explain their version of events.

The SEB disagrees with the conclusion in respect of the motivation of the Hospital's senior management team, which was driven not by financial cost but by the importance of ensuring a harmonious working relationship within a small team of three consultants and by a loss of trust and confidence in Mr Alwitry. It accepts (and has accepted since November 2012) that a payment should be made to Mr Alwitry to reflect the absence of a period of notice and the offer of a procedure. This was a difficult decision and the easy option for the Hospital's senior management would have been not to withdraw the contract. The senior management team rightly chose not to take the easy option for the benefit of the Hospital.

Verbal and written feedback has been received from successful and unsuccessful candidates and Royal College representatives complimenting the Hospital on its recruitment process. The SEB has seen emails from ten Consultants commenting on the positive experience of the recruitment process in Jersey, including positive comparisons with the NHS recruitment process.

Finally, the management structure at the Hospital has been further strengthened since the appointment of the current Managing Director, who was not in post in 2012. There is an appropriate focus on clinical governance which is in line with structures in the NHS. The SEB are assured that improvements in relation to recruitment, particularly in relation to start dates and hours worked have been implemented.

Introduction

This response of the States Employment Board (the "SEB") follows the numbering and structure of the report (the "Report") of the Complaints Board (the "Board") constituted to consider a complaint by Mr A Alwitry[1] against the SEB following the hearings before the Board on 16 and 17 (a.m.) March 2016.

The SEB has endeavoured to provide the Board with a detailed response to its Report. However, in the time available the SEB has not been able to provide a specific response to every line of the Report, particularly as regards the details findings in Annex A. The fact that the SEB does not comment specifically on a section of the Report should not be interpreted as meaning that the SEB agrees with it.

A lengthy letter before action and draft Order of Justice has been received by the SEB on Friday 30 September 2016. The SEB has been unable to review the letter before action and draft Order of Justice before submitting this response to the Board and at this stage it is uncertain whether Mr Alwitry intends to persist with parallel proceedings before the Board and potentially in the Royal Court. Nothing in the response should be interpreted as being

[1] The correct form of address for a surgeon is to refer to him or her as Mr or Mrs, not Dr. The States Employment Board therefore refers to Mr Alwitry throughout this document rather than referring to Dr Alwitry as the Complaints Board has done.

an admission in relation to any future claim by Mr Alwitry and the SEB's position in relation thereto remains entirely reserved.

Paragraphs 1 to 7 (pages 1 to 68) of the Report - the hearings, evidence presented and submissions of the parties

The SEB notes that the Report does not set out the Terms of Reference of the Board.

The SEB refers to the emails of the Deputy Greffier of the States (which are set out below) containing directions concerning the procedure which the Board intended to follow - namely that they were reviewing the procedure followed in relation to the withdrawal of Mr Alwitry's employment to the position of Consultant Ophthalmologist and not whether the decision was reasonable. Whilst the SEB accepts that the Law provides that it is for the Board to regulate its own procedure, these directions were relied on by the SEB and led it to limit the evidence which it presented at the hearing to the evidence of Mr Riley.

Relevant procedural history

The Complainant filed his complaint in March 2014. Subsequently the complaint was adjourned by the Complainant to allow parallel Jersey Employment and Discrimination Tribunal proceedings to conclude.

Notwithstanding the adjournment, the Complainant withdrew the Tribunal proceedings on 6 December 2014 prior to the final hearing.

The complaint was listed by the Deputy Greffier of the States of Jersey to be heard on 14 April 2015, at 10.00am. Prior to the listed hearing formal submissions were filed and lists of witnesses who were to attend the hearing were confirmed to the Board on or about 9 March 2015.

Following correspondence from the Complainant, the Deputy Greffier wrote a letter to him on 1 April 2015[2], explaining the limitations of the powers of the Board.

Following a letter from Messrs Sinels (the Complainant's Advocates) to the Deputy Greffier on 8 April 2015[3], the Deputy Greffier emailed the Complainant and his legal representative the following day[4] and reiterated the basis upon which the Board would be considering the complaint. The email is written in clear terms and states -

> *"I must take this opportunity to remind you both that we are not an employment tribunal and will not consider whether the SEB had reasonable grounds for seeking to terminate the contract. The discussions over start date, job plan, etc, are not therefore critical to the Board's deliberations. I note that Mr Alwitry has provided a list of people who will accompany him, but*

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[2] Appendix 1. Document 1
[3] Appendix 1. Document 2
[4] Appendix 1. Document 3

as the Board's deliberations will be confined to whether the SEB followed due process in terminating the contract, he may wish to rethink who he wishes to accompany him. The Board can only deal with the administration of the employment process and not drift into clinical considerations - this I not within its jurisdiction at all.

The Board is keen for Mr Alwitry to be given every opportunity to see the hearing of his own complaint, but has to respect its boundaries. The hearing is not a legal environment - it is an informal meeting at which both sides present their case and then the Board adjudicates."

On 30 April 2015, the Deputy Greffier emailed the Complainant once more[5]. The email confirmed a new date for the hearing and also repeated the basis upon which the Board would be hearing the complaint. Once again the email was written in clear and unambiguous terms and stated -

"I passed on your comments to the Chairman and members regarding the scope of the hearing and they are adamant that they will not be looking at the grounds on which SEB withdrew the contract, let alone the merits of those grounds. They will also not be looking at matters relating to patient safety or whistle-blower protection.

The decision that the panel will be considering (on which the Solicitor General has already admitted was unsatisfactory) involves the process resulting in the revocation of your contract."

The hearing did not take place in 2015, following various requests from the Complainant for the hearing to take place on alternative dates. During the various correspondence between the parties during 2015, the Board's terms of reference were called into question and on 3 June 2015 the Deputy Greffier reiterated, once again, to both parties the basis upon which the Board would be considering the complaint[6]. The following was stated -

"The decision that the Panel will be considering involves the process resulting in the revocation of Mr Alwitry's contract. It will not be looking at the grounds on which SEB withdrew the contract nor the merits of those grounds. They will also not be looking at matters relating to patient safety or whistle-blower protection.

The papers previously circulated for the hearing, which was deferred in April 2015, are the only papers which will be under consideration and the Panel will disregard any elements which are not pertinent to the issue under consideration (as aforementioned). No correspondence received

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[5] Appendix 1. Document 4
[6] Appendix 1. Document 5

> *subsequently has been forwarded to the Panel for consideration as part of the process."*

Following further postponements, the Deputy Greffier listed the complaint to be heard on 1 March 2016.

Upon receipt of confirmation from the Complainant that he would be unavailable to attend the listed hearing, the hearing was relisted to 16 March 2016. This was the second occasion upon which the Complainant had sought a relisting of the hearing in order to ensure that he would be available to attend.

On 24 February 2016 (following a suggestion that the Complainant had attempted to introduce additional papers to those that should be before the Board), the Deputy Greffier confirmed the following[7] -

> *"I wish to confirm that the basis upon which the case will be heard is unchanged -*
>
> *The decision that the Panel will be considering involves the process resulting in the revocation of Mr Alwitry's contract. It will not be looking at the grounds on which SEB withdrew the contract nor the merits of those grounds. They will also not be looking at matters relating to patient safety or whistle-blower protection.*
>
> *The papers previously circulated are the only papers which will be under consideration and the Panel will disregard any elements which are not pertinent to the issue under consideration (as aforementioned)*."

On 2 March 2016, the Deputy Greffier received an email from Messrs Sinels seeking a further postponement of the hearing on the basis of the recently handed down Royal Court judgment concerning the Complainant's application before the Royal Court under the Data Protection legislation.

On the same day, the Deputy Greffier emailed Messrs Sinels[8] confirming that the hearing would not be adjourned and will proceed on 16 March 2016, as previously listed. The email further stated the basis upon which the Board would hear the complaint as follows -

> *"The Chairman says -*
>
> *We have informed the parties that we will limit our enquiry to the process by which the contract of employment was terminated/withdrawn, and not the ground upon which the decision was taken. I will expect any disclosure*

[7] Appendix 1. Document 6
[8] Appendix 1. Document 7

pursuant to the judgment would impact on the grounds rather than the process.

If, however, Mr Alwitry (or indeed the Board) during the course of our hearing believes that the consideration of the process would be assisted by having available data produced following the Court Order, then the hearing could be adjourned to allow the Board and the parties that newly available data.

I hope that this is an acceptable way forward."

Given all of the correspondence concerning the complaint, the SEB was left in no doubt that the hearing of the complaint would be restricted to examining the policies, procedures and process involved in the termination of Mr Alwitry's contract of employment. Furthermore, that the Board would not consider any other issues given the previous directions of the Deputy Greffier and the Chairman; nor any evidence on any other such issues.

It was reasonable for the SEB to expect the Complainant and/or his witnesses to appear in person at the hearing and for them to answer questions from both the Board and the SEB's representative. This would have allowed the Board to have access to first hand evidence about the events in question.

The Board acknowledges in its Report that the absence of the Complainant and his witnesses was unsatisfactory.

The SEB acknowledges that it is perhaps understandable, given the considerable delay there had been in arranging the hearing due to the objections raised by the Complainant which eventually took place two years after the complaint was first lodged, that the Board was reluctant to adjourn the hearing any further.

However, the absence of the additional witness evidence and the rejection of a request from both Mr Riley and the SEB's legal representative to call other witnesses, in circumstances where it was apparent that Mr Riley himself did not have first-hand evidence of many of the events (his evidence was in relation to the procedure which is admitted was deficient), leads the SEB to conclude that the Board did not have access to the evidence required to enable it to come to many of the findings it did; in particular those which concern the reasonableness of the decision and patient safety. The SEB therefore considers that a number of the Board's findings either cannot be relied upon or, at the very least, are materially diminished as a result.

This is in contrast to the investigation conducted by the former Solicitor General who interviewed 11 witnesses in depth during a period of over one month. Two witnesses (Mr Alwitry and Mr Downes) were interviewed twice. The transcripts of those interviews run to over 1,000 pages and contain relevant and significant evidence concerning the reasons for the withdrawal of Mr Alwitry's contract or his dismissal from employment by the SEB. In this case the SEB considers that documentary evidence alone is not sufficient to understand the procedure followed in relation to Mr Alwitry's dismissal. Oral evidence should have been

heard if the Board was deciding the reasonableness of the decision to withdraw Mr Alwitry's contract of employment and patient safety.

The transcripts of the former Solicitor General's interviews with the 11 witnesses were sent to the SEB after the hearing. However, they are not referred to in the Board's report. The SEB considers that this was a fundamental deficiency in the Board's report and it is a key reason why the SEB does not agree with most of the findings of the Board's report.

The SEB otherwise makes no comment on the summaries of the hearings, evidence presented and submissions of the parties set out in pages 1 to 68 of the Report.

In conclusion, the SEB considers that the Board conducted the hearing outside of its own terms of reference as set out in the Deputy Greffier's emailed directions and that the Board did not hear sufficient witness evidence relevant to the enlarged scope of the Board's review. The findings and recommendations fall considerably outside those terms and are not supported by witness evidence.

8 - The Board's findings (pages 68 - 70)

For ease of reference the Board's Findings are included before the SEB response and appear in italics. The SEB has grouped together responses to paragraphs where appropriate. The adoption of the language used in the Board's Report is made for convenience only and without any admissions.

Paragraph 8.1 - "*Mr Alwitry's contract of employment as a Consultant Ophthalmologist was entered into unconditionally in August 2012."*

SEB Response - This is agreed. The contract agreed was initially part time (three days a week) starting 3 December 2012 moving to full time in February 2013.

Equally however, once a binding contract was formed there were also obligations on Mr Alwitry, including an obligation to comply with the reasonable requests of the Hospital's senior management such as Mr McLaughlin and Mr Downes, as well as a duty of mutual trust and confidence between employer and employee. He did not comply with these requests and the relationship of trust and confidence between employer and employee broke down; consequently the SEB considers that the Hospital had reasonable grounds for withdrawing Mr Alwitry's contract.

A negotiation of Mr Alwitry's timetable had already taken place between Mr Alwitry and his Clinical Director, Mr Downes, in September 2012 which had resulted in the timetable that was issued by Mr Downes in his email to Mr Alwitry of 24 September 2012. This had been preceded by the "negotiation" which had taken place over his start date in August which had resulted in the letter from the Managing Director of the Hospital dated 10 August 2012 which, as set out below, Mr McLaughlin referred to as "*remarkable*" and "*unique*" in his experience, leading him and others to doubt in August 2012 whether Mr Alwitry should be engaged as an employee at all.

Following Mr Downes' email of 24 September 2012 Mr Alwitry then proceeded to contact a plethora of staff in the Hospital seeking to go behind it and rearrange the timetable set out in Mr Downes' email. This was unacceptable and resulted in Mr Downes' letter of 9 October 2012 which clearly indicated the behaviour expected of Mr Alwitry in the organisation. Mr Downes expected to meet Mr Alwitry to discuss his arrangements for starting work in December 2012 when he came to the Island on 22 and 23 October 2012 but Mr Alwitry did not make any effort to meet him, nor did he attempt to meet any other member of Hospital management. Instead, following disclosure of documentation that was subsequently obtained from the BMA, it transpires that he was in discussions with the BMA and it did not suit him tactically to meet with Mr Downes at that time.

Mr Downes was left in the dark as to whether Mr Alwitry was intending to start work or not at the Hospital which led him to contact a consultant ophthalmologist at Derby Hospital where Mr Alwitry was then working to ask whether Mr Alwitry was coming or not. Whilst he was told that Mr Alwitry was coming to Jersey it is remarkable that Mr Alwitry made no effort to contact Mr Downes, despite being told by the Derby colleague that Mr Downes had contacted him to ask this question.

The relationship of trust and confidence between Mr Downes and Mr Alwitry had broken down by this stage and there were already doubts with senior management as to whether Mr Alwitry should be employed at all as they did not want to have a dysfunctional team of consultants in the Ophthalmology Department. It was in this context it was learnt on 12 November that Mr Alwitry had instructed the BMA to contact the Hospital's HR Department in an email which stated as follows: "*Dr Alwitry has run into a few problems with the consultant lead*" - ie his Clinical Director Mr Downes. It is disputed as to whether this approach from the BMA was a complaint, an informal complaint, a negotiating lever, a clarification of the number of Mr Alwitry's PA's in his contract as against his timetable or something else[9], but it was seen by the senior management as consistent with the pattern of disruptive and unmanageable behaviour that Mr Alwitry had already amply demonstrated from August onward. This was the "last straw" for senior management causing the Hospital to decide that his contract should be revoked or that his employment should be terminated.

Following receipt of a letter from Mr Alwitry's wife senior management were prepared to re-consider this decision but it was then learnt that Derby Hospital were not willing to re-engage Mr Alwitry as a consultant, something which was also "extraordinary".[10] This confirmed to senior management that they had taken the correct decision.

Paragraph 8.2 - "*The action of the SEB in breaching the contract . . . on 22 November 2012 was unlawful in that it represented a clear and fundamental breach of the contract by the SEB".*

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[9] It is to be noted that Mr Alwitry subsequently pursued a grievance against Mr Downes to the General Medical Council which was dismissed by the GMC.

[10] Pages 89 of the Transcript of interview with Mr Downes dated 25 November 2013 and page 105 of Transcript of interview with Mr McLaughlin dated 22 November 2013.

and

Paragraph 8.4 - "*The decision to 'withdraw' Mr Alwitry's contract of employment was contrary to law, unjust, oppressive, based on irrelevant considerations and misunderstandings as to the factual position and conclusions on alleged facts and law that could not have been reached by a reasonable body of persons properly directing themselves as to the facts and law, and was in breach of the fundamental principles of natural justice applicable to the circumstances of this case.*

SEB Response - The SEB strongly disagrees that the decision to withdraw Mr Alwitry's employment was not one which a reasonable body of persons could make. The ability to work harmoniously with colleagues is fundamental to the employer/employee relationship and there were reasonable grounds for senior management at the Hospital to consider that Mr Alwitry would not work harmoniously within a small team based on his behaviour from August to November 2012. Further, that ability is particularly important in a Hospital where a lack of a harmonious relationship within teams can result in serious adverse consequences for patient safety and clinical governance.

Mr Alwitry's conduct between his interview on 1 August and the letter sent to him on 22 November 2012 withdrawing his contract of employment demonstrated to senior management at the Hospital that he was extremely difficult if not impossible to manage. The Hospital's senior management (in particular Mr McLaughlin, Mr Downes, Mr Siodlak and Mrs Body, none of whom were interviewed by the Board) had never encountered such behaviour previously and they therefore reluctantly concluded that they had to dismiss Mr Alwitry. It was a difficult decision but they took it in the greater interests of the Hospital and the Island. The SEB agrees with that decision.

For example, Mr McLaughlin (the Managing Director of the Hospital) commented as follows in his evidence to the former Solicitor General -

> "*Well I've never had to write a letter like that to a consultant ever, and I've appointed dozens and dozens of consultants over the years. I mean this was such a remarkably unusual process from the time that the job offer was made to the time that the job offer was withdrawn, it, it frankly, it's quite remarkable; there's no other word for it*."[11]

As regards the multiple discussions with Mr Alwitry over his start date Mr McLaughlin states this -

> "*the fact that that was within, effectively a, a working week, certainly not much more, of the interview, is unheard of. I mean, I, I, I've just never had to do that ever before. This was, and I am incredibly …how can I put this word? You have to be incredibly patient and flexible when you are dealing with*

[11] Page 20 of Mr McLaughlin's transcript of interview on 22 November 2013 commenting in relation to his letter to Mr Alwitry dated 10 August 2012.

consultants, 'cause they expect to have access to the, the people running the organisation, when it suites them, frankly at no notice. And you get used to the, because they're very able, intelligent people, they're used to getting that access. So you can't stand on ceremony; you certainly can't say 'no', because if they've got to come and see you or have made the time to come and see you, I always make the time to, to let that conversation take place. But that doesn't mean that there isn't a job to be done and eventually that needs to come to an end you need to get on with doing it. So the fact that my patience had been tested to that degree within days of an appointments panel, is unique."[12]

As regards the "negotiations" over Mr Alwitry's timetable once he was due to start work full time in February 2013 Mr McLaughlin says this -

"*The term 'high maintenance' springs to mind, that there was an enormous amount of work that was generated by this individual, who still hadn't actually started working in the organisation. And it, it, just to give you an example there, flipping a list from Akin Famoriyo on Thursday afternoon in day surgery unit isn't as simple as it sounds, because he's a consultant gynaecologist and the nursing staff, the theatre staff that would be there to support, and the anaesthetist that would be there to support his operating would not necessarily be the same staff that would be needed to support and ophthalmology list, and it's also the case that when you have an ophthalmology list there are, because the risk of cross-infection is very high when you are dealing with people's eye, there are certain things you don't want to have recovering in the recovery room immediately before or people arriving for. So, so there, it's not just a case of whether it suits Mr Suchandsuch to flip his list from morning till afternoon or from one day to another, there is a, a, a raft of implications in staffing related issues that Mr Alwitry just either didn't understand or just didn't care about. And because he was firing off in so many directions simultaneously, you know, he talks about the fact, "I could speak to Mr Famoriyo," well there are probably examples, I'm not aware of them, where, but it wouldn't surprise me, where he called a consultant and said, "I understand you've got a day's surgery list on such and such an afternoon, would you mind swapping it to this?" And of course that sets all sorts of hares running, because staff have their own personal arrangements around the fact that they operate on a particular day, and I'm not talking about the consultants, I'm talking about the nursing staff or the, the other staff that support a theatre session; and when they hear that a consultant's moving a list from day to another day, potentially it means their operating day is going to be changed and their schedules are going to be changed. And there are often knock on effects for all of these things about*

[12] Page 24 of Mr McLaughlin's transcript of interview on 22 November 2013.

access to ITU beds, about, you know, how many patients are going to be cancelled.."[13]

"*The idea that you, as a consultant, who hasn't even started working in the organisation yet, rings a member of staff who, whilst she is a very senior and experienced nurse, she is relatively junior in the hierarchy, and you put what this email includes, which is a raft of alternative suggestions about moving this to there, doing this, doing that, doing the other, "I can simply ditch …" This is something that is totally inappropriate and just shouldn't happen, and I can't think of an occasion where I've come across this before…*

And frankly it just gives you an indication that you cannot, we were having real difficulty pinning this individual down to agreeing to anything that enabled us to put our plans in place to make it work in practice. And it didn't matter how often we thought we had got agreement, the debate was then reopened, usually with a conversation with a relatively junior member of staff who would have been trying to help and trying to say what the art of the possible was, but with imperfect knowledge of the other conflicting factors that need to be considered."[14]

As regards the decision to withdraw Mr Alwitry's offer of employment following the contact made to the Hospital by the BMA, Mr McLaughlin illustrates the difficult nature of the decision as follows -

"*I think the 'final straw' comment is probably a good way to describe it. On its own it's just a very small insignificant thing, it's just a piece of straw, but it was the last thing, when it was added to everything else that happened before, that kind of just said, "Look, there isn't actually a way back on this individual, let's just go with the gut feel on this," however painful it's going to be, that this individual will be a nightmare in the organisation to manage, and, and we need to do the right thing, not because there's any advantage to us in doing it, quite the reverse, it's going to be horribly painful to do it, but the alternative is that we land Jersey with a consultant, who is clearly unmanageable in governance terms, for the next 20 years, and, and that's not an appropriate way to do your duty. So we did the difficult thing even though there was no advantage for us in doing it, because we weren't going to be around to have to deal with the chap anyway. So if we'd just said, "Just appoint him," it's going to be our successors' problems, not our problem. Well that's an easy thing to do. Why would you go into the world of pain of withdrawing his contract, unless you had a really, really powerful feeling that that was the right thing for Jersey to do? That's exactly where we were and*

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[13] Pages 53 of transcript of interview with Mr McLaughlin.
[14] Page 54 of Transcript of interview with Mr McLaughlin

> *the BMA was just the final tipping point; it wasn't actually significant. If it hadn't have been there, would we have come to the same decision? Yes, is my view. So it, it looks as if it was the final tipping point, but was it in and of its own right massively significant? No, it was just symptomatic of everything that had gone before.*"[15]

As regards the importance of harmonious relationships in teams within the Hospital and patient safety Mr McLaughlin states this -

> "*when I first arrived I was brought in specifically to deal with a number of issues, one of which was the relationship issue, which had broken down between the consultants in obs and gynae, and that related to the, to the tragic death of Mrs Rourke during a routine procedure a number of years ago, which had led to police investigations and other investigations, GMC enquiries, the lot. There was a difficult relationship between the consultants in that department and it needed mediation to sort out, and part of what I was doing when I first came in was actually conducting that mediation between the consultants in that department. I can think of at least three other departments where there were multiple BMA complaints raised by consultants against their consultant colleagues, very poor relationships, and that compromises potentially, potentially compromises patient care. Now there was, so there is a very clear link between behaviours of consultants and the relationships between consultants within the department and their ability to deliver safe care ultimately to patients.*"[16]

This is highly relevant and significant evidence from a hugely experienced hospital director who has previously successfully managed large NHS trusts in the United Kingdom. A myriad of similar comments were provided in evidence by other members of the senior management team such as Mr Downes, Mr Siodlak and Mrs Body and some of that evidence is set out later in this response. Unfortunately, their evidence appears to have been wholly ignored by the Board in its Report.

Whilst it is entirely accepted that there could be improvements in the way this was handled, the SEB and the Hospital remain convinced that it was the correct decision in the best interests of the Hospital and of the Island of Jersey. There were procedural failings which the SEB had previously acknowledged. However, the SEB strongly invites the Board to reconsider the remainder of its findings.

Paragraph 8.3 - "*It is for the States Assembly to consider whether it is acceptable general policy to knowingly breach a contract that it has freely entered into but the Board is of the unanimous view that while there may conceivably be exceptional circumstances that would*

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[15] Page 92 of Transcript of interview with Mr McLaughlin
[16] Page 97 of Transcript of interview with Mr McLaughlin

justify a breach of contract if it were clearly in the public interest to do so, we can see no such justification in this case"

SEB Response - The SEB notes that the Board recognises that *"there may be exceptional circumstances that would justify a breach of contract if it were clearly in the public interest to do so".* It is submitted by the SEB that there were such exceptional circumstances here.

The general interests of the Hospital and the Island of Jersey in this case have already been referred to in the evidence of Mr McLaughlin. Mrs Body (the Director of Operations of the Hospital) comments on the wider considerations as follows -

> "*…is that the way you act as a team? You're coming in to a new hospital and you're saying, "Well, by the way, that gynae lot can have my Friday list, 'cause I don't want it." You know, and, and ophthalmology is largely a day, a day procedure. Patients come in the morning and go home at night, and we do have complications and Mr Alwitry's quite right, but he's got, for patients that are, are deemed to be complex and, and you can't always tell when something goes wrong, but you can put those complex cases on the Tuesday list that he had. Gynae patients invariably stay in for three or four days and so we steer away from trying to do gynae operating. We do have to do it and, and Mr Famoriyo had to take a Friday morning, but you try and steer away from it, so that you put those cases on the beginning of the week so that they can recover and go home by the end of the week. It's much better, it's safer and it's better use of, of all resources and it's much nicer for the patient. So but the, just the, the team spirit of saying, "Oh, let that lot have it 'cause I don't want it," is, is not right. But what was frustrating is you've now got everybody 'cause, 'cause he was having conversation with the theatre manager, the, the clinic nurse, you know, Bartley, Richard, even myself, not much with myself, when I first copied in, I could see, you know, what was happening. Nobody knew where, where they were going. You didn't know what you were going to set up and, and the time is going on, and it takes a while to set up your profiles and, and, and to get the right systems in place. And so, you know, I've been in, in quite a few appointments and sometimes closer than this one, and, and sometimes more distant, but I've never experienced this.*"[17]

She also states -

> "*…I would hope there was an organisation strong enough to say, "Hang on a minute," you know, "It isn't just about whether you are very good clinically, it is whether you are right for the hospital, for the benefit of the healthcare service," 'cause we do need consultants to be managers. We need them to make big important decisions with managers in the interests of, of patient*

[17] Page 22 of Transcript of interview with Mrs Body on 15 November 2013.

care, and direct clinical care as well. And my worry is this sort of thing will make managers in the future, "Phhh, I don't think I'll go there."[18]

Similarly, Mr Downes' evidence (Mr Downes was the Clinical Director for Ophthalmology and Mr Alwitry's future direct line manager) was follows -

"*Because within the organisation you need to work within a team, you need to work within a hospital structure and you need to be able to relate with your colleagues without perhaps causing all sorts of problems before you've even started in post. The theatre is just one example, with Mr Famoriyo; you know, Bartley wasn't prepared to change his timetable right from the outset. All he was prepared to do ever was to change his, his on call, which didn't really make much difference one way or the other. The, the, the way in which the department runs, it has to be, you've got to have an overview with regard to what the rest of the staff are doing, what the rest of the facilities are and what the nursing staff are doing. And the overview fits with this timetable, and that's the timetable that he was going to be taking up. That was it, that was the timetable that's organised for him, that was the definitive timetable that was arranged, and that is the one that I expected him to, to adhere to….*

I spoke with Judith as well about this. Judith said, "I don't want to hear from that man [ie Mr Alwitry] again. I am completely fed up with him pestering me by emails and telephone calls, expecting me to do things which I have told him I can't alter. Andrew has, was, in the meantime, saying, you know, he was getting other discussions of not a dissimilar thing from other people including Mr Famoriyo and one of the anaesthetists. So he was probably aware of a wider hospital wide problem. And my feeling was, at this stage enough was enough, Amar [Alwitry] needed to understand that we had done what we could and I didn't really want to be entering into myriads more of emails until he got into post. When he was in post, when he knew things would be able to change, that's the time to do things, if indeed we were able to do that. But, you know, that was the best we could do. There was no point in him continuing to badger everybody, different individuals; if he doesn't get the answer he wants from one person, he goes to another, doesn't get it from that person, he goes to another. If he doesn't do that, he tries to undermine other people's authority and also their recommendations with regard to things like, you know, the timetable and working conditions."[19]

In circumstances where Mr Alwitry's behaviour was so exceptionally disruptive to the arrangements of the Hospital there were reasonable grounds to withdraw Mr Alwitry's contract of employment before he occupied a permanent post as a consultant where he would cause more disruption contrary to the interests of the Hospital and of patients.

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[18] Page 57 of Transcript of interview with Mrs Body on 15 November 2013.
[19] Page 51 of transcript of interview with Mr Downes on 25 November 2013.

Paragraph 8.5.1 - "*Dr Alwitry was given no opportunity to answer the charges against him before the final termination decision was taken: he was not even aware of any charges against him before his contract was terminated*".

And paragraph 8.5.2 - "*Dr Alwitry was allowed no right of appeal, notwithstanding that a right of appeal was clearly set out in his employment contract."*

And paragraph 8.5.3 - "*The persons raising the charges brought against Mr Alwitry were, to all intents and purposes the same as those who took the decision to terminate the contract. There was absolutely no independent review of the charges brought.*"

And paragraph 8.5.4 - "*At no time was Dr Alwitry given a fair hearing, or indeed a hearing at all.*"

SEB Response: - It is accepted that the decision to withdraw the offer of employment was procedurally deficient in that he was not allowed an opportunity to answer the charges against him at a hearing or a right of appeal. However, it is not entirely correct to state that the persons raising the charges against him were the same as those who took the decision in that Mr Luksza and Mr Siodlak had not been materially involved in the events leading to the decision to withdraw the offer. Further, Mr Downes who was a person *"raising the charges brought against Mr Alwitry*" was not present at the meeting on 12 November 2012 at which the decision was taken as he was away in the United States and unaware of the meeting or the decision. The advice from Mr Riley of the Hospital's HR Department to senior management (Mr Riley was present at the meeting of senior management on 12 November 2012) was to proceed with the decision without giving a hearing or right of appeal to Mr Alwitry based on his experience of withdrawing contracts in the NHS in the United Kingdom. Further, the decision was subsequently checked with Mrs Garbutt, the Chief Executive of the Health and Social Services who was not present at the meeting on 12 November 2012 who decided to brief the then Minister for Health concerning it. Nevertheless, in the event that there was a future need to withdraw an offer of employment from a consultant before their commencement date there will be a meeting with that consultant to provide him or her with the opportunity to explain their version of events.

Paragraph 8.5.3 - "*The Minister failed to exercise any scrutiny of the decision and the SEB seemed concerned only that the decision should not attract the attention of the Health and Social Services Scrutiny Panel. This was particularly inexplicable as they had directly received third party evidence in complete contradiction of the submission of the Hospital Management.*"

And paragraph 8.5.4 - "*At the SEB meeting at which the Hospital management decision to terminate the contract was ratified, a large delegation of those senior members of the Hospital staff - clinicians and management - making the allegations were present, in order to put additional pressure on the SEB. That could not have happened if the decision to terminate the contract had been arrived at following an independent review of the charges brought*".

The decision to recruit and dismiss employees lies with the relevant Chief Officers in line with the general scheme of delegation agreed by the SEB and in accordance with the Employment of States of Jersey Employees (Jersey) Law 2005 and accompanying Regulations. The Director of Human Resources for Health and Social Services alerted the Chief Executive for Health and Social Services about this case on 13 November 2012. The Chief Executive of Health and Social Services briefed the then Minister for Health and Social Services on or about 14 or 15 November 2012 as it was recognised that this was an unusual situation concerning a senior clinician.

The Chief Executive (of Health and Social Services) foresaw the likelihood that Mr Alwitry would seek to engage politicians and the media in an attempt to bring pressure to bear on the Department and for that reason members of the SEB were advised about this case before Mr Alwitry was informed of the decision to withdraw the offer of employment. The Chief Executive of Health and Social Services and the Minister received letters and emails from a variety of people, including members of Mr Alwitry's family challenging the decision from 29 November 2012. Mr Alwitry's letter to the Chief Minister dated 18 December 2012 was not received by the Chief Minister until after the SEB's meeting on 18 December 2012.

It is accepted that the meeting of the SEB on 18 December 2012 was attended by seven members of Hospital staff and also by the then Minister for Health. The attendance of Hospital staff at part of the SEB meeting gave SEB members the opportunity to question them directly, although equally Mr Alwitry was not present at this meeting.

The SEB is the body which employs all States of Jersey employees. It is the body which might be sued and/or criticised in the Assembly notwithstanding any powers delegated to officers. It was right therefore for the SEB to be briefed about this case.

The SEB`s delegation of authority to the Chief Executive and onwards to the Chief Officers of Departments properly ensures that the decisions for the recruitment and termination of contract together with the application of policies which support Human Resource Management are taken at the appropriate level. In the event that decisions or outcomes need to be challenged, then clearly defined appeal or grievance processes exist. The position has been further clarified by P.60/2015, amending the Employment of States of Jersey Employees (Jersey) Law 2005, and the development of appropriate Codes of Practice.

As for the Board's finding that the SEB "*seemed concerned only that the decision should not attract the attention of the Health, Social Security and Housing Scrutiny Panel [Scrutiny Panel]*." Presumably this finding was made on the basis of the minute of the meeting on 18 December 2012 having heard no evidence from any of the members of the SEB who were present at the meeting on 18 December 2012. However, the minute of the meeting on 18 December 2012 also refers to Standing Order 136 of the States of Jersey and to the Code of Practice for Scrutiny Panels. Standing Order 136 sets out the terms of reference for scrutiny panels and this issue could only potentially have fallen within *"(a) to hold reviews into such*

issues and matters of public importance as it, after consultation with the chairmen's committee, may decide".

Firstly, it is at least questionable whether the withdrawal of Mr Alwitry's contract of employment is a matter of public importance or a private law issue for which the jurisdiction and remedy prescribed by statute is the Court or Tribunal as provided by the Employment (Jersey) Law 2003 [and in Mr Alwitry's contract of employment]. It is noted that in a Record of Meeting of the Health, Social Security and Housing Scrutiny Panel dated 11 November 2013, the Panel was advised that this emanated from a grievance matter (which Scrutiny was not permitted to undertake reviews into) and that the Panel agreed that if it were to undertake a review it would not include any personal matters relating to the grievance case. Clearly, Scrutiny Panels have independent status - determination of their business is a matter for them within the statutory framework and Codes within which they operate. Secondly, even if this was a matter of public importance there had been no consultation with the chairmen's committee as at 18 December 2012 as required by Standing Order 136, which is a requirement to ensure that Scrutiny Panel's valuable resources are properly allocated. In these circumstances it was appropriate for the SEB to seek clarification of how the Panel's interest would accord with the terms of Standing Order 136.

Thirdly, as regards the Board's finding that the SEB meeting on 18 December 2012 "ratified" the Hospital management's decision the SEB decided that the Director of Human Resources should conduct a review of the recruitment process as soon as possible and report his findings to the Board. At the meeting of the SEB on 4 March 2012 the SEB clarified that the H&SS was only able to proceed to appoint a locum to the Ophthalmology Department. Only after the independent review by Mr Beal had been completed would a decision on the way ahead be made. The SEB submits that this this does not amount to a ratification of the Hospital's decision.

Finally, the SEB does not accept that the notion of "ratification" is appropriate in the context of the decision-making process. Whilst individual members of the SEB were consulted prior to the actual decision being taken, the SEB's role was to maintain an appropriate level of political oversight and not to interfere with operational issues.

Paragraph 8.6 - "*The Board makes no finding as to whether, had there been a properly independent review of the claims made in respect of Mr Alwitry's behaviour, such review would have been likely to find in favour of the employer or the employee….It is however appropriate for us to make it clear that there was nothing produced to the Board during the hearing which could, in the Board's view, reasonable [sic] the summary termination of Mr Alwitry's contract of employment.*"

SEB Response - Mr Beal's review was an independent review.[20] Mr Beal is an experienced external HR Consultant based in the UK without connections to the Island. Mr Beal

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[20] Appendix 1 Document 41

interviewed 18 witnesses including Mr Alwitry. Mr Beal's conclusions were in summary form as follows -

> *". . . this was a measured and reasonable response from the SMT in the HSSD to rescind this offer of employment to this Consultant."*
>
> *"The process was not robust and lacked objectivity and integrity as outlined in the report"*
>
> *"The concerns around AA's attitude and behaviour before taking up his post rightly concerned the senior team"*
>
> *"The team took a reasoned and well thought through approach, taking soundings on the matter from the law office, informed SEB of their view and took the appropriate action based on clinical need and service delivery. I believe they followed due process to try and resolve the issues with AA on his start date and that they tried to seek agreement on the job plan with him."*
>
> *"Clearly the trust and confidence between the employer and AA has broken down and this was a reasonable response to the situation at the time. AA appears to lack insight into his part in this situation he now finds himself in which is most unfortunate for him as a consultant."*

The Board's Report does not explain why it dismisses the conclusions of Mr Beal, which is the consequence of its finding in paragraph 8.6

The former Solicitor General's report was also an independent review. The former Solicitor General also concluded in briefest summary that it was reasonable for the Hospital to terminate Mr Alwitry's contract. The Board's comments on the former Solicitor General (later in the Report) betray a fundamental misunderstanding of the role of Crown Officers who are independent of the States of Jersey and appointed by Letters Patent. The former Solicitor General has previously prosecuted a doctor at the Hospital for manslaughter and the SEB for serious health and safety offences. If he was sufficiently independent to do that, the former Solicitor General was equally independent to conduct an employment law enquiry into a group of professionals at the Hospital with whom he had had no prior contact or knowledge.

The Board's findings stand in stark contrast to the findings of Mr Beal and the former Solicitor General, both of whom had interviewed many witnesses, including Mr Alwitry, unlike the Board. The SEB therefore considers that the conclusions of Mr Beal and the former Solicitor General are reliable and soundly based.

<u>The Board's Recommendations (pages 70 to 74 of the report)</u>

For ease of reference the Board's Recommendations are included before the SEB response.

_R9.1_ *On a personal level the decision to terminate Mr Alwitry's contract of employment has destroyed his professional life. He was very highly regarded by his professional peers and was a leader in his field. He was raised and schooled in Jersey and until the unlawful and unjustifiable termination of his contract, was set to return to his childhood home for the remainder of his working life. That was taken from him without any consideration apparently being given to the consequences other than the immediate financial cost. Mr Alwitry gave up a secure consultancy position on accepting the position in Jersey and has been obliged to take locum and temporary positions since his contract was unlawfully terminated. His career has, in effect, gone backwards. The effect on his personal life will presumably have been similarly traumatic.*

A9.1 The decision to withdraw the contract of employment was not one which was taken lightly. The SEB disagrees with the unqualified conclusions set out in this paragraph. The Board describes Mr Alwitry in the next recommendation as "*a young, highly regarded and motivated consultant with a particular specialism in glaucoma".* A surgeon with those skills should be able to gain a suitable position with relative ease.

The SEB profoundly disagrees with the conclusion in respect of the motivation of the Hospital's senior management team, which was driven not by financial cost but by ensuring a harmonious working relationship within a small team of three consultants and not creating a dysfunctional Ophthalmology Department, with consequential risks to patient safety. The easy option for the members of the Hospital's senior management team would have been not to withdraw Mr Alwitry's contract but they declined to take the easy option in the interests of the Hospital overall and of the Island

The former Solicitor General found that Mr Alwitry's behaviour was a legitimate cause for concern at the conclusion of his investigation, as did Mr Beal.

The inappropriate use of patient safety in an attempt to change a timetable and persistent and unfounded allegations made by Mr Alwitry thereafter made it impossible, in the view of the former Solicitor General, for Mr Alwitry to work in the Ophthalmology Department of the hospital.

Mr Alwitry was not prepared to abide by a decision made by a member of the hospital management when it was given to him. He was prepared to seek out the views of other managers or junior staff in order to obtain a different answer or in order to put pressure on the original decision maker to reconsider.

Mr Alwitry's communications with management were a concern in terms of the accuracy of the information he provided. His evidence to the former Solicitor General in interview was poor and as noted above, he was and remains prepared to persist in pursuing serious allegations that have no merit. For example, he persisted with a complaint against Mr Downes to the General Medical Council which was dismissed

by the GMC in 2015, and where no evidence was identified by the GMC in relation to six specific allegations.

By 10 October 2012, Mr Alwitry had effectively ceased communication with the individual who would become his line manager and with the senior management team at the Hospital. His relationship with his future line manager had become dysfunctional at this stage. He declined to meet with his future manager on or around the 23 October 2012 even though he had offered to do so. This would have given Mr Alwitry an opportunity to discuss his concerns in person.. Mr Alwitry maintained this communication style even when Mr Downes sought to reach out via a mutual acquaintance.

R9.2 *Based on the comments after his interview and the independent references that we have seen, as a result of the unlawful termination of Mr Alwitry's contract of employment, the community in Jersey was deprived of the opportunity to have at the Hospital a young, highly regarded and motivated consultant with a particular specialism in glaucoma. We also cannot help but conclude that the manner in which Mr Alwitry was treated - something we have described by way of understatement as "appallingly shabby" - is highly likely to have damaged the reputation of the medical service as a potential employer of high quality staff.*

A9.2 The SEB respectfully disagrees. The Hospital has since appointed three young highly regarded and motivated consultants with complementary specialisms to work in the ophthalmology department. In total the Hospital has successfully recruited 21 Consultants since 2012 using revised processes which were not all in place during the period covered by the Complaints Board. Indeed verbal and written feedback has been received from successful and unsuccessful candidates and Royal College representatives complimenting the Hospital on its recruitment process. Included in the appendix are emails from ten Consultants commenting on the positive experience of the recruitment process in Jersey, including positive comparisons with the NHS recruitment process[21].

R9.3 *In an ideal world the recommendation of the Board would be that the contract which was unlawfully breached by the Respondent should be reinstated and Mr Alwitry take up the position as soon as he was able to make appropriate arrangements for the relocation of his family. The Board further considers that it would not be inappropriate for Mr Alwitry to receive payment of the salary to which he would have been entitled from 1st December 2012 to go some way towards compensating him for the wrong he has suffered.*

A9.3 The Hospital now has a full complement of ophthalmologists and, for the avoidance of doubt, the SEB will not reinstate Mr Alwitry.

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[21] Appendix 1. Document 8

R9.4 *The Board acknowledges that this is probably not going to happen. We are now nearly 4 years on from the time that Mr Alwitry was offered the job and over 3½ years on since he was arbitrarily dismissed. The Board understands that the consultancy positions in the Ophthalmology Department of the Hospital have been filled and so there is now no vacancy available, even if Mr Alwitry was of a mind to accept a position if it were to be offered to him. Given the way in which he was treated, a reluctance or refusal on his part to work with the senior personnel at the Hospital would, in our view, be perfectly reasonable and justified.*

A9.4 See answer to Paragraph A9.3

R9.5 *The best alternative that the Board is able to recommend is that the Chief Minister and the Minister for Health and Social Services give Mr Alwitry an absolute and unqualified acknowledgement that the termination of his contract was unlawful and contrary to natural justice. This acknowledgement should be given without a thought to the consequences that may flow from it. The SEB and the Department of Health and Social Services have brought that on themselves.*

A9.5 The SEB acknowledges that the withdrawal of Mr Alwitry's contract constituted a termination of his contract. This was not done lightly, however it was Mr Alwitry's conduct and behaviour alone which led to this step being taken

The SEB accepts that the withdrawal of the contract did not provide Mr Alwitry with a period of notice nor offer a procedure (such as a right of appeal). It accepts (and has accepted since November 2012) that a payment should be made to Mr Alwitry to reflect the absence of a period of notice and the offer of a procedure.

In matters of employment law, it is necessary to consider whether an employer has acted reasonably. That is to say there is, in any employment situation, likely to be a range of reasonable decisions that might be taken by an employer. The issue for a Tribunal is to consider whether the decision taken by the employer fell within that band of reasonableness. Clearly, this is a materially different test from a Tribunal deciding whether it would have taken the same decision were the Tribunal in the employer's position.

In certain employment matters, a dismissal may be justified when the integrity or competence of the employee is not in issue but where the cause for concern is personality and the inability of the employee to build and maintain essential working relationships with others in the workplace. In Perkins v St Georges Healthcare NHS Trust [2005] EWCA Civ 1174, the English Court of Appeal considered the appeal of an employee who had been dismissed because they were unable to work harmoniously with other colleagues, which was an essential part of the role. The English Court of Appeal confirmed that such an issue in the workplace can justify dismissal. The employee's response to the criticism made of him by his employer was to launch a sustained and manifestly ill-founded attack upon the honesty and

integrity of his colleagues. These allegations made it impossible for the employee to continue in his employment and due to their nature and persistence, they were found to corroborate the original concern; that the employee was near-impossible to work with.

Employment Tribunals in both England and Jersey frequently hear unfair dismissal cases whereby an employer has good grounds to dismiss an employee but has failed to follow a fair procedure before taking the decision to dismiss. In such circumstances, Tribunals are highly likely to make a finding of unfair dismissal, awarding a measure of compensation to the employee. However, if it is found that the decision to dismiss had merit, this may be a relevant factor in assessing the level of compensation awarded. In these circumstances, the employee's conduct would be a relevant consideration and Tribunals have been known to reduce an award to zero, based on the employee's conduct.

In the context of this case, it is also important to acknowledge that it is not uncommon for employers to decide that the situation with an employee is such that it would be better to terminate the contract and make a payment to the employee equal to the compensatory award that may be due. This is in order to draw a line under the matter and quickly move on, should that be in the best interests of the company or organisation. Clearly such a decision should only be taken only after very careful thought, however the SEB does not regard such action as extraordinary or rare as the Board appears to suggest.

The Hospital's overriding motivation in withdrawing Mr Alwitry's contract of employment was because it had lost trust and confidence in him and to ensure a harmonious working relationship within a small team of consultant ophthalmologists in the interests of patients.

R9.6 *As will be apparent from our findings in Annex A, the Board hopes that the States of Jersey will take urgent and effective steps to compensate him and his family for the wrongs which they have suffered at the hands of the States irrespective of the strict legal position. If the States decide to maintain its offer of 3 months' salary plus limited additional expenses, we would recommend that a detailed explanation for that decision is given in public. This is because it would amount to saying, in effect, that the Respondent, headed by the Chief Minister, believes that it is acceptable for a States Department to disregard fundamental principles which should guide proper decision-making (and, indeed, reflect common decency) in relation to its employees irrespective of the consequences to the individual concerned as long as it pays the minimum compensation to the person whose life is affected by it. If that is the position and policy of the States and the Respondent, we would suggest that the public of Jersey has the right and legitimate expectation that its elected officials should say so clearly and unequivocally.*

A9.6 To the extent that the issue is not resolved by agreement with Mr Alwitry, the question of the appropriate amount of compensation payable to Mr Alwitry will be determined ultimately by the Royal Court. The SEB will not conduct negotiations involving public money via the Board.

R9.7 *As far as the Hospital is concerned, the Board has a number of recommendations. These include -*

R9.7.1 *As a matter of the urgency a comprehensive and independent review be undertaken of the management structure and practices for recruitment and disciplinary matters. It appears from this case that senior clinicians (at least in the Ophthalmology Department) have uncontrolled autonomy over aspects of the decision making processes at the Hospital which far exceed their clinical expertise. Their role in management, if any, needs to be clearly defined.*

A9.7.1 The SEB does not accept the finding that there is a need for *"a comprehensive and independent review of the management structure and practices for recruitment and disciplinary matters."* This is an extra-ordinary recommendation extrapolated from a limited evidential base. Further, there are now specific recruitment processes for Consultant appointments which are in line with those followed by the NHS. The SEB refers to the aforementioned correspondence attached from a number of doctors complimenting the Hospital on the Recruitment process followed[22].

The disciplinary process for Consultants is the "Policy for the Handling of Concerns and Disciplinary Procedures relating to the Conduct and Performance of Doctors and Dentists".[23] If disciplinary action is required then the SEB approved policy is adhered to. This was updated in 2014. The SEB remains satisfied that these are fit for purpose.

Recruitment and disciplinary decisions in relation to Consultants are not taken by senior clinicians acting alone; they are always taken in conjunction with the Managing Director and the Medical Director.

Clinical leadership is essential in the effective management of hospital services. All specialities have a clinical lead and all Consultant recruitment involves several Consultants. Jersey would be an outlier amongst its peers if it did not involve clinicians in management decisions.

The decision making process in respect of recruitment and disciplinary matters is distinct from the process followed in agreeing operating timetables. It is commonplace for the Clinical Director to be responsible for agreeing timetables with their Consultant colleagues.

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[22] Appendix 1. Document 8
[23] Appendix 1. Document 40

The Management Structure at the Hospital has been further strengthened since the appointment of Helen O'Shea, the Managing Director, in 2013. Attached is a chart which shows the current structure[24]. There is an appropriate focus on clinical governance which is in line with structures in the NHS.

R9.7.2 *The role of the Human Resources Director in disciplinary matters be clarified. It is his task to ensure that the human resources policies of the employer are implemented in the best interests of the organisation, in particular by ensuring that in employment and disciplinary matters objective and detached assessments and recommendations are made at all stages of the process. We consider that, in the case of recruitment, issues which the employer deems critical should be highlighted in the recruitment pack and expressly brought to the attention of the applicant. Amongst other things, in the present case it is incredible (in the true sense of the word) that -*

- *the Respondent in this case sought to blame Mr Alwitry for not having raised at interview the matter of his start date, when he had at the time of applying for the post made his availability crystal clear, while the recruitment pack gave no indication that an early start date was critical;*
- *Mr Alwitry was given a contract of employment which specified that he was to work a certain number of hours without mentioning the important fact that he would also be expected to work a certain number of additional hours for free (for which he would be compensated by being permitted to pursue his private practice).*

A9.7.2 The Hospital took the relatively unusual step of including an indicative time frame within the advert. The job description, which did not include a start date, was approved by the Royal College of Ophthalmologists. It is the SEB's understanding and the evidence provided to the former Solicitor General that in the NHS, it is not unusual for advertisements for Consultant posts to have no start date. As the inclusion of a start date is not the norm, it should have alerted potential applicants to the need to explore this further but Mr Alwitry did not raise this in his pre-interview meetings or at interview.

Mr McLaughlin (who chaired the interviews of candidates for the position) commented as follows in relation to the start date -

> "*it's very unusual for it to be anything other than that expected position, and that expected position is that a consultant appointment, if they're resigning from an appointment to take up a new appointment, they would be expected to give a maximum of three months' notice. Everybody works on three months' notice in my*

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[24] Appendix 1. Document 41

experience and I've been working in hospitals for, for many, many years….

it's, it is very unusual that there would be a six month delay between an appointment and a start date. But that's' why it's, it's unusual that when we had the interview itself, or the interviews, that there was absolutely no, it just wasn't raised."[25] Nevertheless, it is accepted that in future, if a particular start date is required, this should be specifically stated.

Mr Alwitry was provided with the contract of employment and the Code of Conduct for Private Practice. If Mr Alwitry had decided not to undertake any privately paid work then he would only have had to work the hours set out in his contract of employment; namely to undertake 40 hours of work with public patients, but he had informed Mr Downes and Mr McNeela that he wanted to carry out private patient work..

R9.7.3 *The Hospital put in place a system whereby any disciplinary complaint is subject to independent assessment and recommendation. Those making allegations of wrong doing should never consider those allegations themselves without any independent scrutiny. In this case the senior clinicians and managers put their perceived criticisms of Mr Alwitry together, concluded that "we ought to sack this bloke before he gets here" and then proceeded to do just that. That process involved no proper scrutiny of the available evidence by the small group who made that decision and, because of their asserted belief that Mr Alwitry had no appeal rights under his executed contract or employment because he had not physically started work, was not subject to any right of appeal or independent scrutiny. We add that it is our very strong view that the conclusion that there was no right of appeal on the latter basis is irrational (i.e. not one to which any reasonable person properly directing themselves could properly reach) and, if it was genuinely held by those involved in the decision-making process, illustrates a profound and deeply worrying lack of understanding on their part which should be rectified by appropriate training. The most cursory independent review of the allegations would have shown they were unsustainable.*

A9.7.3 The SEB are assured that improvements in relation to recruitment, particularly in relation to start dates and hours worked have been implemented. There is a formal disciplinary process in place as referred to above. The SEB commissioned two reviews, both of which concluded that the decision made was correct. Neither was cursory and both were independent.

R9.7.4 *The Hospital put in place a proper and efficient system for recording contemporaneously matters which are relevant to the decisions that are made. In the*

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[25] Pages 13 and 14 of Transcripts of interview with Mr McLaughlin dated 22 November 2013.

present case, absolutely no contemporaneous records were kept of the conversations or telephone calls giving rise to the majority of the allegations made against Mr Alwitry. The records that do exist support his version of events rather than those of the Respondent. No adequate records were made of the meetings and discussions between senior clinicians in relation to Mr Alwitry. Even when the final decision was made to terminate his contract at the meeting on 13th November 2012, the record of the meeting is short and at such a level of generality as to be almost worthless other than as an illustration of the depths of the flaws in the process. Had an independent review procedure been in place any allegation not properly supported by an adequate and contemporaneous record would no doubt have been ruled out immediately.

A9.7.4 There were many email exchanges with Mr Alwitry which recorded key conversations which had taken place, all of which are available. An example of the volume of email traffic is that over 3 days there were thirteen emails from Mr Alwitry to and from a variety of staff at the Hospital.

It is accepted that phone calls and meetings were not documented which should have been; however it is not realistic to expect that contemporaneous notes of all conversations can be or should be made by Hospital staff. In hindsight, once concerns started to accumulate about Mr Alwitry, those involved should have kept comprehensive records of their telephone calls and meetings.

R9.7.5 *The Board therefore recommends that all appropriate staff receive training on the vital importance of proper record keeping in all matters which may result in disciplinary proceedings of any kind. All meetings at which matters which may result in disciplinary proceedings are considered should be identified as such with an appropriate degree of formality and due process (including notifying the person concerned of the details of the allegations made against them and allowing them an adequate opportunity to respond/defend themselves). Other than in exceptional circumstances, accurate contemporaneous records of such meetings and any telephone discussions are to be kept.*

A9.7.5 As soon as a manager becomes aware of the possibility of a matter leading to disciplinary or other formal proceedings, they are fully aware of the requirement to make appropriate records. Should a manager be concerned about potential disciplinary action, they are expected to seek advice from Human Resources who are able to offer advice about a range of issues, including appropriate record keeping.

This is an issue that is routinely addressed as part of managerial training and development.

R9.7.6 *The role of both the Minister and of the SEB in disciplinary matters, and in particular the extent to which powers of termination are delegated to management, is to be clearly identified in order that management duties retained by the Minister and SEB are clearly understood and discharged by a clear and appropriate process. The role*

of the Minister for Health and Social Services and of the SEB in this case is unclear. What is clear is that the Minister for Health and Social Services and the Chief Minister as Chair of the SEB knew of and supported the decision to terminate Mr Alwitry's contract, although there is no record of the basis of their consideration of the matter. The letter to Mr Alwitry terminating his contract was only sent after consultation with the Minister and the Chief Minister and so it is assumed that their involvement was more that 'for information purposes'. It was not made clear to us whether existing procedures required the Minister and the Chief Minister to authorise the termination of the contract, or whether the Hospital management merely wanted the comfort of ministerial support. Either way, both the Minister and the Chief Minister can in our view be justifiably criticised for, in effect, merely rubber stamping the decision of the Hospital management. Each had the opportunity and responsibility to interrogate those seeking support of the decision as to the appropriateness of the process by which the decision was reached. They each failed to take that opportunity or take that responsibility. Similarly, when the matter came before the full SEB on 18th December (after Mr Alwitry had been notified of the termination) the Board failed to do anything other than limit what they saw as political fall-out.

A9.7.6 See response to paragraph 8.5.3 above.

It is not correct to suggest that the SEB did not take this matter seriously or seek appropriate assurances about the actions of the Health and Social Services Department. It is for this reason that the SEB commissioned the Beal Report and the investigation by the former Solicitor General. The investigations were thorough and wide ranging. The former Solicitor General interviewed 11 witnesses over a one month period, two of whom were interviewed twice, including Mr Alwitry. Mr Beal interviewed 18 witnesses, including Mr Alwitry.

R9.7.7 *We do not know whether what we have referred to in our findings as 'significant institutional failings' were confined to the Ophthalmology Department, but given the role of the Human Resources Director, the Managing Director and indeed the Minister we would be very surprised if the same or similar failings were not evident in other Departments of the Hospital. We therefore recommend that an independent and wide-ranging review of the management of the Hospital and, in particular, the role of senior clinicians in such management be urgently commissioned and the findings publicised.*

A9.7.7 The SEB has received detailed and comprehensive evidence of improvements made since 2012. This recommendation is an unnecessary and disproportionate response to an employment law dispute with one individual. Any process failings which have been identified have now been rectified.

There is no evidence to suggest this is systemic or widespread. The SEB refers to the paragraph above where information is provided regarding the successful recruitment of many outstanding candidates across many specialities since 2012.

ANNEX A - DETAILED FINDINGS

A. Summary (pages 75 to 78 of the report)

The SEB responds to the detailed findings below rather than in response to the Summary.

B. Preliminary matters

i. The duty of candour and open dealing with the Complaints Board (pages 78 - 79)

The SEB notes the Board's comments in relation to the open basis upon which material has been provided to it.

ii The obligation to provide complete evidence to the Complaints Board (79 - 80)

Please see comments earlier which set out the extensive correspondence regarding the terms of reference which unequivocally stated that patient safety issues would not be considered.

iii The former Solicitor General's report (pages 81 - 84)

On 5 September 2013, the former Solicitor General was asked by the SEB to investigate this case with the primary focus being to ascertain the true reasons for the decision taken. In particular, he was to determine if there was any truth in the allegations being made by Mr Alwitry that the decision had been taken in bad faith.

The former Solicitor General was a Law Officer appointed by Letters Patent. During his time in office, he previously prosecuted a doctor at the hospital for manslaughter and the SEB for serious health and safety offences. Given that he was sufficiently independent to prosecute a doctor for manslaughter and the SEB for other criminal offences, it is respectfully submitted that he was equally sufficiently independent to conduct an employment law inquiry into a group of professionals at a hospital with whom he had had no prior contact or knowledge.

As the Board itself acknowledges, the Law Officers' Department had not given advice as to the merits of the decision to terminate or the procedure to be followed prior to the decision taken by the hospital on 13 November 2012 but had merely provided limited advice as to the potential financial consequences were a decision to withdraw the contract taken. That advice was disclosed as part of the interview bundle. It did not matter whether it was right or wrong (the Board appears to accept it was correct); the former Solicitor General was not investigating its accuracy.

The former Solicitor General's objective was to ascertain the true reasons for a decision that had already been taken; on the 13 November 2013.

The SEB is advised by the former Solicitor General that he would have corrected any previous advice had it been required to do so, and that there is precedent for such correction, including on one occasion by a previous Attorney General.

Mr Alwitry was provided with a draft of the former Solicitor General's report and given a full opportunity to respond.

Whilst employment law investigations often preclude lawyers from having any involvement at all in an investigation, Mr Alwitry's lawyer was permitted to attend the interviews and to make submissions on receipt of the draft report.

The findings of fact of the former Solicitor General are primarily based on what was admitted by Mr Alwitry in interview when considered with relevant documentary evidence. The former Solicitor General tried to avoid reaching conclusions based solely on the Hospital's evidence. Indeed, he preferred Mr Alwitry's evidence to Mr Downes' on an important point relating to likely glaucoma patient numbers, when it later transpired that he was incorrect to do so.

In comparative terms, the observation that the former Solicitor General's involvement and conclusions are "unusual" is not made out. Employment Tribunals frequently find that employers have reached a correct decision, thereby preferring the evidence of the employer on this aspect of the case, using an incorrect procedure, thereby accepting that dismissal was unfair and preferring the employee's evidence on that point.

It is noted that the Board agrees with the former Solicitor General on a number of matters. As to the matters on which there is disagreement, very few of the findings are in fact described as unreasonable in the Board's report.

iv Mr Riley's evidence (pages 84 - 85)

It is submitted that it was not appropriate for the Board to come to any conclusions about the reasonableness of the decision to dismiss without hearing first hand evidence from those involved at the time, including Mr Alwitry but also the Hospital's senior management who took the decision. Mr Riley could not do this alone as his evidence largely went to procedural matters.

Furthermore, it submitted that it was not possible or appropriate for the Board to make recommendations about improvements required without hearing evidence about the current systems and procedures in place at the Hospital. In any event, the events analysed in the Report took place four years ago and there have many improvements and changes made by the Hospital in the intervening period.

v. Mr Alwitry (pages 85 - 89)

The Board did not hear evidence from Mr Alwitry. However, Mr McLaughlin, the Managing Director of the Hospital who had enormous experience of dealing with consultants in NHS hospitals in the United Kingdom, commented vividly on attempting to manage Mr Alwitry in his evidence to the former Solicitor General as follows -

> "*when you, when you're having a conversation with him it's a bit like somebody who's playing you as a piano, to, to press as many notes as they can and then they find one of the notes that actually gets a response and they, they play on that one as hard as they can, but some of the ones where they've played and they don't get the right response, they don't get tapped again. So there, there, there's, it's, it's a very subtle exploration of where the potential routes in, routes out ways of negotiating are, and it frankly is immensely tiring when you are just trying to run a hospital, to have to deal with somebody who is that wrapped up as they are in, in every detail of every aspect of what they're going to be doing when they come.*" [26]

It is submitted that the explanations of his behaviour which Mr Alwitry gave to the former Solicitor General as recorded in the transcript of the two interviews with him are consistent with the comments of Mr McLaughlin set out above and were not credible. This is particularly the case in relation to inconsistencies in the evidence he gave in relation to his dealings with the BMA in his two interviews, the second of which took place after receipt of disclosure of documentation from the BMA.[27]

Mr Alwitry's references were considered by the former Solicitor General when preparing his report.

The SEB notes the Board's comments that not hearing evidence from Mr Alwitry constituted a disadvantage. The former Solicitor General interviewed Mr Alwitry at length on two occasions (as well as other witnesses).

The extent of such interviews (running to in excess of 1000 pages) and the fact that the former Solicitor General interviewed 11 witnesses explains why the former Solicitor General and the Board have reached different conclusions. Although the Board was provided with the former Solicitor General's report and the transcripts of the witness interviews, there is no reference to the content of those interviews in the Board's Report.

The SEB disputes the notion that Mr Alwitry's overriding concern was patient safety at the relevant time and agrees with the conclusion of the former Solicitor General

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[26] Page 109 of Transcript of interview with Mr McLaughlin on 22 November 2013.
[27] See pages 24 to 69 of the Transcript of interview with Mr Alwitry on 16 December 2013.

that Mr Alwitry's predominant concern was his family. Mr Alwitry wrote to the Minister for Health and Social Services on 29 November 2012[28] and the Medical Director of the Hospital on 30 November 2012[29]stating to the Medical Director that he had allowed family concerns to cloud his judgement.

Mr Alwitry was very troubled by the prospect of being separated from his family for long periods of time before they were able to move to Jersey in July 2013. This is not a criticism of Mr Alwitry but it does help to explain why a doctor with good references might start to engage in inappropriate conduct. In the view of the former Solicitor General, Mr Alwitry's primary objective from the outset was to start full time work in Jersey in February 2013 with a view to arranging a timetable that would enable him to maximize his time in the United Kingdom until July 2013 at which time his family would move to Jersey. The SEB does not accept the Board's apparent suggestion that family was just a factor in this case. In the SEB's view, and as supported by the former Solicitor General's investigation, it was the dominant factor and obviously so from consideration of both the evidence given by Mr Alwitry and the documentation.

There were two main disputes that resulted in the decision to terminate the contract. One related to Mr Alwitry's start date. The other concerned his timetable which required him to be at the Hospital every Friday morning and to operate every second Friday (and thereby potentially prevent a return to the UK at the weekend).

Start date

An indicative start date was included in the advert. The job description, which did not include a start date, was approved by the Royal College[30]. The SEB understands in the NHS that it is not unusual for advertisements for Consultant posts not to have a start date.

It is however accepted that if there is a particular need for a Consultant to start on or by a particular date this should be stated in the advert. It is accepted that this should have occurred both pre- interview and post-interview. That is now the procedure in place at the Hospital.

The issues about start date in August 2012 were driven by Mr Alwitry's desire to spend as much time as possible in the United Kingdom with his family until July 2013 when they planned to move to Jersey.

Mr Alwitry told the former Solicitor General that he gave serious thought to declining the offer of employment once he knew he was expected to start on 1 December 2012 rather than 1 February 2013: "*because I was thinking that I was going to struggle to*

[28] Appendix 1. Document 9
[29] Appendix 1. Document 10
[30] Appendix 1. Document 11

come over here and leave my family and four small kids when they really needed me. Then I was wondering well do I wait until the next post comes up…or do I jump ship and leave my family to struggle" Mr Alwitry said that he had been 'soul searching' at this time and the former Solicitor General understood that to be his genuine description as to his state of mind. He gave serious consideration to declining the job offer once he realised that a February 2013 start was not achievable. In August 2012, Mr Alwitry raised the prospect with the Hospital of working part-time until July 2013, when his family was scheduled to move to Jersey. He ruled out working a three-day week once he realised that the mid-week travel arrangements would make it difficult for him to "*be back on Wednesday evening for the kids on Thursday*"[31]. This supports the view of how important the family issue was.

vi Patient safety (pages 89 - 92)

It appears that the Board accepts that Mr Alwitry did not wish to operate on a Friday for family reasons: Board's report paragraph 148.1. That is obviously correct having regard to Mr Alwitry's strength of feeling over his family and a reading of the other evidence in the case that includes the following -

Date	**Emails from Mr Alwitry**
10.08.12[32]	*Just realised that if they dump Friday afternoon on me then it may fall on you too. Sorry*
03.09.12[33]	*Looking at the timetable it looks like that will shunt my two sessions off in lieu to Fridays which is great as that will mean that when I'm not on call I can come back to the mainland on Friday morning to see the wife and the kids for the weekend.*
05.09.12[34]	*As you know [Mr Alwitry's wife] and the Kids will not be joining me until July so I am planning on booking flights up back and forth at the weekends*
24.09.12[35]	*I tend to bring back patients for review on day one which obviously wouldn't work on a Saturday, Besides that it also messes up my chance of getting back to see the misses and the 4 kids!*
29.09.12[36]	*Did you have any joy speaking to [redacted name] for me about allowing me to do every Thursday afternoon in DSU?*

[31] Appendix 1. Document 12
[32] Appendix 1. Document 13
[33] Appendix 1. Document 14
[34] Appendix 1. Document 15
[35] Appendix 1. Document 16
[36] Appendix 1. Document 17

	Even if he could do it just until July when my family come over to join me that would be a great help
01.10.12[37]	*If I do Monday on call it will mean that I can fly off Thursday evening if I'm not operating on the Friday. I have the two little ones Friday so it would work out well* *The timetable is too heavy anyway….. so I'll definitely be ditching Friday alt morning clinic*
02.10.12[38]	*I do not want to do the alt Friday mornings…This means I'll be able to fly back to the Island Monday morning 1st thing which means I get all day Sunday with the family. I'm over the moon as it will make the period till the end of the school year (when they'll all come over and join me) much more bearable*

An indicative timetable, included in the job description sent to Mr Alwitry, was approved by the Royal College: Board's report paragraph 5.1. This is part of the usual process followed in Jersey and in England before a Consultant post is advertised.

It is accepted practice that this is an indicative timetable and that there are may be minor revisions to the timetable. Royal College approval is not required to amend the timetable.

On 24 September 2012, Mr Alwitry was provided with a final timetable by Mr Downes [39]that required him to work full time from 1 February 2013 and to operate on alternate Fridays Mr Downes had previously discussed the indicative timetable with Mr Alwitry and in the revised timetable he sought to take account of Mr Alwitry's wishes balanced against the wider constraints of the Hospital such as theatre and clinic availabilities. Mr Alwitry received the timetable at 11:57am on the 24 September. At 1:24pm the same day[40], Mr Alwitry emailed the Theatre Sister about the "proposed" timetable in order to ascertain if he could move his Friday operating slot. Mr Downes, his line manager who had produced the final report, was not copied into this email. Mr Alwitry's justification to the Theatre Sister for seeking a change was as follows -

> *I'm not keen on operating the day before a weekend when we have no junior cover to review the patients if there are any complications and also I tend to bring back patients for review on day one which obviously wouldn't work on a Saturday. <u>Besides that it also messes</u>*

[37] Appendix 1. Document 18
[38] Appendix 1. Document 19
[39] Appendix 1. Document 20
[40] Appendix 1. Document 16

up my chance of getting back to see the misses and the four kids! - they aren't joining me till mid-July.

(emphasis added)

Mr Alwitry put forward two reasons for his desire to move the Friday slot: (a) patient safety and (b) personal family reasons. There can be no doubt that Mr Alwitry wished to move his Friday slot for family reasons and, as already noted, the Board accepts this. The issue that arose to determine in the former Solicitor General's investigation was whether the Friday slot also happened to raise genuine patient safety issues that required further consideration or whether the issue was being raised as a means to manipulate the timetable.

The former Solicitor General concluded in his original report that those patient safety concerns were without merit and that in truth, Mr Alwitry wished to avoid Friday operating to keep his weekends clear and had raised patient safety as a means to achieve that change to the timetable.

The Board strongly disagrees with that view but, strikingly and in somewhat contradictory terms, also admits that it is not "*in a position to judge the precise merits of the concerns raised*": page 87, paragraph 39.

The General Medical Council rejected Mr Alwitry's complaint relating to patient safety issues in August 2015[41].

The patient safety concern raised by Mr Alwitry can be summarised thus: if a doctor operates on a glaucoma patient on day one then that patient should receive follow up care from the doctor on day two. The former Solicitor General accepted that this proposition was correct in his original report: see paragraph 94.

The Board suggests that the former Solicitor General should have obtained expert evidence on this general principle. This is surprising, given that the former Solicitor General had accepted Mr Alwitry's evidence on the point: see Board's Report at paragraph 42 and note the contrast with paragraph 94 of his report.

Moreover, it does not automatically follow that the acceptance of a general principle means that a safety issue arose for consideration on the facts of the particular case. It is necessary to apply the principle to the facts and, in doing so, two issues in particular arise. The first issue is whether Mr Alwitry would have such a vast number of glaucoma patients that Friday surgery for such patients would be unavoidable. Mr Alwitry had eight surgery slots during his four-week timetable, only two of which were scheduled for a Friday morning. Mr Alwitry was required to be on call one weekend in four, therefore there would only be one Friday operating list per month

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[41] Appendix 1. Document 21

when he would not be available for follow up checks on a Saturday. The second issue is whether, were Friday surgery unavoidable for such patients, Mr Alwitry would be able to attend on the Saturday to provide cover if necessary?

As to the first issue, the former Solicitor General had assumed in Mr Alwitry's favour in his original report; that alternative Friday operating was inevitable. Mr Alwitry had told the former Solicitor General in interview that 30% to 40% of all ophthalmology is glaucoma and so "*my clinics are going to be 'chocca' with glaucoma*".

The former Solicitor General proceeded on this basis in Mr Alwitry's favour notwithstanding the fact that Mr Downes had provided the following evidence during the course of his investigation -

> *"the sort of surgery that he is talking about is glaucoma surgery, he's probably not going to be doing more than maybe 20 or 30 of these a year at the outset, and they can all be done on his Tuesday list, so, you know, the Friday list, this was just, I thought this guy is being very disingenuous and really trying to manipulate the system here."*[42]

This is an example of an important dispute of fact that the former Solicitor General resolved in Mr Alwitry's favour in his original report.

Subsequently, the Ophthalmology Department has provided the following information: the total annual public surgical procedures for Ophthalmology Department average 871. Of these, 2.6% were in-patients. 97.4% were day cases. In respect of trabuculectomies (complex glaucoma cases), the maximum number of such operations in any one year in Jersey has been eight. The number of cataract cases with a recorded co-morbidity of glaucoma averages 65 per year. The number of all procedures with a recorded co-morbidity of glaucoma averages 68 per year. Even assuming that Mr Alwitry were to undertake all of these cases, then he would only have to operate on around 1-2 per working week of the year. The SEB understands that the average theatre session in ophthalmology has five cases in each list, therefore undertaking these more complex cases on the Tuesday or even the alternate Thursday list would have been possible and would not have introduced a patient safety risk at all.

In light of this evidence, there would be no need for Mr Alwitry to operate on a glaucoma patient during his alternate Friday list and therefore his patient safety issue of Saturday cover did not arise on the facts of this case.

Mr Alwitry worked as a locum at the Hospital on three previous occasions prior to August 2012 and it is reasonable to conclude that he obtained at least some knowledge and insight of the workings of the Ophthalmology Department. A careful

[42] Page 46 of the Transcript of interview with Mr Downes dated 25 November 2013.

review of other parts of Mr Alwitry's evidence in interview suggests that he was aware that the patients who might genuinely require follow up care would be limited in number -

> *But it doesn't take away from the fact that some patients on a Saturday would have glaucoma, they would need their pressure check the next day. There is nobody available to check the pressure apart from the ophthalmologist. Now, that was going to be me after July when, when I wasn't flying away, but I was going to be flying away, so I didn't have anybody to do it for me. In my email I said, "Look, I will try and be on call, definitely, for most of my list, but is there a chance that you could just see the odd patient? It won't happen frequently but is there a chance you could just see the odd patient just to keep them safe?"*[43]
>
> Emphasis added

Mr Alwitry emailed the Theatre Sister on 3 October [44]to suggest that he could conduct his glaucoma list on Monday afternoon when Mr Downes was on leave -

> *Had a mini brain wave. As you know I had an issue about needing lists on consecutive days so I could take my glaucoma cases back to theatre if they needed it. How would you feel about my taking Richard's Monday afternoon list when he's away on holiday and putting my glaucoma surgeries on there. This would only be once in a while and by arrangement well in advance. I'd identify cases that needed doing and then see when RND is next on leave, speak to you to make sure you are happy with me jumping onto that Monday afternoon and then book them on and do the list".*

The reference to the glaucoma list is in the singular and its infrequent nature is suggestive of an appreciation on Mr Alwitry's part as to the likely numbers of glaucoma patients he might be required to treat. The Theatre Sister responded on 3 October - [45]

> *"I certainly don't have an issue with you taking Richard's Monday DSU list when he is on leave. The one thing I absolutely hate is free lists which I work very hard at avoiding so that plan will work fine".*

On 4 October, Mr Alwitry contacted a nurse in the Ophthalmology Department in order to commence a different negotiation about his timetable, stating that "*I'm*

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[43] Page [ ] of Transcript of interview with Mr Alwitry on [ ] 2013.
[44] Appendix 1. Document 22
[45] Appendix 1. Document 23

hoping to do glaucoma surgeries on my Tuesday AM list"[46]. Once again, Mr Alwitry appears to refer to a single list per week for his glaucoma patients.

When Mr Alwitry emailed his line manager on 7 October[47], the message was materially different. Mr Alwitry asserted that he would need to operate on his glaucoma patients during his alternative Friday slot and therefore went on to suggest that the need to provide cover on a Saturday raised patient safety issues given the lack of "*junior worker bees to look after patients at weekends*". Mr Downes was asked, against the background of patient safety, to revisit the timetable and move the Friday slot to Thursday.

When Mr Downes replied by email on 9 October[48] confirming that the timetable stood, Mr Alwitry contacted his trade union. The BMA asked to see "*a copy of your email to the Clinical Director and a copy of his response*[49]". This was a direct and obvious request to see Mr Alwitry's email of 7 October and the 9 October reply from Mr Downes. Mr Alwitry did not provide the 7 October email to the BMA. Instead he choose to provide his own trade union with (a) an earlier email he had sent to Mr Downes on 24 September [50]that simply said "*I have some issues with the proposed timetable which I'll discuss direct with you.*." and (b) Mr Downes' "reply" of 9 October.

It is difficult to avoid the conclusion that Mr Alwitry chose to provide his Union with incomplete and misleading information.

Mr Alwitry wrote to two States Members[51] and to the Medical Director [52]following the withdrawal of the job offer. In both cases he did not raise patient safety as an issue, only family reasons. This was his opportunity to 'wave the red flag of patient safety' to the Medical Director, whose role it is to respond to such issues. It was also his intention, as stated in the letter, to give the politicians the facts - however patient safety was not mentioned.

A doctor who has genuine patient safety concerns has a duty to report those concerns. The BMA did not spot any patient safety issue in their conversations with Mr Alwitry during October 2012 and instead suggested to Mr Alwitry that they need not get involved. Given the Board's description of Mr Alwitry as being tenacious and demanding in seeking platinum standard for patient care at paragraph 30 of its report, it is nothing short of remarkable that he declined his contractual right to appeal his job plan and failed to press patient safety with his own trade union, if such issues were a genuine concern. Mr Alwitry did not lodge a formal complaint about

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[46] Appendix 1. Document 24
[47] Appendix 1. Document 25
[48] Appendix 1. Document 26
[49] Appendix 1. Document 27
[50] Appendix 1. Document 28
[51] Appendix 1. Document 9 and Document 9A
[52] Appendix 1. Document 10

patient safety with senior management at the hospital and indeed barely raised the issue at all. In short, Mr Alwitry did the very opposite of what one would expect of a doctor raising genuine patient concerns until his belated 2015 complaint to the GMC that was then rejected on the basis that there was no evidence to support it[53]. The Board do not comment on these aspects of the case.

It is the SEB's view that there is no patient safety issue in respect of the alternate Friday operating slot on the particular facts of the case and that Mr Alwitry's limited attempts to raise such concerns with the hospital in 2012 and then his much later formal complaint to the GMC in 2015 were and remain without justification. The SEB is of the view that these matters were raised in order to secure a timetable that better suited his family circumstances.

It is axiomatic that patient safety issues are of central importance to the running of a hospital. If one doctor decides to seek to manipulate safety issues for personal gain then the inevitable result is that the employer will become concerned about the working relationship with that doctor. This conduct raised issues about Mr Alwitry's integrity. What is particularly troubling is that Mr Alwitry chose to lodge his complaint to the GMC after the former Solicitor General had concluded that his allegations had no evidential basis. His persistence in pursuing these allegations is a further cause for concern.

The former Solicitor General observed in his original report that Mr Alwitry was entitled to ask questions about his contract and the number of hours he was required to work compared to his timetable. This was a conversation that should have taken place with the Hospital and been resolved without great difficulty. The SEB presumes that this is the reason that Mr Alwitry told that the former Solicitor General that he accepted that it would have been reasonable for the hospital to require him to provide Saturday cover, if required.

These issues were a separate matter and cannot be used to justify the attempt to use patient safety issue concerns in order to force a revision of the timetable. Sensible conversations about the issue would have resulted in Mr Alwitry being provided with the usual concessions relevant to his private practice arrangements.

Mr Alwitry raised patient safety issues only in an attempt to secure a more favourable timetable. In 2014, the former Solicitor General rejected Mr Alwitry's allegations that Mr Downes had put patient safety at risk. The General Medical Council rejected the same allegation in 2015[54], finding no evidence to support it. Mr Alwitry has persisted in making this same allegation to the Board who notably record in their decision that they do not feel able to assess its "precise merits": page 87, paragraph 39. Mr Alwitry has persisted in other unsupported allegations of bad faith. Mr Downes

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[53] Appendix 1. Document 21
[54] Appendix 1. Document 21

would have been Mr Alwitry's line manager at the hospital had he been allowed to take up his appointment.

Whilst it is accepted that it would be valid to raise a patient safety issue regarding operating on complex cases on a Friday, the suggested timetable enabled Mr Alwitry to plan his work to avoid operating on such cases on a Friday. Therefore, the patient safety argument had no basis.

On the contrary, the decision taken to dismiss Mr Alwitry was in significant part driven by the interests of patient safety and good clinical governance. The concerns regarding the patient safety risks arising from dysfunctional teams expressed by Mr McLaughlin, Mr Downes and Mrs Body have already been set out above. Mr Siodlak, the surgical Medical Director of the Hospital commented in his interview with the former Solicitor General as follows -

> "*Because this had been going on since August and he was becoming more and more difficult to deal with, and whenever anyone said one thing to him, he just went to somebody else and it kept going round and round. And we had to have some sort of governance within the organisation that shows that, you know, if, if people had just been difficult and appear to want to just do stuff for themselves and don't, won't play in a team, it makes it difficult….*
>
> *. . . the conduct was just out of, extraordinary out of anything that I've ever seen before. Most people have a bit of a discussion about how their timetable will run. Nobody really wants to work Friday but most people have to work Friday and then they accept it when they say, "Well, this is how it will be, do you want to come or not?" and then they accept the status quo and come, and then when they get in, they try to influence things once they are in. But he was continually, from my conversations with other people in the management group, continually, when he was told, "You can't do that by one person", he would go to another person, and say, "Can I do…? Can I …"? the same thing to try and get a different answer, to try and undermine what I was going on within the management group…*
>
> *. . . I mean, it's called clinical governance, it's called looking to see what's going on within the hospital to make sure that people are doing their job properly and safely… and to always improve what we are trying to do for the patients. And if some doctors feel that they can operate outside that, it's sometimes very difficult to control them.*"[55]

[55] Pages 8, 10, and 13 of the Transcripts of interview with Mr Siodlak on 14 November 2013.

C - The basis on which the Respondent conducted the appeal (pages 93 to 94)

See comments earlier about the terms of reference of the Board.

D - The job description and draft terms and conditions of appointment (pages 94 - 97)

Paragraph 51.3. The schedule of the Consultant Terms and Conditions document makes provision for Consultants working outside normal working hours and would have applied to Mr Alwitry. He would have received one full day off as time in lieu for working outside normal working hours and received payment for covering when one of his team was on leave.

Paragraph 53 (page 95). "*It is and was inappropriate for the draft conditions of employment to fail to identify that remuneration in Jersey was capped at 10 PAs but that the consultant would be expected to work more than that or to give the impression that the consultant could be paid additional PAs for work outside normal working hours if that was not in fact the case.*"

It appears that the Board has misunderstood this aspect of the Consultant Contract (Jersey) 2004. A Consultant cannot be paid twice for the same period of time. If the States of Jersey remunerate a Consultant for being present in theatre for a whole session yet that Consultant operates on a private patient who pays a fee to the Consultant, the Consultant is being paid twice. The additional 1.5 PAs in Mr Alwitry's timetable were in recognition of the fact that he intended to operate on private patients in States funded periods of time, in the operating theatre. He would therefore be obliged to 'pay back' this time to his public hours of work, the 40 hours he is contracted to provide for public patient activity. In doing so, he would not be working 'for free'.

E - Mr Alwitry's Application and the start date (pages 97 - 100)

And

F - 8 to 15 August 2012 (pages 100 - 109)

It is common ground that Mr Alwitry had requested a delay of six months to his start date on his application form. This issue was not raised at the interview process and it should have been. However, the failure to raise the issue of start date at interview has to be put in its proper context and considered against all the evidence in the case.

Mr Alwitry's interview took place on 1 August 2012.

(a) Mr Alwitry accepts that at the pre-interview meeting on 31 July 2012, Mr Downes, informed him that the "*we had a pressing need for a variety of reasons for the appointment to be taken up ASAP*". He was provided with the waiting lists at around this time by Mrs. Body.

(b) The Board concluded that by the end of the 1 August interview process, "*we think it likely that Mr Alwitry was told by whoever telephoned him on 1 August 2012 that the start date would need to be agreed and it seems likely that he was expecting at least some negotiations over the precise date": paragraph 69.*

(c) The Board also reached the view that Mr Alwitry's email exchange with Mr Downes' medical secretary on 1 August[56] shortly after his interview proves that Mr Alwitry realised he was "*expecting at least some pressure on him to come earlier than February 2013*": paragraph 69. That email exchange expressly raised the prospect of Mr Alwitry being in Jersey in time for the Christmas Party.

(d) Mr Alwitry was emailed the day after his interview on 2 August at 10:08 by one of the doctors who had interviewed him- Mr Alan Thompson. Mr Thompson's tone was of genuine congratulations: "very impressive interview". Mr Thompson then asked: "*I assume that you have to work your notice back home in the UK and so your arrival will be around October/November*". Mr Alwitry replied by email the same day but his answer was extremely vague. He did not mention a delayed February 2013 start and nor did he rule out an October/November start.

There does not appear to be any serious dispute that by 2 August, Mr Alwitry had learned from two members of his interview panel (Mr Downes and Mr Thompson[57]) that he was required to start 'ASAP' and that the assumption was that he would be starting in October/November. On the basis of the findings of the former Solicitor General, which the Board only disputes "on balance", Mr Alwitry had also been told by Mr Downes that he needed to start by Christmas at the latest.

The Board accepted that the evidence is "*consistent with him [Mr Alwitry] expecting at least some pressure on him to come earlier than February 2013*" paragraph 69. However, when that "*pressure*" came in the form of Mr Downes requesting a start date of 1 December, the Board goes on to express the view that *". . . Having failed to make these matters clear to Mr Alwitry either before or during the interview, it was equally inappropriate retrospectively to seek to impose on him [Mr Alwitry] a different commencement date to the one that he reasonably anticipated . . .*": paragraph 82. The Board also states that the hospital was "*rewriting the job offer*".

Even on the Board's findings of fact, Mr Alwitry was fully aware that he was going to face some pressure to start earlier than February 2013. The SEB does not view the subsequent request to start on 1 December 2012, as opposed to 1 February 2013, as anything other than the Hospital seeking to secure an earlier start date as was reasonably anticipated by Mr Alwitry on the Board's own findings.

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[56] Appendix 1. Document 29
[57] Appendix 1. Document 30

Moreover, the Hospital cannot reasonably be accused of rewriting the job offer given the Board's express finding of fact that Mr Alwitry knew that start date was still to be negotiated and that this was communicated to him at the time he was told that he was the successful candidate. By definition, a term that is to be negotiated has not yet been written and therefore there was nothing to rewrite. Mr Alwitry knew that a start date prior to Christmas was to be proposed by the Hospital and indeed it was.

If a hospital has a genuine need for a doctor to be in post by a certain time in order to address a problem such as growing waiting lists, then it must be open to that hospital to identify any mistake made at interview and quickly remedy it so that a doctor is appointed within the required timeframe, as the Hospital did in this case. The Hospital's overriding concern was to reduce patient waiting lists for both surgery and clinics as it is not acceptable to have patients waiting for more than 3 months to have, for example, a cataract operation.

In the view of the SEB, the Hospital was not fixed by or stuck with the mistake made at the interview stage. It was entitled to say to an interviewee "*we are sorry this was not made clear earlier to you (if it be the case) but our particular requirements are x because of these demands on our services*".

The Hospital's decision to inform Mr Alwitry that they needed him to start work by 1 December was a decision that was reasonably open to them. All the evidence points towards the management of the Hospital seeking to appoint a new consultant quickly, principally because waiting lists were "through the roof".

The Hospital was also entitled to decide that the negotiations should have a limited timeframe, not least because if the answer from Mr Alwitry was ultimately "no", then there may have been a need to quickly approach another doctor.

Although the error at interview is embarrassing for the Hospital, it is also easy to lose sight of the fact that Mr Alwitry gained a considerable advantage from this mistake. Were Mr Alwitry to have been asked at interview when he was able to start, it is assumed that his answer would have been "February 2013", consistent with his application form. That answer may well have led to the interview panel rejecting his application in favour of another candidate who was able to start full time in November 2012. Instead, Mr Alwitry had from 2 until 15 August to consider if he wanted the job, having regard to the Hospital's requirements.

The SEB is unimpressed by Mr Alwitry's repeated protestations to management in mid-August that he had no idea that the Hospital wanted a pre-Christmas start given Mr Thompson's email about an October start[58] that he had acknowledged on 2 August [59]and the Board's own finding that he knew he would face pressure to start earlier than he wanted to.

There are further aspects of Mr Alwitry's behaviour that also remain a concern.

[58] Appendix 1. Document 30
[59] Appendix 1. Document 31

Mr Alwitry response to his telephone conversation with Mr Downes on 8 August, and on learning of the 1 December start requirement, was to contact Mr Leeming in the Hospital's HR Department[60]. He contacted Mr Leeming without Mr Downes' knowledge and he did so in an attempt to secure an employment contract with more favourable terms than had been proposed by Mr Downes at that stage. On any view, Mr Leeming is a more junior member of staff. The Board do not challenge any of the former Solicitor General's findings in respect of this incident: paragraph 77. The Board is right to observe that the attempt failed. This was an example of Mr Alwitry receiving an answer from his line manager that was not to his liking and then seeking a different answer from an alternative member of staff. The attempt failed only because Mr Leeming contacted Mr Downes before taking any action.

The initial conversations between Mr Downes and Mr Alwitry had been amicable on 8 August but what then followed was (a) the attempt to get a better answer from Mr Leeming and (b) a refusal to come earlier than February 2013 once it became apparent that mid-week travel did not suit Mr Alwitry's family arrangements. In the view of the SEB, the Managing Director, Andrew McLaughlin, was entitled to commit the Hospital's position on start date to writing at this stage not least so as to ensure there was only one conversation between the Hospital and Mr Alwitry on the issue.

It was for the Hospital and not Mr Alwitry to determine what start date was appropriate having regard to patient needs. The error at interview meant that Mr Downes was extremely diplomatic in his earlier conversations with Mr Alwitry on 8 August but by the 10 August the nature of conversation had materially changed. Mr Alwitry was now refusing to come other than on his terms. The Hospital was entitled to say, as any employer in this situation would be, that the appointment was to be on their terms. It therefore did so.

In the view of the SEB, it follows that the Board's conclusion at paragraph 83 onwards, that the 10 August 2012 letter by Mr McLaughlin[61] reflected an inappropriate culture that required 'blind obedience' from its consultants, constitutes a significant misunderstanding of the position. The purpose of the letter of 10 August was not to require Mr Alwitry to obey orders without question. The employer was entitled to set out what start date it felt was appropriate.

After the 10 August letter was sent, there was a period between 10 August and 14 August when the Hospital management agreed to reconsider Mr Alwitry's request for a delayed start beyond 1 December. This is inconsistent with the Board's view that management was demanding slavish obedience.

During this short period, Mr Alwitry engaged in behaviour that raised further issues of trust and confidence.

Within about an hour of Mr McLaughlin's letter being sent Mr Alwitry was on the telephone and his evidence concerning that conversation was as follows -

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[60] Appendix 1. Document 32
[61] Appendix 1. Document 33

"*So I said I'd take the call and I went into my office and I think we were on the phone for at least 40 minutes and it might even have been longer. And it was exactly what I had described before, where, you know, "I want 'X'," "No, no, no, can I offer you 'Y'?" "No, we can't have 'Y' because …" "Well can I offer you 'Z'?" "No, no, we can't have 'Z' because …" And all the time I was trying to be flexible in terms of, "Could you do this, could you extend, why can't you do this?" You know, why, I, I was trying to understand what it was that was stopping him working compressed hours, three day weeks and starting from the 1st of December. Because frankly that seemed a very reasonable compromise, and he was talking about starting fulltime, I believe, in the end of January, early February time, so we were only talking about two months, and then he was saying, "Oh, well actually you've got Christmas and New Year, so that's two weeks after that, so why don't I just not start until January, well call it the second week in January, I'll tell you what, why I just start on the 1st of Feb?" And, "Look, you're not understanding this, we've got staffed theatre sessions, we've got a backlog of patients that we have to clear, we can't go, the only person that is out there that is available to do a locum is the candidate we turned down to appoint you to this post." So it would be awkward, to put it mildly, to go to a candidate you had turned down to perform the job because the candidate you appointed, it's not convenient for them to come and start at the date that everybody expected that they're be there in post. And I, I gave him a lot of time. I, I explained my reasoning and I explained the needs of the organisation and I was quite careful to be as accommodating as I could whilst maintaining a firm like that we expected him be in the organisation and working by the 1st of December. Because we had already experienced the fact that you could put something down as a line in the sand, and then following our conversation you'd, you'd, you'd give on one area on the basis that something else was going to come instead. And then you found in the next conversation that the thing you had given was assumed into the baseline position, but the thing that had been offered in exchange for that now wasn't on the table. And, and it was a very frustrating negotiation process. So I had decided that the line in the sand was the 1st of December and I was prepared to be as flexible as I could be in virtually every other aspect to get something that was agreeable to him so that he could start work on clearing the backlog on the waiting list from the 1st of December. And when we got to the end of the conversation, where he'd said, "Okay, so I'll start on the 1st of December and I'll work a compressed three day week until …" blah-blah-blah, he then went back again and said, "But why can't …" And you just thought, "Oh gosh," you know, here we go, I, I don't want to go round this buoy one more time.* "[62]

[62] Page 27 of the Transcript of interview with Mr McLaughlin on 22 November 2013.

After speaking to the Managing Director of the Hospital on 10 August 2012 Mr Alwitry then proceeded to contact various other members of staff to try to get his way on his start date.

In the Report of the former Solicitor General, he concluded that Mr Alwitry had made a number of statements about Angela Body and the status of the waiting lists which were deemed to be unfair and inaccurate. The Board states in its report that it is not in a position to assess his conclusion: paragraph 91. The SEB supports the view that Mr Alwitry played down the significance of the waiting lists and misquoted Ms. Body in order, he hoped, to secure an outcome that better suited his family circumstances. The Board does not express any view about this conduct. However, Mrs Body's evidence to the former Solicitor General on this point was clear and was as follows -

> "*there's another email where I totally refute that . . .*
>
> *I'm very disappointed 'cause I worked with Mr Alwitry and I was …watching events that were happening throughout the course of the days, you know 9 o'clock, it was still going on at 5 o'clock, the next day, ditto, about what the start dates were...*
>
> *There is no way I would have said, "We don't need a third consultant," and if we did, we needn't have gone to advert for this post anyway.*
>
> *And we should not have patients waiting over three months for a cataract operation and, and we did, so I certainly didn't say anything.*"

The SEB is of the view that if a doctor is prepared to make inaccurate statements about a patient care issue to benefit their personal circumstances, then that is a legitimate cause for concern.

Mr Alwitry also contacted other members of senior management in order to obtain their support against the clear line being taken by the Managing Director. He even wrote to Mr Downes on 14 August[63] openly criticising the line taken by the Managing Director and raising the prospect of further disagreements with the management in the future. This conduct raised obvious issues about how Mr Alwitry and management were going to work constructively together in the future.

Mr Downes' evidence concerning Mr Alwitry's email to him of 14 August 2012 was as follows -

> "*I thought, well, you know, that perhaps indicates his lack of understanding of my role within the department of the organisation at that stage. He knew I was the clinical director, he knows what clinical directors are supposed to be doing and that they have a managerial responsibility. It also made, you*

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[63] Appendix 1. Document 34

know, there were further, alarm bells were starting to really ring by this stage. You know, this is someone that is, you know, has really bucked up against management, obviously, in the past.

The alarm bells is that someone is, is feeling that they need, it, it almost is going to be essential to be confrontational with management to get anything done, and, you know, that is just so, so twentieth century it's untrue. You know, you can't get anything done by upsetting management, you know, you have to work together, you know, that, that's the whole, the whole point of the new management structure, that's the reason for having doctors in management, and that's the reason why he wouldn't have ever had to have had any arguments with management, because in my role as the clinical director I would have protected him from a lot of that.

I found that really, you know, pretty, pretty unacceptable and particularly saying, "I'll be led by you in them," and I thought well I'm not quite sure about that, I must say."[64]

On the 14 August, the Hospital informed Mr Alwitry that they were unable to accommodate his requests and that the 1 December start date had to stand[65]. Mr Alwitry then put forward yet further proposals. The Board is critical of the Hospital for failing to reconsider its position in light of these further suggestions. It is the SEB's view that the Hospital was not obliged to engage in endless dialogue with Mr Alwitry until it gave in to his demands. It was entitled to conclude the negotiations on 14 August having spent four days considering the position and a total of six days in conversation with Mr Alwitry. There is no obligation on any employer to engage in unlimited negotiations until or unless the employee secures what they wish.

<u>G - The Contract of Employment is agreed</u> (pages 109 - 110)

The SEB agrees that a binding contract was formed once an offer was sent to Mr Alwitry and agreed on 21 August 2012.

<u>H - The discussions in September/October 2012 about clinics and surgery times (page 110)</u>

There is common ground regarding the expectation that a newly appointed Consultant will agree their final timetable with their new employer. It is normal practice that this negotiation and agreement takes place with the relevant Clinical Director for the service, this can be seen in most current recruitment packs.

The SEB notes that it is not good practice to negotiate a job plan and surgery times with multiple persons behind the back of Mr Alwitry's future Line Manager and Clinical Director.

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[64] Page 35 of Transcript of interview with Mr Downes on 25 November 2013.
[65] Appendix 1. Document 35

I - The discussions over the permanent timetable (pages 110 to 135 of the report)

The major issue over timetable related to operating on a Friday.

In January 2010, Verita, an independent consultancy firm based in London, provided the Health and Social Services Minister of Jersey with an independent investigation into the care, treatment and management of Mrs Elizabeth Rourke who had died during routine day care surgery at Jersey General Hospital on 17 October 2006. The report was produced with the assistance of Mr Julian Woolfson, Consultant Obstetrician and Gynaecologist adviser at the Royal College of Obstetricians and Gynaecologists. Verita made a number of findings about the wider management issues at the hospital and concluded at page 14 of its report, *inter alia*, that -

> *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.*

Verita described a lack of involvement on the part of the hospital's Clinical Directors in management meetings as a major management weakness (page 196). There was a need for the Clinical Directors to take on more of leading role. Following this report the role of Hospital Managing Director was created.

In the view of the SEB, the Hospital management should take the lead in determining timetables for surgery in order to maximise the use of the operating theatres, having regard to the overall available staff and resources required to effectively and safely operate and run these facilities. It cannot be that the Hospital management are required to accept whatever suits the particular Consultant or be presented with 'swaps' negotiated by doctors in private without any thought as to the consequences for the Hospital or its patients. The job planning process requires discussion between manager and doctor, not the doctor and a wide range of hospital staff. Mr McLaughlin's evidence to the former Solicitor General was very clear about this in the context of this particular case -

> *"The lead clinician is Richard Downes; Richard Downes has taken his views into account, had given him a timetable that was the best compromise he could come up with as the lead clinician in that department. The idea that you, as a consultant, who hasn't even started working in the organisation yet, rings a member of staff who, whilst she is a very senior and experienced nurse, she is relatively junior in the hierarchy, and you put what this email includes, which is a raft of alternative suggestions about moving this to there, doing this, doing that, doing the other, "I can simply ditch ..." This is*

something that is totally inappropriate and just shouldn't happen, and I can't think of an occasion where I've come across this before".[66]

The SEB is wholly unpersuaded by the Board's conclusion that it was acceptable for Mr Alwitry to run, in parallel, three lines of negotiation in respect of his timetable with (a) Mr Downes (his line manager) (b) Judith Gindill (Head of Nursing & Divisional Lead, Theatre Sister) and (c) Carol Hockenhull (clinic Sister). Mr Alwitry's contract expressly provides for job planning with his manager and not the 'myriad of individuals' who became involved in discussions about his timetable in this case. That is perhaps why Mr Alwitry commented to Ms. Gindill "*if you'd rather stay out of this*[67]" or why Ms. Hockenhull was invited by him to "*keep this email discussion just between us*"[68]. It also perhaps further explains why Mr Alwitry did not disclose his 7 October [69]email to his own trade union when asked by the BMA to do so.

The Board do not comment on Mr Alwitry's criticisms of Mr Downes made to the Theatre Sister during these discussions "*I would have hoped my senior colleagues could have sorted it for me but clearly the support isn't there*". It is the SEB's view that these remarks were not conducive in maintaining a working relationship with his new line manager nor were they the first or last time that Mr Alwitry would make or circulate similar comments about Mr Downes and other members of management.

The SEB refers to paragraph 113 onwards of the Board's report concerning an email from the Theatre Sister sent on 25 September[70]. The Board cites this document to support the view that Mr Downes had given Mr Alwitry his approval to try and swap his alternative Friday shifts. The weight of evidence is that he did not.

The relevant part of the email from the Head of Nursing reads -

> *As far as I understand and I had a telephone conversation this morning with RD [Mr Downes] he will be keeping the Monday afternoon, Tuesday am is for you Wednesday pm and Thursday am is Bartley and you will to alternative Thursday pm and alternate Friday am in mains - if you and [redacted name] agree to change this then that is OK with me.*

The background to the telephone call referred to in the email is that the Theatre Sister had telephoned Mr Downes to clarify the position in terms of the timetable. The SEB supports the view that the Theatre Sister's reference to the conversation with Mr Downes ended with the word "mains" and her own views start with the use of "if" in the final sentence. The use of the phrase "OK with me" in the final sentence is rather key here and "me" is a rather obvious reference to the Theatre Sister who wrote the email rather than Mr Downes who is referred to as "he" in this email.

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[66] Transcript of interview with Mr McLaughlin on 22 November 2013.
[67] Appendix 1. Document 36
[68] Appendix 1. Document 37
[69] Appendix 1. Document 25
[70] Appendix 1. Document 38

In any event, Mr Alwitry did not suggest in interview that he thought Mr Downes had authorised these attempts to change his timetable, which is a much better guide to the correct interpretation of the 25 September email[71]. Rather he justified his conduct on the basis of patient safety issues -

> "*Q Mr Downes has sent you an email on the 24 of September. He's part of management and I presume you understand that the management need to fix an overall timetable at the hospital which takes into account everybody, not just yours. . .*
>
> *AA: Absolutely. Yeah, absolutely.*
>
> *Q: .Why are you emailing Mrs Gindill on your own volition on the 29th of September and trying, in effect, to change the timetable that Mr Downes has given you, without going straight back to Mr Downes, and say . . .*
>
> *AA: Because I didn't want to cause problems with, with Mr Downes, because he said that he had done the best he could. He said that he had put in the groundwork for the, for the Thursday afternoon and so I presumed that it, it was something that was almost done, and I had patient safety concerns. And Judith was, was very, very friendly, very, very nice, very, very welcoming and she said, "If you have any concerns or any, any worries or do you want to chat about anything, please contact me." So I thought if it was a simple matter to get it sorted out and that it was already done in, in her timetable version of (inaudible) which you have seen, and then it was changed back again, that it would be a very simple matter for her to change it, the, the, the other, other way round and I would save Richard a job, effectively.*
>
> *Q: You would save him a job?*
>
> *AA: Yeah, absolutely.*
>
> *Q: another view about this is that this is another example of you not liking the management decision and then shopping around for a different answer. What do you say to that?*
>
> *AA: I, I think that there's kind of a bit of validity to that comment, because I had patient safety concerns and if the management decision hadn't really gone into them enough and sorted out a proper solution, then I thought that it was entirely reasonable to speak to the theatre sister and see if I could sort them out."*[72]
>
> (emphasis added)

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[71] Appendix 1. Document 38
[72] Pages 48 to 49 of Transcript of interview with Mr Alwitry on 18 November 2013.

The Board heard evidence from Tony Riley, HR Director at the Hospital and places heavy reliance on his comments that a '*certain amount of horse trading*' was usual in respect of theatre slots (paragraph 4.20). However, no context is provided to this comment and it would appear that Mr Riley was not invited by the Board to directly comment on whether Mr Alwitry's negotiations were within his usual experience of what is acceptable. On this point, Mr Alwitry did not seek to justify his behaviour to the former Solicitor General.

The SEB supports the view that the Hospital cannot and should not be run on the basis that the Hospital management spend considerable time and effort setting down a final timetable, to be seen only as a starting point or springboard from which further negotiations can take place between individual doctors and other staff.

When Mr Downes emailed Mr Alwitry on 9 October 2012[73], he did so in firm terms. It was clear that he was unimpressed that conversations about the timetable had gone on behind his back.

The former Solicitor General concluded in his original report that Mr Downes' primary intention with this email was to re-establish that any conversations about timetable were to be with him or senior management only: "*if you have any further queries questions concerns in relation to the above please address them to myself Andrew or Angela rather than involving a myriad of different individuals which simply serves to confuse*".

The Board concluded that it was not reasonable for the former Solicitor General to reach that conclusion and that the email was intended to be a stern warning to 'toe the line' and to signal the end of the negotiations about timetable (paragraph 131).

Mr Alwitry's response was to telephone Mr Downes on the 10 October and there was a conversation between the two men that lasted some eight minutes. This conversation was followed by Mr Alwitry immediately contacting his trade union to inform the BMA that he was "*feeling helpless and quite distraught.*"

<u>J - The involvement of the BMA (pages 122 to 124 of the report)</u>

The SEB notes that Mr Alwitry did not supply the BMA with Mr Downes' email which the BMA had specifically requested[74].

The former Solicitor General concluded in his original report that Mr Alwitry broke off all communications with Mr Downes and the hospital management on 10 October. He did not take the opportunity to speak to Mr Downes during his visit in late October and ignored Mr Downes' subsequent attempt to reach out through a mutual colleague at Derby Hospital. The former Solicitor General expressed the view that Mr Alwitry did all of this because he was waiting for the BMA to intervene on his behalf and speak to the Medical Staff at the Hospital. The former Solicitor General also observed that Mr Alwitry failed to provide any of

[73] Appendix 1. Document 26
[74] Appendix 1. Document 27

this information to him in his first interview. It was only upon receipt of the BMA records that he disclosed that the former Solicitor General finally understood why he had maintained a silence from 10 October onwards. The Board do not challenge these conclusions.

There is no doubt from the BMA records that Mr Alwitry had attended the hospital on 23 October and spoken to staff, but not management, about the timetable. This coincided with Mr Downes confirmation that he had received reports from staff that Mr Alwitry was unhappy with his timetable and a range of other matters.. At this time, the Hospital Managing Director summarized the ongoing concern from the hospital's point of view[75] -

> *. . . he [Mr Alwitry] will not accept anything he does not like without an argument and when he doesn't get the answer he wants he tries someone else for a different result and so on. Whenever we do call his bluff he appears to back down but then starts the debate all over again . . .*

Although it is not material, the Board may have misread paragraph 135 of the former Solicitor General's original report where he expresses the view that the BMA did not share Mr Alwitry's opinion that the son was suffering for the sins of his father - an allegation of bad faith directed towards Mr Downes. The BMA instead suggested to Mr Alwitry that they should not become involved, hence the conclusion that the BMA did not see Mr Downes' conduct in the same light.

Mr Downes summarised the fact of the involvement of the BMA and its relative insignificance in the decision taken to terminate Mr Alwitry's contract of employment as follows -

> "*That wasn't the reason the contract was terminated, that was one of several reasons the contract was terminated. You will see Tony [Riley] had written down here, it, he doesn't, he said one of the four things relates to the BMA; it's not all the rest. I mean, the contract was terminated because this just illustrated, yet again, the rather, sort of, bizarre way that Mr Alwitry went around doing things, his complete disregard for anything and anybody, including management and, you know, myself. I, I just, I, I just find, that's, I found it absolutely extraordinary, when I got back, that he had decided to report me to the BMA, that, I just, you know, I just can't say anymore. I just found it quite extraordinary. And that was yet another factor to take into account with regard to whether this was an individual that we wanted to work within the organisation. It wasn't the only factor, it wasn't the precipitating factor, but it was the final factor that made people sit round and think, "Well, you know, what on earth is this guy playing at, what on earth is going on here?*"[76]

[75] Appendix 1. Document 39
[76] Page 85 of the Transcript of interview with Mr Downes dated 25 November 2013.

K - The senior staff at the Hospital decide to sack Mr Alwitry (pages 124 to 143 of the report)

Whilst the SEB accepts there were procedural deficiencies, the motivation for the withdrawal of the contract of employment was ensuring a harmonious working relationship within a small team of three consultants.

Whilst it does not feature in the Board's Report after the decision to terminate Mr Alwitry's employment on 13 November 2012 but before sending the letter of termination on 22 November 2012, the Hospital's senior management received information that Mr Alwitry's current hospital were not willing to take him back as a consultant as they were not legally obliged to do so.

Mr Downes heard personally from the clinical director at Derby hospital and

similar information was received from a nurse at Loughborough hospital.[77]

Mr McLaughlin commented in relation to the information that Derby hospital as follows -

> "…*Because one of the things that we were looking at was if, if, if have a consultant that has resigned in the hospital, the first thing you do is, you go to the consultants and say, "Why are you resigning? Is there anything we can do to stop you resigning?" Because you're going to have a break in service, you're usually losing a valued staff member and the last thing you want is for them to leave, and you have that discussion. If, at that point, they say, "No, it's my ideal job, it's back where I was born, I've got all my friends and relatives there, we're going to move back with the family, and, you know, it's my ideal," you can say, "Okay, it's not ideal for us, but we can see that it's, it's the right thing for the individual and you then begin the process of filling that vacancy or potential vacancy to minimalise the break in service, because it takes about six to nine months to appoint a consultant from initial notification, and normally they're only on a three month notice period, so you're going to have a gap in service, so you have to move quite quickly. If at any point before you have stuck the advert out, a consultant that's resigned says, "Oh actually, you know, on reflection I don't think I want to go and do this, you just breathe a sigh of relief and say, "Thank heaven for that, come back, you know, you start Monday, you're back in your old rota and, and, and carry on as you were." The idea that you wouldn't take a consultant back that you've had on your books, just, frankly, is, isn't credible. So the idea that by having the job offer withdrawn here, Mr Alwitry wasn't then going to just go, "Oops," and put his weight back into the hospital he was in previously and carry on as he had been until the next appointment came up, just, you know, that only emerged later really, that there was no way he was going to be accepted*

[77] Page 89 of Transcript of interview with Mr Downes on 25 November 2013

back by that hospital, which I can only assume was because of the behaviours he evidenced while he worked at that hospital."[78]

L - The States Employment Board (pages 143 to 146 of the report)

The SEB has commented on its role in this case earlier in this response.

M - The reports commissioned by the Director of Human Resources for the States Employment Board (pages 146 to 148 of the report)

The SEB notes the credentials of Miss Haste and Mr Beal, and that they interviewed witnesses (including Mr Alwitry).

N - Private practice (pages 148 to 149 of the report)

Paragraph 213 - the SEB notes that the Board makes no findings in relation to Mr Alwitry's allegations about private practice in relation to Mr Downes.

Paragraph 214 - "*We repeat that we are not suggesting that anything untoward actually happened in the present case. We do, however, believe that it would be prudent for there to be a procedure which ensures that there is disclosure by those involved in the decision-making process (including the applicant/person who is the subject of the decision) of any discussions/agreements about private practice and for such disclosure to be properly recorded and considered (if relevant) as part of the decision. Obviously if the disclosure revealed a potential conflict of interest, the conflicted person on the management side should not ordinarily participate in the decision-making process itself.*"

The SEB accepts that the private practice arrangements in Jersey differ from those generally experienced when working in the NHS. The composition of the interview panel, who are the decision makers regarding appointments, is intended to ensure that there are panel members who would not and could not have a conflict of interest regarding private practice. Each Consultant, within a specialty that attracts private practice, is potentially in competition with their specialty colleagues, this is unavoidable. Potential candidates for Consultant position are now informed of the private practice landscape at pre-interview meetings with the Medical Director, the Hospital Managing Director and the Medical Staffing lead. If a candidate choses to explore business options out with the hospital they are perfectly at liberty to do so and it is not within the jurisdiction of the HSSD team to intervene.

Although this has not affected the outcome of this case practice in this respect has been changed in the period since 2012.

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[78] Page 105 of Transcript of interview with Mr McLaughlin on 22 November 2013.

O - Conclusion on the procedure leading to the deliberate breach of Mr Alwitry's contract (pages 149 to 150 of the report)

The SEB acknowledges that the procedure prior to the decision to withdraw the offer of employment could have been better. However, the Hospital's overriding motivation in withdrawing the offer of employment was to prevent the creation of a dysfunctional Ophthalmology Department in the interests of the Hospital and the Island overall and because it had lost trust and confidence in Mr Alwitry.

States Employment Board

4 October 2016

Health and Social Services Department
Corporate Administration
Peter Crill House, Gloucester Street
St Helier, Jersey, JE1 3QS
Tel: +44 (0)1534 442285
Fax:+44 (0)1534 442887

14th January 2013

Our Ref: JG/ef

Dear Minister

Ref: OPHTHALMOLOGY CONSULTANT AND INDEPENDENT REVIEW

Following a meeting on Friday 11th January attended by the Health and Social Services Minister, Assistant Minister, CEO, Directors and Jersey General Hospital Senior Doctors, we the undersigned wish to ensure that you are fully aware of the following facts, views, concerns and risks which we hope will be taken into account in any deliberations or decisions made in respect of this matter.

The recommendation to withdraw the job offer to Mr Alwitry was not made without grave and careful deliberation and was a unanimous and collective position informed by a series of discussions involving senior doctors and senior managers, including [in no particular order] the Clinical Director of Ophthalmology, the senior surgeon and physician who job share the Hospital Medical Director role, the Hospital Managing Director , the Hospital Operations Director , the CEO and HR Director for HSS . This was then subsequently unequivocally endorsed by the HSS Ministerial team. Advice from Law Officers Department was received and re-checked as to the financial risks that might arise from the withdrawal. All parties acknowledged that the greater risk was political and possibly media campaigning on behalf of Mr Alwitry.

Agreement to and endorsement of the appropriateness of this course of action was subsequently secured from SEB, initially and unanimously by e-mail and then by a quorate SEB held on December 18th 2012. In view of the serious nature of this decision, The CEO for H&SS, the Director of HR for H&SS, the Managing Director for the Hospital, the Director of Operations for the Hospital, the Joint Medical Directors and the Clinical Director for Ophthalmology all attended this meeting. SEB also identified a need for a review of consultant recruitment processes and supported the proposal to offer the vacant post to another candidate who had been confirmed as above the line and appointable by the Appointments Advisory Committee including the Royal College of Ophthalmology.

Subsequently, SEB have modified the nature of the review to include consideration of the rationale for the decision to withdraw the offer and to postpone finalising the employment of the second candidate until the outcome of the review is known.

We are aware that 3rd parties have suggested that Mr Alwitry's behaviour was in fact within the norms frequently manifested by medical consultants during job offer discussions. We would remind you that the 3 doctors and 2 senior managers who attended SEB in December did address this point and emphasised that in their collected decades of experience of appointing doctors, they had never encountered such extremes of behaviour as those that prompted this situation.

There is also a 3rd party view that the decisions about Mr Alwitry and the other candidate should be referred back to the AAC. This misunderstands the advisory nature of that group - once they confirm which candidates are appointable it becomes a management decision and this has recently been reinforced by the Royal College advisor to that AAC.

Finally it is being suggested that some compromise position of engaging Mr Alwitry as a locum or under a fixed term probation contract may be a way forward. This is not seen as feasible or practical by the signatories below. The more clinically and operationally desirable solution would be to engage the second choice candidate on a locum basis pending [and not pre-empting] the outcome of the review.

The signatories to this letter wish to bring the following matters to your attention:

the risk of losing the second candidate as a result of any delay exceeding 1-2 weeks, caused by this revised review, is extremely significant.

losing the second candidate in itself poses risks to effective delivery of ophthalmology services and the achievement of acceptable waiting times for patients in the short and medium term.

should the review produce an outcome whereby SEB concludes that it is necessary to instruct HSS to reinstate the job offer to Mr Alwitry the risks and consequences are particularly grave. This would inevitably lead to the resignation of the current Clinical Director both in that capacity and as a Consultant Ophthalmologist. The only other Consultant in the current team has been indicating for some time his intention to retire some time after April 2013. Taken together this inevitably has a seriously destabilising effect on the service and creates worryingly inappropriate delays for patients.

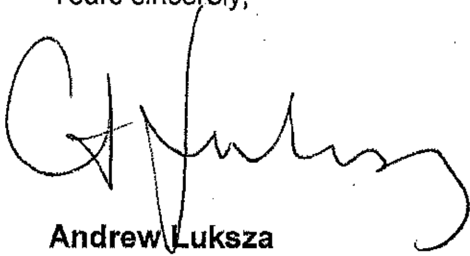
As you aware, Dr Luksza our physician half of the Medical Director team, is due to leave us in the next few weeks and Mr Siodlak, the other Medical Director, is highly unlikely to stay in this post if the original decision is in any way reversed. This, together with the loss of an influential Clinical Director, causes irreparable damage to the hitherto strong and effective Clinical Engagement, Clinical Leadership and Clinical Governance arrangements that these doctors have helped to create with Andrew McLaughlin and Angela Body since the production of the Verita Report and which were recognised by Verita in their progress report. These arrangements were also strongly praised by Professor Aitkenhead who explicitly identified that any dilution of these structures poses a significant risk to hospital care in Jersey.

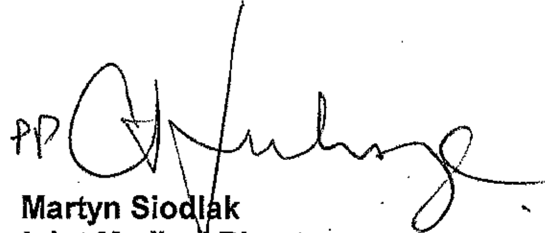
All parties at HSS accept that the consultant recruitment processes here, whilst satisfactory and consistent with those applied elsewhere in hospitals of our size, could benefit from a review. Indeed, an internal report has already made recommendations as to how these might be further strengthened and any additional suggestions along these lines that the independent review might make will be welcomed and actioned.

We believe that the overwhelming majority of the consultant body at the hospital would be very disappointed, and the Clinical Director group would be demoralised, if the medical leadership and Hospital Directors were to be seen to be overruled and undermined in this matter. There must also be a high risk that this will create a precedent whereby senior doctors and indeed other staff will perceive that the most effective way in which to challenge or circumvent decisions made by senior officers and clinicians and/or SEB is to simply garner the support of vociferous politicians.

In summary we wish to put on record that the risks to service provision, Clinical Governance/Engagement/Leadership and the future relationship between doctors, managers and politicians, would be most serious and should not be underestimated.

Yours sincerely,

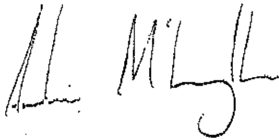


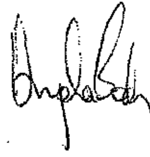


Andrew Luksza
Joint Medical Director
Direct dial: +44(0)1534 442270
Email: a.luksza@health.gov.je
www.gov.je

pp **Martyn Siodlak**
Joint Medical Director
Direct dial: + 44(0)1534 442270
Email: m.siodlak@health.gov.je
www.gov.je

Richard Downes
Clinical Director - Surgery
Direct dial: +44(0)1534 442798
Email: r.downes@health.gov.je
www.gov.je





Andrew McLaughlin
Managing Director
Direct dial: +44(0)1534 442280
Email: a.mclaughlin@health.gov.je
www.gov.je

Angela Body
Director of Operations
Direct dial: +44(0)1534 442280
Email: a.body@health.gov.je
www.gov.je

Julie Garbutt
Chief Executive
Direct dial: +44 (0)1534 442285
Email: j.garbutt@health.gov.je
www.gov.je

Tony Riley
Human Resources Director
Direct dial: +44 (0)1534 445411
Email: t.riley@health.gov.je
www.gov.je

APPENDIX 3 to P.137/2016 Com.

Report on the independent Conflict Analysis carried out for John Richardson, Chief Executive, States of Jersey

Practitioner: Michelle Haste

Report prepared: 26 February 2013

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T: 01763 852225

E: info@cmpresolutions.co.uk

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1. Introduction

CMP Resolutions was commissioned by States of Jersey to undertake an independent assessment to explore the potential for mediation to resolve the dispute between Mr Amar Alwitry and hospital managers and senior clinicians at the General Hospital Jersey.

1.1. Background to the brief

Mr Amar Alwitry is a Consultant Ophthalmologist. He applied for a new Consultant post at Jersey General Hospital in 2012. Following a standard recruitment and appointment process, in early August he was offered the post which he formally accepted on 21 August 2012. The offer was subsequently withdrawn on 22 November 2012. Different positions have been taken about potential ways forward, and CMP Resolutions was commissioned to explore whether mediation was a feasible option for resolving the situation.

1.2. The process followed

The following individuals were interviewed as to their perceptions of the situation and their expectations for resolution:

- Mr Amar Alwitry, Consultant Ophthalmologist
- Mr Andrew McLaughlin, Former Managing Director, Jersey General Hospital
- Dr Andrew Luksza, Consultant Physician in Thoracic and general medicine, Medical Director, Jersey General Hospital
- Mr Martyn Siodlak, Consultant ENT surgeon, Medical Director, Jersey General Hospital
- Mr Richard Downs, Consultant Ophthalmologist, Clinical Director for surgery, Jersey General Hospital
- Mr Bartley McNeela, Consultant Ophthalmologist, Jersey General Hospital
- Ms Angela Body, Director of Operations, Jersey General Hospital
- Mr Tony Riley, HR Director, Jersey Health and Social Services Department
- Ms Julie Garbutt, Chief Executive, Jersey Health and Social Services Department

All individuals were interviewed by telephone save for Mr Alwitry, who was interviewed in person. The interviews took place between 8 February 2013 and 14 February 2013. At the outset of each interview the following matters were outlined to the interviewees.

1.3 The purpose of the interview

It was explained that the purpose of the interview was to understand the interviewee's perception of the conflict and to explore their view on mediation as an appropriate means of resolving the conflict. Each interview was also an opportunity to explain the key principles of mediation, as follow.

1.4 Principles of mediation

The principles of mediation were explained to the interviewees so that they could understand the process, and participate meaningfully in giving their views on the potential for mediation as a viable option for resolution. The key principles outlined were:

- **The voluntary nature of the process**

It was explained that one of the main tenets of mediation is that the parties participate on a voluntary basis, and can, at any point discontinue their involvement.

- **Confidentiality**

It was explained that mediation is a confidential process and as such the interviewee had absolute control over how much or how little was shared with States of Jersey from these initial interviews. It was explained to each interviewee that I would be preparing this report on the feasibility of mediation as the first stage in the process, and therefore it would be helpful to be able to reference the interviewee's perspectives in the report, but that the decision was entirely the interviewee's. Some interviewees indicated that they were happy to have all matters discussed disclosed and referenced (Mr Alwitry). Other interviewees adopted a different stance and were clear that they were willing for me to disclose some aspects of the discussion, while they wished other matters to remain confidential between us.

- **Objectivity**

Objectivity is an important tenet of mediation. I explained that mediators are trained to remain neutral and impartial and to help both/all parties equally. Mediators do not to express opinions or make judgements about who is right or wrong, and any choices and decisions made during mediation are participants' decisions and choices. I explained the role of CMP and my role as a consultant practitioner for CMP. I also disclosed to all interviewees that I had conducted an objective fact-finding investigation into a workplace

issue for States of Jersey (on behalf of CMP Resolutions) in 2012. That investigation did not relate to the Hospital or any of the interviewees. I confirmed to all interviewees that my involvement in that investigation did not, in my view, affect my neutrality or objectivity.

1.5 Ability to call the mediator to give evidence

It was explained to all interviewees that any documents submitted to me and matters discussed during the mediation and the initial interviews were for resolution purposes only; and as such I would not willingly testify on behalf of any party or submit any type of report save for this report.

Key points were summarised with the interviewees to ensure that they accurately reflected what had been discussed. Any quotes (which are shown in italics) have been taken from my notes of the interviews.

The intention of this report is to present a balanced perspective, representing the various views presented.

1.6 Report structure

The report is organised as follows:

- Description of background factors, which may have contributed to conflict between Mr Alwitry and the Hospital Managers and Clinicians.
- An assessment of whether mediation would be a feasible conflict resolution mechanism
- Next steps.

2 Background factors that may have contributed to conflict

This section summarises the background factors that may have contributed to the current situation.

2.1 Mr Alwitry's perspective

2.1.1 Overview of the response

When I met with Mr Alwitry he confirmed to me that while he did not consider he had done anything wrong, he was most anxious to have the decision to withdraw his appointment rescinded. He told me that he would consider the application of any condition to secure the appointment. It is important to note that Mr Alwitry gave his specific consent to disclose the

content of my discussion with him, which was given freely in response to my explanation that our interview was confidential. He felt it important to waive confidentiality in order that his perspective was properly understood.

After some probing it emerged that although he did not accept that he had done anything wrong, he accepted that he might have been overzealous in his job planning, and also speculated that the decision to rescind may be connected to private patients and his father.

2.1.2 Job Planning

Mr Alwitry explained to me that he considered Job Planning to be a key part of the process following appointment. He indicated to me that he had actively job planned in advance of his previous consultant appointments; indeed he cited an NHS text that indicated that hospitals and consultants need to mutually agree a job plan and make every effort to reach agreement.

Mr Alwitry understood the clinic Sister to indicate that the proposed timetable was unworkable and therefore considered that it was appropriate to revisit the timetabling to achieve a more workable solution. Conversely, senior managers and clinicians took the view that the correspondence around the job planning and theatre lists was inappropriate. This post was a new Consultant post, and as such much internal negotiation had taken place to secure additional theatre slots, and the perception was that Mr Alwitry had demonstrated an inordinate lack of insight for the negative impact that his actions had caused. The consensus was that his efforts were centred on his need to change the timetabling to suit his requirements rather than considering the needs of the hospital as a whole and other consultants outside his department, which was thought to be unfair.

2.1.3 Private patients

Mr Alwitry felt that being a "*Jersey Boy*" he may get significant private patient referrals at the cost of other consultants. Senior managers and clinicians disputed that this would have any impact on private patient numbers, as there is a significant amount of private work available on the Island, and this had no bearing on the decision to withdraw the offer to Mr Alwitry. Mr Alwitry discussed private practice opportunities with both Mr Downes and Mr McNeela, although no arrangements had been concluded.

2.1.4 Mr Alwitry senior

Mr Alwitry's father was formerly a consultant ophthalmologist at Jersey General Hospital. Mr Alwitry suggested to me that he was concerned that his father had worked with Mr Downes and others, and had on occasion been perceived as difficult. Mr Alwitry was concerned that this had influenced the decision to withdraw the offer.

The consensus of opinion from the Hospital managers and clinicians was that this had no influence; indeed, if this had been an issue Mr Alwitry would not have been offered the post.

2.2 Senior Managers' and Clinicians' perspectives

2.2.1 Overview

Senior Managers and Clinicians cited Mr Alwitry's attitude and behaviour following appointment as the reason for withdrawing the offer of appointment. Examples were given which I itemise under the following headings.

2.2.2 Changes to proposed start date and adjustment to timetable

Of particular concern were Mr Alwitry's efforts to adjust the proposed start date and his efforts to change the arrangements for clinics and theatres. I was told that there was a substantial volume of correspondence between Mr Alwitry and others in this regard, which was most unusual, and there was a perception that if Mr Alwitry did not secure the desired response from one source he would approach another source. I was told that the volume, tone and stance were unusual and inappropriate. In one email Mr Alwitry was cautioned "… *I would finally advise / warn that making too many demands at this stage of your appointment is unlikely to bode well for your future relationships within the organisation…"*

2.2.3 Complaint to the BMA

I was told about a complaint made to the BMA by Mr Alwitry about Mr Downes. Mr Alwitry denies that he ever made such a complaint; he states that he was seeking advice on issues surrounding the appointment including the job planning and Programmed Activities (PAs), which he suggests is standard practice. I have been advised that the hospital was told by the BMA that a complaint was made, and that the person who called the hospital on behalf of the BMA has been on long-term sick leave and was not available to advise as to the content of the discussion on behalf of the BMA or verify her side of the discussion. Mr

Alwitry does have correspondence from the BMA confirming their perspective that no complaint was made.

2.2.4 Other perspectives

I spoke to another clinician who while involved in the recruitment process was not involved in the decision to rescind, and as such feels excluded from that decision and disagrees with it wholeheartedly. He considers the decision to be profoundly unjust and he considers there is no basis for it, particularly as Mr Alwitry had acted as a locum for the department and therefore was a "*known quantity*". He is therefore emphatic that Mr Alwitry must be appointed, and has expressed serious concerns in respect of the appointment of the second candidate.

3 Assessment of whether mediation is a feasible dispute resolution mechanism

During the course of the interviews enormous strength of feeling was exhibited. In respect of Mr Alwitry, he told me that he did not see an alternative to the decision being rescinded - he and his family are utterly committed to the Island and could not conceive of not fulfilling this commitment. When I probed how this would be workable given the level of conflict to date, he indicated that he "*did not wish to discuss it*", that "*everything would be fine*", and although I suggested that the conflict would need to be worked through to ensure a manageable working relationship, he was very reluctant to entertain this, indicating that once he started everything "*would be fine*".

It is clear that Mr Alwitry considers that rescinding the withdrawal is the only possible route to resolution, and he is more than happy to participate in any process to secure the withdrawal, including mediation. I am concerned that Mr Alwitry appears reluctant to explore both the reasons for the conflict and any strategies for improving the working relationship; rather he is solely focused on restoring the appointment.

When I interviewed the senior managers and clinicians they (independently) made it clear that they had taken great care in reaching the decision to withdraw the offer, and expressed great concern about the prospect of rescinding the withdrawal of the offer. It was pointed out to me that many of the decision makers were due to retire or finish their posts and therefore had nothing to gain by the decision, indeed they pointed out that if they wished to take an easy decision this would not be it.

They cited the following concerns as reasons why the decision to withdraw should not be entertained:

- They felt that it would be very difficult to manage Mr Alwitry and other consultants when their decision had been overturned by what they described as political pressure.
- They felt that the decision making of the senior management would be devalued generally.
- They felt that there would be irreparable damage to clinical engagement, which had been a focus of the management of the hospital since the Veritas enquiry into the death of Mrs Rourke.
- They felt that there was a risk to succession planning at the hospital.
- Their view was that there was a significant risk of senior-level resignations.

A view often given was that the managers would have no on-going control if the careful decision of experts at the hospital was to be overturned as a result of what was described as political pressure. It was seen as a question of who is actually running the hospital for the best interests of the hospital and the patients, and it was a widely-held view that this issue was not about the ophthalmology department but the hospital as a whole.

It was also regularly stated that it would be "*untenable*" for the management authority to be devalued by rescinding the decision, which was a result of very strongly held concerns and beliefs.

Many made extensive reference to the Veritas report (following the death of Mrs Rourke), and indicated that if the decision to withdraw was rescinded then Mr Alwitry would be "*bombproof*", which would inevitably be difficult and damaging for clinical engagement, and for the effective management of Mr Alwitry and other clinicians.

The decision makers believe the decision was right for the hospital and the patients and they stand by it. They expressed grave reservations in respect of a decision to rescind the withdrawal, and indicated that as they would not voluntarily opt for that route, it could only be imposed upon them. It was stated that if the decision were to be rescinded then resignations would inevitably follow.

It is notable that at no time prior to the decision to withdraw the appointment was there any effort to meet with Mr Alwitry and identify the concerns that had emerged and the potential consequences (such as a risk that the appointment would be withdrawn) and to discuss these with him. At that stage it is likely that mediation would have been a most valuable tool, either to resolve the conflict between the parties, or at the very least for Mr Alwitry to

have a clear understanding of what the issues are. Mr Alwitry speculates about the reason for withdrawal, but states that he does not actually know what these reasons are.

On that basis I believe it would be useful for the parties to meet in joint session to explore the reasons for the conflict and also explore whether resolution is feasible.

However, I have concerns about the feasibility of mediation as a dispute resolution mechanism *per se* given not only Mr Alwitry's reluctance to explore the issues except as a means to the end of achieving the reinstatement of the appointment; but also because of the clear consensus from the decision makers that a reversal of the decision to withdraw is not tenable.

However, parties' perceived positions often change during the joint mediation session, when misunderstanding and miscommunication is clarified; and obviously the oxymoron of court-ordered mediation is successful notwithstanding the parties' reluctance to voluntarily mediate the issues.

Therefore I recommend that careful thought is given to the points raised by both sides in respect of the conflict, and also the reasons advanced by the decision makers as to why the withdrawal should not be rescinded.

If a joint mediation session is to be scheduled, then advance preparation should be undertaken to ensure that the parties representing the States Employment Board are fully apprised of the facts of the conflict and of the positions of various stakeholders, and have the authority to reach agreement - whatever that agreement might be – in the mediation.

In a joint mediation session I would encourage Mr Alwitry to reflect on the conflict and the issues surrounding the conflict, notwithstanding his desire to simply move on.

4 Next steps

States Employment Board needs to determine whether a joint mediation session is to be scheduled, and if so who is to attend on behalf of States Employment Board. The nominated individual(s) would not only be representing the interests of the employer, but would also need to deal with the interests and concerns of the hospital management and clinicians given the very serious reservations noted by them and the suggestion that any decision to withdraw would need to be imposed upon them. Needless to say they would also need appropriate authority to mediate.

We are happy to participate in any briefing sessions to be set up with interviewees or the States Employment Board, and advise further about the mechanics for the joint mediation session if it is to be held.

States of Jersey
Independent Case Review

Commissioning Manager
John Richardson, Chief Executive Officer

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5. Best practice references

1. **Introduction**

The State's Employment Board has commissioned an Independent Case Review.
The terms of reference are attached to this report, **appendix 1.** The commissioning manager is John Richardson, CEO of the States of Jersey. The Report will be presented to the State's Employment Board.

This report is private and confidential and for the State's Employment Board.

2**. Independent case reviewer**

X, **X**of **X**, a HR Consultancy business from the UK mainland was commissioned to carry out the case review. **X** is an experienced HR professional who has worked as an Executive Director of HR in the NHS and carried out many investigations at a senior level reporting to Boards. **X** is a Fellow of the CIPD.

3. Process

The State's Employment Board (SEB) signed off the terms of reference on Tuesday 5 March 2013. This formed the basis of the case review to be carried out into the recruitment process to a post at the Hospital to a Consultant Ophthalmologist and the subsequent rescinding of the offer.

The purpose of the Case Review is to review

(i) The robustness and integrity of the recruitment process by which the consultant was appointed,

(ii)The decision making process from the offer stage until the decision to rescind the offer of employment

Each person involved in this case review was interviewed against a standard set of questions, attached in **appendix 2.** In some instances there were follow up interviews to seek points of clarification after interviewing **X**.

All Interviewees were given the opportunity to agree and sign off the notes to ensure they were an accurate record of the meeting they attended. The interview notes have not been attached to this report for reasons of confidentiality.

4. Interviewees

The list of all interviewees is attached in **appendix 3.** The Case Reviewer interviewed all parties involved in the appointment process, senior managers and clinicians who were involved in rescinding the offer of employment. **X** was interviewed to get **X** view of how the States of Jersey had acted throughout this process and to give **X** the opportunity to give **X** version of events.

A number of politicians requested to be interviewed who had been involved in the SEB decision to rescind the offer or had expressed an interest in the case.

I confirm the conclusions within this report are independent, based on all of the evidence collected during the case review including papers on file relating to the process, documented interactions between key parties in the form of emails and the interviews undertaken with key witnesses. Where there has been more than one version of events given, I have formed a conclusion based on the reasonableness of the evidence and considering any supporting documentation.

5. Findings

5.1*The robustness and integrity of the recruitment process by which the consultant was appointed (ToR)*

5.2 The process for recruitment and selection in this case was within the normal custom and practice for a Hospital Consultant within the States of Jersey. There is an agreed policy on the recruitment process for Hospital consultants.

A business case was agreed for the post in line with normal practice. Senior management and clinicians drafted the job description and person specification, with support from the medical staffing team. This was approved by the Royal College, the post was advertised as normal and applications were received through talent-link, the recruitment system.

5.3 The interview panel was as follows:

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Panel members described an interview process for the role based on the job description and person specification. The Royal College Assessor's role is to ensure the Consultant is professionally registered and is fit to practice as a Consultant within Royal College guidelines.

5.4 Review of the interview process

There were initially five candidates shortlisted, the panel finally agreed on four candidates, one candidate subsequently withdrew from the process before the interview. Therefore three candidates participated in the interview process: **X**, **X** and **X**. The interviews took place on 1 August 2012. It is normal practice in Jersey for candidates to conduct informal meetings with key stakeholders, this does not form part of the interview process.

They met with the following people informally on the 31 July 2012.

- Julie Garbutt, CEO for Health and Social Services

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At the end of the interview process there was a discussion about the three candidates' performance at interview. There were varied views from the panel, some thought all three were appointable; others thought two candidates were appointable.

From the interviews, it was unclear that there was a robust and objective discussion about each candidate's performance based on the person specification to inform the panel's decision.

5.4.1 Audit of shortlisting and interview paperwork

On auditing and reviewing the file, I have drawn a number of conclusions:

- The shortlisting forms are incomplete and many un-scored against the person specification

- Interview record forms are in-complete and un-scored with very little evidence and commentary documented by the panel

- The person specification lacks rigor and depth for a post at this level and includes some subjective criteria

- Overall the paperwork did not demonstrate an objective and robust assessment process.

This demonstrates a poor HR process for this senior post, not in line with best HR practice. Best practice would ensure the best candidate is appointed through an objective assessment process based on the needs of the role.

The Chair of the panel has a responsibility within the process, to ensure:

- The evidence is gathered at interview to inform the panel's decision
- All panel members score each candidate objectively
- The paperwork is completed for each candidate
- A robust debate occurs within the panel to inform the decision

The role of the **X** is primarily administrative, by gathering all the paperwork and ensuring this is completed and filed in line with policy and best practice.

5.4.2 Recommendations

- All panel members to be trained in future on interviewing techniques to carry out an objective assessment process against the person specification

- Review of person specifications to ensure they are fit for purpose in line with best practice

- The Chair has a responsibility to ensure all paperwork is completed in full and fully scored before being returned to the Medical Staffing Team

- Reinforce the role of the Royal College Advisor to ensure the Consultant is registered, fit to practice and in future use the re-validation process to inform the assessment process

- Review of the recruitment and selection process for Consultants in line with best practice. This should include the constitution of the panel, assessment process, use of informal meetings and developing a competency-based approach which is in line with best HR practice

- Consider an assessment centre approach to recruitment and selection to include presentations, psychometrics tests and stakeholder engagement events

- In terms of Medical HR support, this should be provided by a more senior HR professional, who is part of the panel and decision making process. This should be at least the Medical HR Manager if not the Director of HR for HSS for a consultant appointment

5.5 Decision to appoint

- The Chair asked who the panel thought were above the line
- All agreed **X** and **X** were above the line

First choice- X

- Was known to the service and Hospital
- Had worked as a Locum at Jersey Hospital in the past
- **TEXT REDACTEDTEXT REDACTEDTEXT REDACTED**Was already a Consultant in **X**
- Clinically accomplished in **X** field
- Good CV
- Well published
- Interest in private practice

Second preferred candidate- X

- The panel agreed was above the line and appointable
- Was already Consultant
- Concerns about asking for unpaid leave on an annual basis year and impact on the service delivery.

Third candidate- X

- Varied views whether appointable to the post from the panel
- Locum consultant
- Some panel members thought demonstrated less leadership potential
- It was agreed that **X** wasn't appointable by the panel after this discussion.

There did not appear to be a discussion about organisational fit or being able to work in a small team from the interview panel. There was no testing of team working or leadership from the interview process. There was no discussion about potential start dates with the candidates.

There was 50 minutes set aside for the interviews, **X** commented that **X** interview was over in around 25-30 minutes, which **X** considered a good sign on the day.

The panel did not review the references provided by the candidates within each application. There was no check by the panel that the candidate's current Clinical Director or line manager was nominated as a referee. There was no discussion about **X**'s statement on **X** application that **X** notice period from **X** role in **X** was 6 months. Equally, **X** did not raise this at interview or at any of the informal meetings with the key stakeholders listed above.

5.5.1 Conclusions

There was no evidence of a robust testing of the person specification. A 30-minute interview with a panel of six for a consultant post is not sufficient to test the applicant's suitability for the role.

There was no evidence of competency based questions or testing out of wider issues such as clinical engagement, leadership and team working for a senior role in a clinical setting.

This demonstrates a poor recruitment and selection process on this appointment; this is supported by the audit of the paperwork. The Chair has a responsibility to ensure the process is carried out in line with best HR practice which should include picking up any issues around references and ensuring any issues on the application form are followed up e.g. notice period and start date.

Overall the process was poor and not comprehensive.

5.5.2 Recommendations

- Review of the recruitment and selection process
- Specific coaching for panel chairs on their role and responsibilities
- Training for all panel members on interview techniques
- Ensure there is a robust process to check references are taken from the appropriate line manager or clinical director for the candidate, this should be the chair's responsibility on the day

5.6 Feedback and communication

X telephoned **X** to offer the post subject to the usual pre- employment checks. Other panel members called other unsuccessful candidates to informal them of the outcome.

5.6.1 Conclusion

This practice is unclear and inconsistent in the approach to inform both successful and unsuccessful candidates of the outcome on the day after the interviews.

5.6.2 Recommendations

The Chair should take responsibility for informing all candidates.
In terms of the offer, it should be clear that it is verbal offer subject to pre-employment checks being completed i.e a conditional offer, this should be followed up by an offer letter within 24 hours.

5.7 Start date

The evidence indicates a discussion started between X and X for a short period in August 2012 on this matter, despite the fact either party never discussed it at interview stage or at the informal meetings. **X** was negotiating that **X** would need six months before **X** could start in post on a full time basis. **X** was clear at the early stages with **X** that a six month wait would not be acceptable from a service perspective for this new consultant post, there was a clear service need for the role due to the waiting lists.

A conditional offer letter was sent to **X** on 8 August 2012 by **X** in line with normal practice along with a contract of employment and other policies and procedures and forms for pre-employment checks.

X then got involved and wrote a letter to **X** on 10 August 2012 outlining **X** expected a start date of 1 December 2012 otherwise the offer would be withdrawn. Following this, **X** had a long telephone discussion with **X** they agreed a compromise. **X** describes this discussion as very frustrating at the time, which took 45 minutes and appeared to go round in circles to get an agreement with **X** on a start date to meet the needs of the service.

Eventually a compromise was made with **X** to start on 3 December 2012 on a part-time basis, 3 days a week and that **X** would be granted leave over the Christmas and New Year period and start full time from February 2013.

X asks **X** to confirm the acceptance of the offer to **X** in writing. **X** did not write this letter. **X** writes to **X** to say **X** has agreed a start date with **X** of the 3 December 2013. **X** then sent a letter on 21 August 2013 offering a final formal offer of permanent employment as Consultant in Ophthalmology, still subject to satisfactory pre-employment checks.

No one in the medical staffing team confirms this with **X** or **X** and they go on the word of the letter of 15 August 2012 from **X**, received on 20 August 2012. **X** then signs the contract on the 24 August 2012, at that point there were still some outstanding pre-employment checks required and the job plan timetable still hasn't been agreed with **X** as the **X**.

5.7.1 Recommendations

- Process to ensure all pre-employment checks cleared before issuing of a full contract of employment
- All contracts for consultants to be signed off by Director of HR, HSS
- Improved communication between Medical HR, senior management and clinicians throughout the process
- Ensure the job plan and timetable have been agreed, before issuing an employment contract
- Training session with medical staffing team on employment contracts

5.8 Job Planning

From the evidence, the discussions then focused on the job planning process to agree the timetable between **X** and **X**.

Note
Medical Consultants are on different terms and conditions of employment from other staff groups. The contract is based on 10 Programmed Activities (PAs). In the States of Jersey this is different from the UK, the consultant is paid 10 PA activities regardless of the timetable. In addition, the consultant can work a third of the job plan on private work, as long as this doesn't affect their direct clinical care to patients.

X negotiated robustly with **X** on the theatre and clinic time from the point of being offered the job. There appeared to be issues from **X** about working on a Friday on site, in particular until **X** took up the role on full-time basis in February 2013.

X believed that **X** had an agreed position with **X** on the job plan before **X** went on leave. During the time when **X** was on leave, **X** then got into discussion with other clinicians, this appeared to re-open the whole timetable debate again.

On return from leave this came to **X**'s attention, **X** stated to **X** that the previous agreed job plan would stand and there were to be no further changes at this stage to the timetable. There would be an opportunity to review this once in post. **X** agreed to this with **X** after an email on 9 October 2012 to that affect was sent by **X**.

X stated in **X** interview that **X** telephoned **X** to accept the job plan. However, **X** then goes on to discuss the job plan with other clinical colleagues.

There is a formal three-stage process to agree a job plan with a right of appeal at the third stage. This process had not been followed formally. It was an informal debate between **X** and **X**, much of which was over email.

5.8.1 Conclusions

- **X** had the right to discuss and negotiate on the job plan with **X** as the **X**
- The evidence indicates that **X** was very clear with **X** about **X** expectations of the timetable to meet the needs of the service, additionally **X** had compromised with **X** where service needs would allow
- **X** undermined the agreement with **X** by opening further discussions with other clinicians in **X**'s absence
- **X** demonstrated a lack of insight in that perhaps **X** could not have all **X** own way with the timetable to meet **X** personal agenda and commitments

5.8.2 Recommendations

- In future a more formal job planning process should be followed with newly appointed consultants, rather than an informal approach
- Training session with Medical Staffing team on job planning process

5.9 Attitudes and Behaviours

The interactions on this matter became inappropriate and not within the norm of behaviour and communication expected from a Consultant before starting a new post. **X** started to feel uncomfortable about the email correspondence on this matter and it was inappropriate to involve others while **X** was on leave. It appeared that if**X** did not get what **X** wanted from **X** as the **X**, **X** would bypass **X** and go to others in the Hospital senior management and clinicians and the medical staffing team.

The concern from the senior team was that **X** was taking a disproportionate amount of senior management time and **X** had not started in post as a consultant. The senior team have many years of experience of dealing with consultants both in Jersey and within the wider NHS and many of them found **X**'s attitude and behaviour outwith the realm of acceptable challenge and behaviour at this early stage of the process.

5.9.1 Conclusions

- **X**'s communication and approach was highly inappropriate and undermining to **X** as **X X**
- **X**'s communication and approach was challenging and inappropriate to a senior management team, in advance of **X** commencing **X** employment in Jersey

5.9.2 Recommendations

Attitudes and behaviours can be tested during the recruitment and selection process through the use of an assessment centre approach by employing psychometric testing, group exercises and role-play.

5.10 Contract of employment

The contract of employment was issued to **X** by **X** together with an offer letter on 8 August 2012, subject to pre-employment checks. **X** had confirmed that **X** had agreed a start date with **X**, **X** informed **X** that **X** had an agreed start date of 3 December 2012 on reduced hours until February 2013. **X** sent a letter on 21 August 2012 confirming a final formal offer of employment, still subject to pre-employment checks. **X** was unaware that there were outstanding issues on the job plan when **X** issued the final formal offer to **X**.

5.10.1 Conclusions

- The offer letter of 21 August 2012 is contradictory stating it is a final formal offer whilst also stating the offer is still subject to satisfactory pre-employment checks

- The contract of employment should not be sent at the offer stage when there are outstanding pre-employment checks and the start date has not been agreed with management along with the job plan.

5.10.2 Recommendations

- Signing of the employment contract should be with the Director of HR, HSS
- There should be clearer communication between the Medical Staffing team with the senior and clinical management to ensure that the job plan has been agreed before a final formal offer is made to a consultant
- Contracts of employment should not be issued without all pre–employment checks in place
- For the avoidance of doubt, the conditional offer letters should state not to resign from current posts at this stage until an unconditional offer is received by candidate
- Review of Medical Staffing policies, procedures and protocols
- Review of the job planning process and appeals
- Review of Consultant recruitment process
- Review of HR processes for non-medical to ensure a consistent approach across HSS and to ensure best practice in matters pertaining to issuing contracts of employment.
- Closer working between central HR States of Jersey and HR, HSS to ensure a more consistent and corporate approach to good HR practice.

5.10.3 Best practice – see appendix 5

There are many good examples of best practice in this area of Medical HR, it may be beneficial for the new Medical HR Manager to spend some time with a Medical Staffing service in the UK.
The Foundation Trust Network in the UK has guidance and best practice on matters of good HR practices to become a successful Foundation Trust.

The National Association of Medical Personnel Specialists which meets on a regular basis and shares best practice in Medical Staffing in the UK.

NHS Employers has a great deal of guidance and policy on Medical Staffing best practice, in particular currently around medical revalidation, which could be used to develop the service.

Chartered Institute of Personnel and Development, CIPD and Advisory and Conciliation Service, ACAS have guidance on HR best practice around recruitment and selection methods, employment and contract law.

Health Care People Management, HPMA and CIPD have developed competency -based approaches to HRM to support a more business partner model of HR delivery

GMC and the BMA have many good practice documents and guidelines on medical personnel matters including medical revalidation.

NHS Confederation also is a good source of good practice within the NHS in the UK in Hospital and clinical settings

Xpert HR is another useful source of good HR practices with more a commercial and business focus as a resource.

There should be a lead Senior HR professional with capacity and capability to take these matters forward from this report over the next few months.

5.10.3 Note

*There was not a substantive full-time **X** in post at this time and the custom and practice was the junior staff issued contracts of employment. There is now a full-time **X** in post who will take these matters forward. This gives some level of assurance that there is professional Medical HR leadership and support in place now.*

5.11 BMA

On 12 November 2012, **X** at the BMA, indicates to **X** that **X** had raised some concerns with **X** regarding **X** future employment in States of Jersey.

There are different versions of events on whether this was a formal complaint to the BMA regarding **X** or an informal discussion to seek advice and clarification from **X** on issues relating to **X** start date and job planning process. What is clear is that **X** did speak to the BMA in August and again in October 2012 on these matters.

X for BMA writes to say this was not an official complaint. **X** also states **X** was seeking advice from the BMA.

5.11.1 Conclusions

- **X** had a right to seek support and advice from BMA on matters pertaining to **X** employment. **X** made initial contact with the BMA in August and was in dialogue with them on this matter

- Some of **X**'s comments in email correspondence with senior management are quite disparaging about management in the Hospital before **X** takes up **X** post. This was of concern to senior managers and clinicians who are working together for the interest of the Hospital

- To involve a trade union at an early stage in this process indicates a level of distrust early on in the discussions to finalise the terms and conditions of the offer.

- The senior team perceives these events as another concern around **X**'s behaviour before **X** had commenced **X** appointment as a Hospital Consultant.

5.11.2 Recommendations

- Much of the correspondence was on email and some over the telephone, which is understandable due to the geography. However, email communication in particular can be misconstrued at times.

- At this point it may have been prudent to call a meeting with **X** at the Hospital to have an honest and robust conversation explaining this behaviour and interactions are not acceptable before making a final decision to rescind the offer. This should have been by the **X** of the Hospital at the time.

5.12 Role of X

The evidence presented by **X** states the issues with **X** were not on '**X** radar' until later on in the process when **X** talks to **X** as the **X** at the time. There appeared to be a lack of senior HR leadership and ownership on this matter until late on in the process. This is compounded by the issue of **X**, was **TEXT REDACTED**. The evidence gathered within the case review suggests the senior accountable officer for the medical staffing service was unclear during this time.

X is mentioned **TEXT REDACTED**. There is no paperwork on file to support this arrangement **TEXT REDACTED**. Some of the documentation for the interviews state **X** is the acting **X** over this period. **X** disagrees with this position.

5.12.1 Conclusions

- There is conflicting evidence on this matter, which led to the issue of the contract of employment being issued to **X** with no clear senior accountability in Medical HR.
- **X** is **X** and was the accountable officer on HR matters for the Hospital service **TEXT REDACTED**

5.12.2 Recommendations

- There should be an accountable senior officer **TEXT REDACTED**
- Consultant Contracts should be signed off by the HR Director for HSS in future to seek assurance.
- The **X** should be more involved with and assured on the process for recruiting and appointing consultants in the future.

5.13 Private Practice

Within the consultant contract in the States of Jersey, consultants may carry out private practice within their job plan as long as this does affect their delivery of care to their patient's, clinics and theatre slots. This may be up to a third of their 10 PAs.

In this case there were discussions between **X**, **X** and **X** regarding **X** working in 'partnership' with one or both of the consultants. There were various versions of events from the three parties, which were inconclusive as to whether there was an agreement between **X** and **X** or **X**.

5.13.1 Conclusion

- The evidence is unclear whether **X** had a formal agreement with **X** or **X** on private practice at the time the offer was rescinded.
- There is no conclusive evidence that this matter affected the decision of the senior management team to rescind the offer to **X**.

5.13.2 Recommendations

- To review of the contractual arrangements in the States of Jersey, regarding Private Practice for consultants and medics.
- To consider best practice in the UK, which has clear guidelines and protocols on these matters to ensure no conflict of interests or potentially adverse impact on patient safety.

5.14 Decision to rescind the offer

This became an issue with the return of **X** from leave to the on-going debate around **X**'s job plan and the information that **X** is now in discussion with the BMA

X writes to **X** outlining **X** concerns on this matter and asks **X** to take legal advice from the law office. **X** duly does this and the advice is that the offer can be withdrawn.

The senior management team meet to discuss this matter, which involves **X**, **X** and **X**. Management then meet with JG to brief her on this matter as the CEO. They agree to brief the Health Minister and they all agree that the offer should be rescinded due to concerns around **X**.

A decision was taken that SEB should be informed on the matter with this being a senior appointment and a local returning to the island with family connections in the community. The team believe this could well become a political issue.

X agreed to take this matter to **X**. **X** writes to **X**. **X** then informs SEB of the matter as outlined in the letter received from **X**. All members of SEB write back to **X** by email to agree with the decision.

The letter 22 November 2012 is sent to **X** to rescind the offer of employment, **X** signs this on behalf of the employer, with the delegated authority from SEB.

Note: The Employment of employees sits with the State's Employment Board (SEB) as the employer

5.14.1 Conclusions

- The evidence indicates the senior team considered all the facts from August 2012 until this point to make this decision to rescind the offer

- The evidence indicates this decision was not taken lightly by any of the senior team and their first priority was patient safety and quality of care.

- The evidence indicates the progress the service had made since the Verita report and the senior team had real concerns around **X**'s attitude and behaviours which they didn't believe was conducive to take the service forward

- From the evidence presented by the senior team and the Health Ministers, the decision to rescind the offer was reasonable and considered, and based on the needs of the service.

- The decision to inform the SEB and gain their support was the correct decision by the senior team. This was not done in a formal meeting and was an email discussion between the members of SEB, who gave the support on the evidence, which was presented to them at the time.

5.14.2 Recommendations

- If there was a similar situation in future, it would be useful to go back to the interview panel members to keep then informed of developments.

- SEB should have asked for a full briefing in a meeting on this matter from the Directorate of Health and Social Services before deciding to support the decision by email.

5.15 Interview with X

X was interviewed for this case review in London on Monday 11 March 2013. **X** brought **X X** as support; a note taker was also present. The interview lasted two and a half hours and took an approach of both discussion and questioning on the series of events. **X** submitted a file of all **X** correspondence on this case, which has been thoroughly reviewed.

- **X** appeared to be a reasonable person throughout the interview
- **X** was clearly committed to **X**
- **X** had a commitment to patients care and quality
- **X** had an impressive medical cv and publishing career in **X** field
- At times **X** lacked insight into **X** role in creating this situation with **X** new employer
- **X** demonstrated no reflection on why this had happened to **X**
- **X** did not believe that **X** had done anything wrong
- **X** believed **X** challenge and communication style throughout was appropriate with Hospital
- **X** stated that although **X** did not think **X** has done anything wrong, **X** still wanted the job and would undertake any mediation or training required to resolve the matter.

5.15.1 Conclusions

- **X** had a different view of many of the events and interactions of the months leading up to the rescinding of the offer. **X** still wanted to come and work in Jersey despite the fact the employer has clearly stated that the relationship has broken down.

- **X** believed **X** had the right to negotiate on the start date, job plan and to take advice from the BMA throughout the process.

- On questioning **X** stated that **X** would not be going back to **X** where **X** had worked previously.

- **X** did not appreciate that not providing **X** current **X** as **X** main referee was not appropriate.

- A meeting should have been arranged with **X** to discuss the concerns face to face before deciding to rescind the offer at such a late stage in the process. CEO and **X**.

- The evidence would suggest, after having some 3 months to reflect on this matter **X** would not be suitable for any mediation due to **X** lack of awareness of **X** and how others may receive **X** attitude and behaviours in the workplace.

5.15.2 Recommendations

- As outlined above the recruitment and selection process needs to be more robust to test candidate's skills wider than clinical.

- More robust checking and process for references

- Discussions about potential start dates and job plan within the assessment process.

- Clarify the roles and responsibility of SEB with senior officers, to ensure a clearer understanding of delegated authority to senior officers in these circumstances.

5.16. Role of States Employment Board

As outlined above the SEB were involved in this matter from the point that the offer was rescinded. SEB agreed to the offer being rescinded to **X** and that **X** should be offered the post as the second preferred candidate. This was all done by email through **X** based on the information **X** was given from **X** at the time on the case. Members of SEB agreed by email to rescinding the offer

There is a view from some of the senior officers in HSS that SEB then began to back track on the decision to support these actions due to the political pressure and correspondence from members of the local community on the Island

There is a counter view that SEB became nervous about the decision as more information on **X** came to light from the HSS team on the case and did not believe they had been given the full picture at the time.

5.16.1 Conclusion

- The evidence would suggest a level of distrust between some members of SEB and the HSS senior management and clinicians due to this matter. This trust needs to be rebuilt as part of the learning from this review.

5.16.2 Recommendations

- The role of SEB should be clarified; the Board is not an operational management decision-making body and the focus should be on strategic workforce matters across the States. The delegated authority for staff appointments sits with the senior officers in the Service.

- The CEO and **X** had a responsibility to fully brief SEB if they were asking for their support on this matter. This should have been through a full and proper briefing face to face rather than through a letter and email debate through **X**.

5.17 Political Context of States of Jersey

The CEO for Health and Social Services is accountable for the delivery and development of this Directorate. This includes the Hospital service, which has a Managing Director. The CEO is a strategic role and is not involved in operational matters for the service delivery.

In this particular case, when this was brought to Julie Garbutt's attention, she took advice from her senior management team, senior clinicians and the **X**. Legal advice was also taken form the States of Jersey Law Officer. The advice indicated an option to rescind the offer and there was a degree of risk, which would need to be managed by the organisation.

JG is an experienced CEO and understands the politics of working within this environment. Rightly, she took the view to brief her Health Ministers who were fully briefed and sought their own assurance on this case before deciding to support the decision to rescind the offer.

The senior team decided to inform SEB of their view to rescind the offer **TEXT REDACTED**

5.17.1 Politicians interviewed

- Anne Pryke, Minister for Health (AP)
- John Refault, Deputy Minister for Health (JR)
- Sarah Ferguson, Chair of Corporate Services Scrutiny Panel (SF)
- Kristina Moore, Chair of Scrutiny Panel (KM)

Both the Health Ministers AP and JR were supportive of the decision to rescind the offer and had sought their own assurance that the decision was right for the Hospital and the service.

Chair of the Scrutiny Panel, KM and Chair of the Corporate Services Scrutiny panel, SF had concerns about the decision making process to rescind the offer and the rights of this decision

TEXT REDACTED. The Chair of the Corporate Scrutiny Panel, SF appeared to be in contact and supporting AA in his case.

5.17.1 Conclusion

- Clearly the political context of the decision to rescind the offer of employment to a consultant with connections on the island has to be considered as part of this report. This was not a part of the terms of reference this case review agreed by SEB.
- As the investigating officer of this case review, I believe it is essential to include this matter as this has been a strong element of the case, the evidence presented through interviewing many officers, senior clinicians and politicians suggests a strength of feeling on this matter.
- My conclusion from reviewing the evidence is that **X**'s **X** is at the centre of this issue. I have not seen evidence to suggest a **X** would have raised such strength of feeling surround the decision to rescind the offer based on ensuring high quality patient care.
- From the evidence presented there is a question as to the appropriateness and objectively in this case by some who were not directly involved.

5.17.2 Recommendations

- I would recommend that SEB look at their employment practices and procedures as part of their workforce modernisation programme, to ensure that they are fair and consistent in line with best practice.

6. Conclusion

Having carried out an independent case review within the agreed terms of reference my conclusions are that this was a measured and reasonable response from the senior management team in the Health and Social Care Directorate to rescind this offer of employment to this Consultant.

6.*1 Robustness and integrity of the recruitment process to appoint the consultant.*

The process was not robust and lacked objectivity and integrity as outlined in the report. This now requires immediate action to ensure the process is improved as a matter of urgency to ensure that this experience is not repeated in future. This needs to be in line with best HR practice as outlined in the report.

6.2 The decision making process from the offer stage until the decision to rescind the offer of employment

The team have a wealth of experience on these matters; dealing with Consultants can be a challenge for senior managers in a Hospital setting. The context of the service in Jersey has to be taken into consideration, the team have been on a journey in the last few years after the Verita report and have made great progress in taking the services forward and now have clinical engagement. The concerns around **X**'s attitude and behaviour before taking up **X** post rightly concerned the senior team.

The team took a reasoned and well thought through approach, taking soundings on the matter form the law office, informed SEB of their view and took the appropriate action based on clinical need and service delivery. I believe they followed due process to try and resolve the issues with **X** on **X** start date and that they tried to seek agreement on the job plan with **X**.

Clearly the trust and confidence between the employer and **X** has broken down and this was a reasonable response to the situation at the time. **X** appears to lack insight into **X** part in this situation **X** now finds **X** in which is most unfortunate for **X** as a consultant.

7. Key learning points

As outlined in the report there are key learning points from this case review, which is summarised in **appendix 4**. There is a great deal of good practice in place in the Health and Social Services Directorate from a management, clinical and HR perspective, with good and committed people who's first priority is patient care and safety.

8. For decision- States Employment Board

- The SEB are requested to agree and note the findings in this report
- Agree the recommendations
- To agree an action plan on the learning points with the service

XHR Consultant
8 April 2013

Appendix 1

Terms of Reference Case Review
States of Jersey

1. Context

The States of Jersey Employment Board (SEB) requested a case review of the decision by Health and Social Services Directorate to rescind the offer of employment to a hospital consultant **X**

The review should be conducted by an external independent source. The requirement will be not to substitute their judgement as to the efficacy of the decision but whether the decision was in the range of reasonableness from a fair and reasonable employer.

It should be conducted expeditiously with a view to the report being made available to the SEB by 31 March 2013, subject to all parties being available for meetings throughout March 2013.

2. Objectives of the case review

The review will examine:

(i) The robustness and integrity of the recruitment process by which the consultant was appointed, including the recruitment, selection and verification of suitability of employment. This will include review of pre-employment checks and use of appropriate assessment tools and techniques, in line with best practice and Royal Colleges guidance.

(ii) The decision making process from the offer stage until the decision to rescind the offer of employment

- Review the interactions between the consultant with the hospital
- Review the correspondence, conversations and meetings between the consultant and clinical colleagues and senior management.
- Review the consultant's attitude and behaviour during interactions that may affect clinical delivery and patient care that could impact on the overall clinical governance and general management of the hospital.
- Identify the process of accepting the consultant contract with the States of Jersey with specific reference to job planning and whether it conformed to normal practice.

This case review will make clear recommendations to the States Employment Board as necessary and identify lessons learned from this case.

X, HR Consultant has been commissioned by Chief Executive to the, States of Jersey to carry out this case review. The final report with recommendations will be presented to the States Employment Board by the author.

Appendix 2

Case Review- Interview Questions
States of Jersey

Introduction

- *Cover terms of Reference*
- *Set of standard questions around the case review*
- *Notes will be taken by **X***
- *There will be an opportunity to sign off the notes*
- *Final Report will be presented to the SEB*
- *Deadline for submission 31* March 2013
- Any questions on the process?

Questions

1. What is your role in the States of Jersey and how long have you been in post?
2. Brief background relation to your role?
3. What has been your involvement in this case to date?
4. Were you involved in drafting the job description or person specification for the role for royal college approval?
5. Were you involved in the assessment process for the role?
6. What was your involvement in making an offer of employment to **X**?
7. Were you involved in any of the negotiations or discussions to agree the job plan?
8. Did you consider any of the communication throughout this process to be unacceptable?
9. What was your involvement in rescinding the offer of employment?
10. What assurance/ legal advice did you take to ensure this would not leave the States of Jersey open to any litigation?
11. Do you believe you had clinical engagement in this decision? How did you seek this assurance?
12. Do you believe the States has followed due process to resolve this matter as a good and reasonable employer?
13. What is your view of the SEB role in this matter?
14. On reflection is there anything you would do differently?
15. What do you believe is the key learning points from this case to recommend to the SEB for the future?
16. Anything else you would like to add that hasn't been covered in the interview?

Summary

- Many thanks for your time today in the interview.
- The notes will be sent to you for checking and sign off on hard copy
- The final report will be submitted to the CEO, States of Jersey, as the Commissioning Manager of the case review and will be presented to States Employment Board.

Appendix 3

Interviewees

Health and Social Services

Management

1. Julie Garbutt, CEO of Health and Social Services (JG)
2. **X**
3. **X**

Senior Clinicians

4. **X**
5. **X**
6. **X**
7. **X**
8. **X**
9. **X**

Human Resources

10. **X**
11. **X**
12. **X**

Corporate

13. **X**

Politicians

14. Anne Pryke, Minister for Health (AP)
15. John Refault, Deputy Minister for Health (JR)
16. Sarah Ferguson, Senator (SF)
17. Kristina Moore, Chair of Scrutiny Panel (KM)

External to States of Jersey

18. **X**

Appendix 4

Key learning points

This section summarises the key actions points from the report

Medical HR team

1. Review of the recruitment process for Medical Consultants
2. Review of Medical Staffing Standard Operating Procedures
3. Consider different selection methods for assessment of Consultants, in line with best practice and senior management appointments
4. All panel members to be trained on good interview practice and selection methods
5. Coaching sessions for panel chairs on role and responsibilities
6. Training sessions for medical staffing team on recruitment best practice
7. Review interview paperwork and scoring methods to ensure this is a tool fit for purpose
8. Review of use of references, ensure line manager/ CD of applicants
9. Review process for agreeing job plans with a clear and robust appeal process
10. Improve communications between Medical HR, management and senior clinicians
11. Review process for issuing of employment contracts to Consultants
12. Consider integration of medical HR with operational HR teams in HSS
13. Closer working between HR in HSS and Central HR for SoJ to ensure a consistent approach to HRM

Senior Management issues

14. Improve communications and rebuild the relationships between HSS Directorate and Corporate areas
15. Clarify the role of SEB with Directorates on Employment matters to ensure understanding of delegated authority
16. Director of HR for HSS to be involved in assessment process for Consultants in future as part of the panel
17. Managing Director of Hospital to Chair all future consultant appointments in line with good practice
18. CEO of HSS to seek assurance of the process to appointment Hospital Consultants in future to seek assurance of process is robust and objective

States Employment Board

19. To agree the report and recommendations
20. Agree the development of an action plan with key milestones and accountabilities
21. Agree the mechanism for feedback to all the interviewees
22. Agree a position on the interview notes
23. To consider how to feedback to **X** the outcome of this report
24. Review approach to employment practices as part of workforce modernisation programme

Appendix 5

Best Practice references - **Sources of HR best practice**

1. CIPD- Chartered Institute of Personnel and Development www.cipd.co.uk
2. NAMPS- National Association of Medical Personnel Specialists www.namps.org.uk
3. NHSE-NHS Employers www.nhsemployers.org.uk
4. FTN-Foundation Trusts Network www.foundationtrustnetwork.org.uk
5. BMA- British Medical Association www.bma.org.uk
6. HPMA- Health Care People Management Association www.hpma.org.uk
7. GMC- General Medical Council www.gm-uk.org
8. ACAS- Advisory and Conciliation Service www.acas.org.uk
9. Xpert HR- www.xperthr.co.uk
10. NHS Confederation www.nhsconfed.org.uk

Priorities 2017 Update from BEAL Action plan

	Head of Medical Staffing	Director of Human Resources
Updated Actions	Immediate Actions	Immediate Actions
1. Medical Staffing to undertake a rigorous review of person specifications, alongside Clinical Directors, and in conjunction with the respective Royal College.	Key Learning point 1 (4) **COMPLETED**	
1. review medical staffing policies and associated procedures	Key learning point 1 (5) **COMPLETE**	
1. Presentations will be introduced at Consultant recruitment panel 2. The organisation of a stakeholder event as part of recruitment days	Key Learning point 3 (1) **COMPLETED** **INTERNAL STAKEHOLDER INVOLVEMENT NOW IN PLACE**	

1. Hospital MD or Deputy to Chair all panels 2. Guidance notes to be formulated which outline the role and responsibilities of the Chair and is provided at each panel	Key Learning point 5 (1) **COMPLETED** **COMPLETED**	
1. The new interview documentation which includes the suite of competency based questions and revised score sheets are used at every panel	Key Learning point 7 (1) **COMPLETED**	
1. The revised reference template is now being used 2. The defined protocol with regards to references is now being followed.	Key Learning point 8 (2) **COMPLETED** **COMPLETED**	

1. Head of Medical Staffing has revised the conditional offer letter in line with learning from Beal report 2. All contracts of employment for Consultants are signed off by Hospital Managing Director, with assurances from the Head of Medical Staffing	Key Learning point 11 (1) **COMPLETED** **COMPLETED**	
1. A training review conducted within the Medical Staffing Team	Key Learning point 6 (1) **COMPLETED**	Key Learning point 3 (2) **COMPLETED**
1. Values based assessment		Key learning point 3 (3) **COMPLETE and ONGOING**
1. Joint discussions to take place between HSS HR and Central HR and the Business Support Team to ensure lessons learned by HSS in terms of the Beal review.	**COMPLETED**	Key Learning point 13 (1,2) **COMPLETED**

	Key Learning Point 1 (1)	Key Learning Point 12 (1)
1. Head of Medical Staffing to lead in communications with regard to the revised recruitment process to ensure that this is embedded into the hospital. This is on-going work. Support has been provided to clinicians with regard to the revisions and responsibilities.	**COMPLETED**	**COMPLETED**
2. Consider merging MS with HR Generalist Team. Feedback was requested and received from a number of UK hospitals with regard to the integration of Medical Staffing with operational HR teams. The unanimous feedback from 7 separate hospitals revealed that there was no experience of a successful merger	**CLOSED**	

1. A Recruitment and selection training package has not been devised as additional capacity is required in Medical Staffing to undertake this piece of work.	Key Learning Point 4 (1) **COMPLETED BY ENSURING ALL NEW PANEL MEMBERS HAVE A 1-1 SESSION ON THE NEW PROCESSES**	
	By August 2013	
1. Training to be implemented within the Medical Staffing Team	Key Learning point 6 (2) **COMPLETED USING NAMPS AND WESSEX MS NETWORK**	
	Ongoing work beyond August 2013	
1. Review the medical staffing policies and associated procedures	Key Learning point 1 (5) **COMPLETED**	Key Learning Point 10 (2) **COMPLETED**
1. There are regular 1-1's between the Hospital Managing Director and Director of HR, and the Hospital Managing Director and the Head of Medical Staffing.	Key Learning point 10 (1) **COMPLETED**	Key Learning Point 10 (1) **COMPLETED**

APPENDIX 5 to P.137/2016 Com.

The recruitment of Mr Alwitry: The Solicitor General's Report

1. On 13th September 2013, I was asked by the States Employment Board to investigate the circumstances surrounding the recruitment of Mr. Alwitry in August 2012. I have done so.

Summary of Conclusions

2. I have reached the following conclusions:

3. On 1st August 2012, Mr. Amar Alwitry was offered the position of Consultant in Ophthalmology at Jersey General Hospital following a successful interview. Mr. Alwitry was the best candidate and there is no doubt he possesses clinical skills that would be of great benefit to the Island. Mr. Alwitry was due to start work on 1st December 2012.

4. From 1st August until 13th November 2012, there were a series of discussions between Mr. Alwitry and the Jersey hospital which were unusual and, from the hospital's point of view, extremely challenging.

5. On 13th November 2012, the hospital management concluded that the relationship with Mr. Alwitry had broken down and was dysfunctional. I agree that the relationship was dysfunctional by 13^{61} November.

6. Mr. Alwitry's employment contract was terminated by letter dated 22nd November 2012.

7. In the circumstances, it was reasonable for the hospital management to terminate the employment contract

8. However, the procedural aspects of this case are unsatisfactory:

   (a) There was a failure to investigate and properly understand an email the hospital received on 12th November 2012. Instead, an assumption was made about the email and that assumption was a reason for the decision to terminate the contract.
   (b) Although there was no legal obligation to do so, the hospital management should have provided Mr. Alwitry with an opportunity to respond to the criticisms made of him prior to the termination of the contract.
   (c) Mr. Alwitry was notified of the decision to terminate extremely late in the day in a manner that does not reflect well on the hospital.

9. If an appropriate procedure had been followed, I have concluded that the outcome would have been the same in this case. A proper investigation of the 12th November 2012 email would have provided confirmation of the dysfunctional relationship and revealed allegations of bad faith. I have interviewed Mr. Alwitry over several hours. I have been unable to reconcile much of his testimony to the other evidence in the case. It was hard to detect any sign of an acceptance of responsibility for the events I describe below. Further allegations of bad faith have been made or raised for my consideration.

10. This is not a case where it is appropriate to consider reinstatement. As I have already indicated, the merits of the decision cannot be criticised and the continued pursuit of allegations of bad faith is not conducive to rebuilding a broken relationship.

11. I advise that the hospital management receive further training in respect of employment law and the importance of procedure.

The recruitment of Mr. Alwitry

12. In 2000, The Ophthalmology Department at Jersey General Hospital had two full time consultants and treated 7,000 outpatients per year. In 2012, the department provided care for 11,000 outpatients per year: see Clinical Director's interview page 4. This increase in workload caused the hospital's Director of Operations to produce a business plan in 2011 which secured extra funding for a third consultant in the department for 2012.

13. On 16th May 2012, the Clinical Director of the Department sent an email to the hospital's Human Resources department and Director of Operations explaining that *"there is a real urgency in relation to this appointment since we are not having much luck with locums and waiting lists are through the roof.* The Clinical Director proposed a recruitment process over the summer of 2012 with a view to the new consultant starting mid/late November 2012.

14. The post was advertised in early June 2012 with a closing date for applications of 22'd June 2012. The advertisement referred to a `*Winter 2012'* start date, a phrase that left room for interpretation.

15. Mr. Alwitry applied for the position. He submitted both his CV and an on-line application form as requested. The online application form stated at page two that Mr. Alwitry desired a six month notice period. This was provided to those who conducted the recruitment process.

16. There was a short listing meeting on 26th June 2012 at which four of the eleven applicants were selected for final interview. Mr. Alwitry was one of the four,

17. There were pre-interview meetings on 3I[st] July 2012. Mr. Alwitry met with both the Clinical Director of Ophthalmology (his new line manager if successful) and the Director of Operations on this day. The Director provided Mr. Alwitry with a copy of the department's waiting list times.

18. The formal interviews took place on l[st] August 2012 and were conducted by an appointment panel. Mr. Alwitry was the successful candidate. He was informed by telephone that afternoon. Mr. Alwitry signed his employment contract later that month.

Mr. Alwitry

19: Mr. Alwitry has put forward a myriad of reasons as to why he took issue with decisions taken by the hospital management. These range from contractual queries to patient safety.

20. In my view, the tensions in this case arose only because Mr. Alwitry applied for the job at Jersey Hospital in the summer of 2012 but did not intend for his wife and young children to join him in Jersey until the summer of 2013. Mr. Alwitry, having been offered the job on l[st] August 2012, wanted a start date and timetable that meant he was able to spend the maximum amount of time in the United Kingdom until the summer of 2013.

21.In stark contrast, the hospital required the new consultant to start full time as soon as possible. After all, this was a new post that had been recently created following a successful bid for extra funding as a response to the growing pressure on waiting lists in the Ophthalmology Department.

22. There was a conflict between these two positions and this resulted in repeated disagreements about a number of issues from August to November 201.2.

Start Date: August

23. There were notable defects in the recruitment process that allowed the conflict described above to go unnoticed by the hospital until after the job had been offered to Mr. Alwitry. A better procedure would have identified the problem straight away and prevented the difficulties that followed.

24.1 have interviewed some but not all of those at the hospital who conducted the interview process. It appears that nobody raised Mr. Alwitry's request for a six month delayed start and the matter was not discussed in the formal interview on 1st August. One is left to wonder if anyone at the hospital troubled themselves to read Mr. Alwitry's online application form.

25.1 was told that it was common knowledge that doctors in the British Isles are expected to start within three months of any job interview (at any hospital) and the onus was on them to raise an issue of a delayed start. It was said that the hospital, the employer, was entitled to assume that an applicant would start within three months unless the applicant raised an issue. I do not agree and what I was told constitutes poor employment practice.

26.At interview, candidates are primarily, if not exclusively, focused on impressing the interview panel with their skills and knowledge. If an employer wishes for a new employee to start within a particular time, it is good (and some might add standard) practice to raise it at interview so that the employee can confirm their availability or otherwise.

27.1 have no doubt that the start date should have been raised by the appointments panel during the interview. The hospital had a particular desire for the successful applicant to start quickly because of pressure on waiting lists. Moreover, the panel knew that they were interviewing UK resident applicants who would have

to relocate in the event of being appointed to the post. From the employer's point of view, start date was an obvious concern and an issue to raise at the interview.

28. On 2nd August 2012, a member of the appointments panel sent Mr. Alwitry a congratulatory email. The email enquired, quite sincerely, whether Mr. Alwitry's young children were going to start school in Jersey in September for the new term. It was an email that was sent with the best of intentions. I wonder whether it was realistic for the hospital to presume that a family with young children would relocate to Jersey in time for the new school year in September when the job offer had only been made on 1st August.

29. I advise that the hospital reviews its recruitment procedures which should include a consideration of the following matters:

    (a) A checklist/other system that ensures that a discussion takes place about start date/any other pertinent issues relevant to the job during the formal interview.

    (b) The advertisements. To consider whether "Winter 2012" or similar phrases accurately reflect the desired start time for a new appointment. In this case, the preferred start date was mid-November 2012 which, officially, is in Autumn.

    (c) <u>When possible,</u> to arrange interviews in the early summer months. An interview on ft August gives the new doctor a slim chance of relocating their family to Jersey in time for the new school year. An interview in June/July might have been more conducive to a smoother transition. Obviously, there will be times when this is simply not possible.

The discussion with the Clinical Director

30.Mr. Alwitry has sought to make much of the fact that his application form requested a six month notice period and that this was not picked up by the hospital. It is fair comment but one has to consider the point in the context of all of the evidence in the case.

31.1 am satisfied that Mr. Alwitry and the Clinical Director had an informal conversation about start date at a pre-interview meeting on 31st July 2012. The Clinical Director recorded part of that conversation in an email dated 15th August 2012:

> *When we met prior to interview for informal discussions and from memory I thought that I had made it quite clear that we had a pressing need for a variety of reasons for any appointment to be taken up ASAP and by Xmas at the latest. No mention was made at this time of a 6 month start date.....*

32. During his first interview with me on 18`h November 2013, Mr. Alwitry accepted that he did meet the Clinical Director but initially did not accept that any such conversation took place. It was pointed out that his emailed reply to the Clinical Director on 15th August 2012 did not deny that the conversation had taken place. Mr. Alwitry said that was only so as to avoid further conflict given the difficult discussions that had taken place in the preceding days (see below).

33. As questions on this topic continued, Mr. Alwitry asked to be referred back to the Clinical Director's email and he was. Mr. Alwitry then read out in interview part of the email:

> *"...1 thought I had made it quite clear that we had a pressing need for a variety of reasons for the appointment to be taken up asap".*

34. Mr. Alwitry then said, *"I would agree with that, but asap, what does that mean exactly? But by Christmas, nobody ever mentioned Christmas at all".* (first interview, page 9)

35.1 also referred Mr. Alwitry to an email exchange he had had with a hospital secretary on August 2012, the day of his interview and job offer:

> Secretary to Mr. Alwitry
>
> *Many congratulations. So when do you start?....I'm arranging the Christmas do on 15 December if you and your lovely wife are here and available.*
>
> Mr. Alwitry to Secretary
>
> *Don't know when starting. Has come at a really dcult time for schools. I will probably have to come over alone and then the kids and boss will have to follow a few months later. Will see. IfI am over by party time will def be there:*
>
> fmy emphasis)

36. Mr. Alwitry told me that his reference to being 'over by party time' was not an indication that he knew on 1st August that he might be required to start by December 2012. He told me that his email was merely a reference as to when he might be visiting family on the Island during the seasonal holiday (first interview page 7).

37.1 disagree. I prefer to attribute much more weight to the striking coincidence that the plain and ordinary meaning of the email exchanges on 1st August is entirely consistent with the Clinical Director's recollection of his conversation with Mr. Alwitry as recorded by email on 15th August 2012.

38. For these reasons, I conclude that the Clinical Director did speak to Mr. Alwitry on 31st July 2012 about start date and that Mr. Alwitry was informed that the hospital were expecting a start as soon as possible and certainly by December 2012. It must have become apparent to Mr. Alwitry that the hospital had not picked up on his request for a six month delay and yet he said nothing either to the Clinical Director or to the panel during the formal interview.

39. In light of these conclusions, Mr. Alwitry's emails to management during the considerable discussions about start date that took place in August 2012 do not flatter him:

(a) *"I honestly am not trying to pull a fast one — not one person mentioned or discussed a start date until after the interview"* (10th August 2012 @ 3:55pm to Managing Director)

(b) *If the 1` December date was so critical to start you would have hoped it would have been mentioned...or discussed pre.. interview. ...Very bewildered and saddened by all this. Seems a bizarre way to treat a new consultant."* (14th August 2012 @ 12:15 to Director of Operations)

(c) *A lot of difficulty and soul searching could have been avoided if someone/anyone (including me) had discussed a start date in advance of the interview (15th* August 2012 @ 12:27pm to Director of Operations)

Start Date Negotiations

40. On 8 August 2012, Mr. Alwitry sent an email to the Clinical Director that raised the prospect of meeting up on 24111 August to discuss a number of matters including start date. This was the first communication with the hospital since the job offer was made on 1st August.

41. The Clinical Director immediately requested that they speak *"asap to organise your start date".* One and possibly several telephone conversations then took place on 8th August between the two men.

42. During those conversations, the Clinical Director emphasised the need for a start in 2012 and that he was not prepared to entertain a six month delay. A compromise of working three days a week from 1^{81} December 2012 until l^{g} February 2013 was discussed. Mr. Alwitry stuck to his line that his application form had stated he needed to give six months notice and that is what he required.

43. On the 8th August 2012, Human Resources sent Mr. Alwitry a letter that began *"Arther to our recent conversation".* I have reached the view that it was Mr Alwitry who initiated this conversation. The letter enclosed an employment contract.

44. This is very curious. The negotiations about start date had not been resolved and, at this early stage, Mr. Alwitry was not prepared to accept anything other than a 2013 start date.

45. The Managing Director's evidence is that he became concerned about Mr. Alwitry's contact with Human Resources when he was told about it shortly after the event. The Managing Director says he was told by Human Resources that Mr. Alwitry had asked them for the employment contract on the basis that he, the Managing Director, had approved this request. He had not. It was suggested that Mr. Alwitry had sought to obtain an employment contract from Human Resources with a 2013 start date. Mr Alwitry denies that he did so.

46. The member of staff at human resources who dealt with this matter was unable to recall the relevant conversation with Mr. Alwitry when I interviewed him. This member of staff had described Mr. Alwitry as a *"bit of a nightmare at the start"* in an email dated 23rd October 2012. This comment related to the discussions about

start date in August 2012. Mr Alwitry admits that he did ask this member of staff about the possiblity of working part time until July 2013: see first interview, transcript top of page 11.

47. I asked Mr. Alwitry about these matters in more detail during his second interview with me that took place on 16th December 2013. He denied that he had requested a contract with a 2013 start date or the allegation that he attempted to give the impression that the Managing Director had authorised such a request. In the second interview, Mr Alwitry could not recall the conversation with Human Resources on 8th August at all. Mr. Alwitry was unable to provide me with any substantive reason or cogent explanation for his decision to telephone Human Resources on that particular day, given that he was already in discussions with the Clinical Director. It cannot have been an act of urgency as Mr. Alwitry suggested to me in the second interview. After all, Mr. Alwitry had told the Clinical Director that discussions about start date could wait until 24th August.

48. I am satisfied that there was telephone conversation on the 8th August between Mr Alwitry and Human Resources. I am equally satisfied that Mr. Alwitry telephoned Human Resources on 8th August 2012 with a view to obtaining an employment contract.

49. The remaining issue is why did Mr Alwitry want an employment contract on 8th August 2012 when he was still negotiating his start date with management. At that time, Mr. Alwitry had rejected all suggestions of a 2012 start date and would continue to do so for some time. Logically, he can only have wanted an employment contract with a 2013 start date on it. I therefore conclude on the balance of probabilities that Mr. Alwitry did make an attempt to obtain such an employment contract during this telephone conversation[1].

Although not material to my conclusion, 1 note that Mr Alwitry engaged in striking similar conduct in September 2012 when he contacted a Theatre Nurse in order to secure a change of a timetable that the Clinical Director had introduced. The theatre nurse was contacted without the Clinical Director's knowledge: see below,

50. I make no finding either way as to whether Mr Alwitry had sought to suggest that the Managing Director had authorised his approach.

51. In the event, the correspondence shows that Human Resources first discussed the . matter with the Clinical Director on 8th August. The employment contract sent out on 8th August featured a 2012 start date.

52. The Hospital's Managing Director wrote to Mr. Alwitry on 10th August 2012 following discussions with the Clinical Director. The letter was firm. It informed Mr. Alwitry that unless he agreed to start work at the hospital on 1st December 2012 part-time, with a view to working full time from 1st February 2013, then the job offer would be withdrawn. The justification given was that the:

> *"...Ophthalmology Department is under considerable pressure and it is imperative that the third consultant starts as soon as possible. Whilst we understand your present circumstances and the reason why you would like to delay your start date, I have met with the Clinical Director of Surgery and am unable to accommodate your request due to service pressures".*

53. This letter highlighted just how difficult the position had become in the forty-eight hours since discussions started on 8th August.

54. The Managing Director told me that he had never had to write such a letter to a consultant and regarded the situation as *"quite remarkable".*

55. The Managing Director's letter was emailed to Mr. Alwitry on 10th August 2012 at 14:25. Mr. Alwitry telephoned the hospital shortly thereafter and the two men spoke: see Mr. Alwitry's first interview, page 36/37 and 38 and Managing Director's interview page 26/27.

56. At 15:55, Mr. Alwitry sent the Managing Director an email that began *"thanks for the conversation today. Have received your letter and fully understand the position".*

57. The timing of Mr. Alwitry's email is consistent (or at least not inconsistent) with the Managing Director's evidence to me that the conversation with Mr. Alwitry lasted forty minutes.

58. The Managing Director's evidence is that the conversation was amicable but that Mr. Alwitry made repeated attempts to persuade him to agree to a 2013 start date:

> *"I gave him a lot of time. I explained my reasoning and I explained the needs of the organisation and I was quite careful to be as accommodating as I could whilst maintaining a firm like that we expected him be in the organisation and working by the ls` December"....*
>
> *...And when we got to the end of conversation where he'd said "Okay so I will start on 1^8` December and I'll work a compressed three day week until ...he then went back again and said "but why can't" and you just thought "oh gosh" you know here we go, I don't want to go round this buoy one more time".*
>
> [page 27/28 interview]

59. Mr. Alwitry accepts that the telephone conversation took place but denies it lasted forty minutes. He says that the conversation only took five minutes or so and provided me with his mobile telephone billing for August 2012 that is said to provide irrefutable evidence as to the short duration of the call. In fact, the billing shows a short telephone conversation with the hospital but on 14th August which of course does not help me with the duration of the call on the 10th August.

60. Mr Alwitry provided me with further documentation on 10th February 2014 that suggests that he was working at an English hospital in clinic from 14:20 until

15:10 on 10th August and then had to immediately drive 31 miles home to attend a fitness session with a personal trainer that started at 16:00. I am informed that the journey home takes 35 minutes if there is no traffic. We know for sure that Mr Alwitry sent an email from home by 15:55 and that his mobile telephone billing shows that the call did not take place during the journey home. Allowing ten minutes for Mr Alwitry to get from his car and into his home, access his emails and then compose a reply, Mr Alwitry would have arrived home no later than 15:45 which in turn suggests a departure from the hospital by 15:10 at the very latest. If correct, this would mean that Mr Alwitry accessed his personal email address at the hospital during his clinic session and then held a conversation with the Managing Director again during this same clinic session. Several questions arise from this chronology but for present purposes I am minded to proceed on the basis that Mr Alwitry is correct about the duration of the call.

61. Mr Alwitry said that there was *"a very pleasant conversation"* on 10th August albeit that the Managing Director said to him:

> *As you know, I work a three day week and I commute and it works out perfectly for me. And frankly if you are not prepared to do that, that sort of commitment then you clearly don't want the job as much as you thought"*

62. Mr. Alwitry says that he asked the Managing Director:

> *"Is there any chance we can push it back to at least January just to give me a bit of breathing space? He said "Well I'm going to have to speak to [the Clinical Director] about it. It's very difficult because of the service commitment....*

63. I accept Mr. Alwitry's evidence that his conversation with the Managing Director concluded on the basis that the management would consider further his counter

proposal of a 1st January 2013 start date albeit that request was to be looked at in the context of the department's needs. Mr. Alwitry sent an email to the Managing Director that followed the conversation in these terms:

Thanks for the conversation today. Have received your letter and fully understand the position. Sorry I've caused you and [the Clinical Director] hassle. It was never my intention to be difficult. I have asked Med Personal to check and there was never any mention of a November start date in anything sent out — I honestly am not trying to pull a fast one — not one person mentioned or discussed a start date until after the interview — all any of the literature said was Winter 2012 which I erroneously presumed was any time up to Spring 2013!

As previously discussed, i f I could start the three day a week thing on Jan and then start properly on Feb 1 Ph that would really help me out. From Jan to Feb I'd have no problem doing 6 clinical sessions on the Monday to Wednesday i.e. clinics and theatres to catch up for what I'd miss in Dec. If I started in December I'd end up taking leave anyway which defeats the object of attempting to catch up with activity.

I also have a vested interest in getting the department back on a level playing field and I am genuinely looking forward to getting cracking.

I'm sure you will be discussing it with [the Clinical Director]

Please let me know what you think.

64.. On 14th August 2012, Mr. Alwitry received an email from the Director of Operations saying

I am aware that you are waiting a formal response from us regarding your start date. As agreed, we have discussed the situation in depth to see if we can accommodate your request of starting later than I" December. Mindful of the demands and considerable pressure on the service that [the Managing Director] has explained to you, unfortunately it still requires the position to be filled as quickly as possible. Therefore it is still necessary that

the December start date stands....

65. It follows that from 10th August until leith August, the hospital management considered and then rejected the proposal of a 201.3 start.

66. During this short period, Mr. Alwitry made a concerted effort to seek out the views of other senior figures in the hospital in order to generate support for his proposal. He obtained quotes from certain individuals which were then deployed in correspondence. Mr. Alwitry also raised the prospects of involvement by his union and Jersey lawyers in order to increase the temperature — and all this on the sole issue of start date.

67. Mr. Alwitry's numerous emails to the Clinical Director during this period included the following remarks:

> *"Been doing a lot of soul searching about coming to Jersey. This letter and ultimatum from [the Managing Director] has shaken me a bit. To be honest if this is typical of the management style of the hospital I'm wondering if it is the sort of place I want to spend the rest of my working life in. I've spoken to the BMA and one of my old school mates who's an employment lawyer at Benests. They too really cannot understand or believe [the Managing Director] 's*

stance. You've been really understanding of my family circumstances but clearly management don't/won't listen to the clinicians"

[13th August 2012 @ 09:32]

...If I do end up coming still then I'm sure me and you will have many arguments with management over the years and I will be led by you in them however on this occasion [the Managing Director's] intransigence is adversely affecting my whole family for no firm reason I can fathom.

[14th August 2012 @ 09:14]

68.1 asked Mr. Alwitry whether he had been "soul searching" during this period. He said yes:

"because I was thinking that I was going to struggle to come over there and leave my family and four small kid when they really needed me. Then I was wondering well do 1 wait until the next post comes up because [the Clinical Director] was going to retire in a couple of years or do I jump ship and leave my family to struggle" (first interview page 17)

69.Mr. Alwitry concluded his email to the Managing Director on 10th August with the words *"I also have a vested interest in getting the department* *__back on a level playing field__...".*. <u>(my emphasis).</u> Against that background, it is therefore surprising that the Director of Operations received an email from Mr. Alwitry on 14th August 2012 that contained the assertion:

I met you in the pre-interview meetings you said you were "ok" for waiting times...

70. In further emails sent to the Clinical Director dated 14th August 2012 @ 09:14am, Mr. Alwitry wrote:

"having spoken to [the Director of Operations] and *seen the waiting times spreadsheet she kindly supplied me, it does not look to me that the short wait will sink the ship"* (my emphasis)

which was followed by another email to the Clinical Director at 03:03pm the same day

"[the Director of Operations] was the one that told me that it wasn't that bad. In fact her and I had a discussion about whether we needed a third consultant at all!"

71. The Director of Operations put together the 2011 business case that secured the extra funding for a third consultant in the Ophthalmology department. She denies the comments that have been attributed to her and makes the point that she felt that there were still considerable pressures on waiting list times. She said that she met Mr. Alwitry on 31st July at a pre-interview meeting and had provided him with a copy of the waiting lists.

72. When I pressed Mr. Alwitry in interview as to whether he had actually read the Director's spreadsheets, he said he had *"glimpsed at them but didn't really assess them"*. I am not persuaded that the views of the Operations Director were fairly or fully reflected in these email exchanges.

73. It was the Director's email on 14th August at 11:29am that confirmed that the hospital was sticking to a December 2012 start date.

74. Mr. Alwitry was not pleased with this news and sent the following email to the Director in reply at 12:15pm:

I'm sending a formal response to [the Managing Director] anyway —BMA are just checking it at the moment.

My problem is that [a consultant] says he's happy with a Feb start and that it wouldn't make that much difference. I met you in pre-interview meetings you said we were 'ok' for waiting times etc and looking at the spreadsheets you kindly sent me, I can't see the big problems which will sink the ship due to a three month delay. [A Medical Director] can't understand the urgency. So I am left confused. [A consultant] has also volunteered to do some extra sessions to keep us afloat.

I made it clear that I would require six months notice for starting for various reasons which I will not bore you with. If the I^{n} December date was so crucial to start you would have hoped it would have been mentioned in the advert, the job description or discussed pre or even during the interview. Also If I was clear on the application form that I had to have six months notice to start why was I shortlisted/interviewed/appointed etc etc etc. Very bewildered and saddened by all this. Seems a bizarre way to treat a potential new consultant. Anyway not your problem.

If you are motivated to (or allowed) could you just let me know what damage will occur with a February start versus a December start —would really help with understanding the situation we are in. It seems clear that the I' December start date will stand but really the decision now is whether I come at all.

If I came over in December and did some free clinics for no pay for you would that help?

75. The Director forwarded this email on to senior management.

76. The Managing Director wrote on 14th August *"This really is not what I would have expected. If he doesn't want to come he does not have to... Even if he does deign to grace us with his presence in December, this chap looks like trouble and if we can I think we should withdraw our offer and take the other candidate while he is still available".*

77. The Clinical Director added: *"This certainly requires careful managing — he has contacted both the BMA and a local employment lawyer ....I am no longer sure we know the full picture but if this is an example of things to come then I agree..".*

78. The Managing Director's letter of 10th August sought a response by close of business on 15th August. On 15th August at 18:21, Mr. Alwitry emailed his unequivocal agreement to a start date of 1st December moving to full time on 1st February 2013.

79. The Director of Operations raised the issue of Mr. Alwitry's behaviour on 16th August. She emailed senior management asking whether or not the appointment should proceed despite the fact that Mr. Alwitry had *"come to the table"* on the start date. For whatever reason there was no meeting to discuss the issue. No-one has been able to explain why.

80. I find that the Director's email should have prompted a meeting. The Managing Director, Clinical Director and Director of Operations had all expressed serious concerns about the appointment by 16th August 2012. The Managing Director had gone so far as to suggest that the hospital should look to appoint another candidate. Alarms bells were ringing loud. There should have been a meeting to consider the point.

81.1 note that when hospital management attended the SEB meeting on 18th December 2012, in order to explain further their decision to terminate Mr. Alwitry's employment contract, reference was made to the events that took place in August.

Timetable: September/October

82. Mr. Alwitry's full time timetable from 1st February 2013 onwards was the subject of considerable discussion from September 2012 onwards. The problems of August were about to repeat themselves.

83. Mr. Alwitry made it clear that he wanted a timetable that would enable him to return to the United Kingdom at weekends for family reasons:

> *That will mean the on the weeks when I'm not on call I can come back to the mainland on Friday morning to see the wife and kids for the weekend. As you know they won't be coming over till July because of school stuff*
>
> *[3rd September 2012 email to Clinical Director]*

> *On the original timetable Monday was my two sessions off in lieu of on-call. I presume that if 1 am working all day Monday from now on then those two sessions will move to the Friday. To be honest, I'm not that fussed as to whether those two sessions are on the Monday or the Friday. In either case it will allow me to go home for the weekends to see the kids when I'm not on call.*
>
> *[51h September email to Consultant in Ophthalmology]*

84.0n 16th September 2012, Mr. Alwitry emailed the Clinical Director to express his desire for a timetable from Monday morning until Thursday so that he could have Friday off in lieu of on-call.

85. What is notable about these three emails is that Mr. Alwitry was asking to have a particular timetable for family reasons.

86. On 24th September 2012, the Clinical Director sent Mr. Alwitry an email at 11:56am with his 1St February 2013 timetable attached. The Clinical Director observed *"Timetable now sorted — not all adhering to your wish list but it is the best 1 can do at present!"*. The timetable featured Mr. Alwitry working from Monday morning to Thursday but also alternative Friday mornings in Theatre. The Clinical Director added that he had *"sown the seeds...."* for further changes to the timetable with a view to moving Mr. Alwitry from Theatre to the Day Surgery Unit at some point in the future.

87. The Clinical Director then went on annual leave.

88. Mr. Alwitry considered the timetable to be completely unacceptable and moved quickly. He contacted the Theatre Nurse without the Clinical Director's knowledge on 24th September 2012 at 1:24pm with a view to swapping his Friday theatre slot with Obstetrics and Gynaecology.

89. At 9:24pm, Mr Alwity emailed the Clinical Director to say that he had *"some issues with the timetable which I'll discuss direct with you.."* The Clinical Director was not told of the earlier email to the Theatre Nurse. Mr. Alwitry informed the Theatre Nurse on 25th September that the Clinical Director's timetable of 24th September was *"provisional"*.

90. That initial contact with the Theatre Nurse was followed up by an email dated 29th September that began:

> *Did you have any joy speaking to [Surgeon in Obstetrics and Gynaecology] for me about allowing me to do every Thursday afternoon in DSU? Even if he could do it just until July when my family comes over to join me that would*

be a great help. I am happy to speak to him myself if you require. I would have hoped my senior colleagues could have sorted it for me but clearly the support isn't there.

I am not trying to be difficult. The need to get over to see my family is important to me but isn't the main thrust of this move to try and avoid Friday operating.................. I will not compromise patient safety.

In fact [the Clinical Director] argued vociferously against Friday operating when he first started — my dad thinks he still has scanned copies of those letters from [the clinical director] so he's going to try and dig those out for me-should make interesting reading considering that now he suddenly thinks it's ok.

91. The Theatre Nurse provided this email to management. A Medical Director, who operates on Friday afternoons at Jersey hospital, read this email and commented *"I think we should sack this bloke before he even gets here"*. The Managing Director observed that this was *"perhaps a portent"*. The Clinical Director told me that he was very concerned when he saw this email.

92. Indeed, it must have begun to dawn on management that the start date problems had not been a one-off. History was repeating itself. In August, Mr. Alwitry received a letter from the Managing Director he did not like. In September, he received a timetable from the Clinical Director he did not like. Mr. Alwitry's response was the same on both occasions: to seek out other hospital management and staff in order to help secure a change of decision that best suited his family

[2] The email referred to complications that can occur n eye surgery and the need to have cover on a Saturday if there were to be operations on a Friday.

circumstances. On both occasions, Mr. Alwitry was prepared to be openly critical of the management in order to obtain what he wanted.

93. Mr. Alwitry stressed during his interviews with me that his primary motivation for seeking to move his Friday operating slot was patient safety as set out in his 29th September email. I disagree. His motivation was to keep his weekends clear so that he could return to the United Kingdom for family reasons.

94. Mr. Alwitry is correct to say that there is a safety consideration when operating on a Friday[3]. There may be some patients on a Friday operating list who will need further care on a Saturday but that merely goes to Mr. Alwitry's personal convenience on the Saturday and not safety. The simple point is that Mr. Alwitry was not looking to put in place suitable Saturday cover. The purpose of his contact with the Theatre Nurse on 24th September was to move his Friday slot to the Thursday to suit his family.

95. In respect of the prospect of Mr. Alwitry staying behind on Saturdays to care for patients in the event of complications:

> *Mr. Alwitry: Now you may argue "well you should have just cancelled your flight home" [on the Saturday]. Okay fine, I accept that But that would have caused conflict and that would have caused tension because I'm bound to feel a bit upset that if they could just check them the next day and they were on call, and I am having to cancel my flight and not see my kids for another week, I felt that that would cause grievance and tension, and I'm sorry, if that's the case but my family is very very important to me".*

[3] Mr Alwitry has particularly focused on the fact that glaucoma patients can experience potential complications that might require attention the following clay. I note that Mr Alwitry had surgery on Tuesdays each week as per the original timetable and therefore assume that Mr Alwitry is saying that he would have had so many glaucoma patients that operations on a Friday would have been unavoidable.

(first interview, page 61)

96. Indeed, Mr. Alwitry told me in questioning that he was only looking to swap his Friday theatre list until his family can move over to Jersey:

> *SG: "I don't want Friday at all. Now can I swap with Obs and Gyn" that is what you were saying to [the theatre nurse] ?*
>
> *Mr Alwitry: Until my family come over, because then, if my family are over, I'm not flying away anywhere at the weekend....*

(page 59)

97. Someone has to operate on a Friday at Jersey hospital. Mr. Alwitry accepted in questioning that Obstetrics and Gynaecology patients are much more likely to stay in hospital and develop complications following surgery when compared to eye clinic patients. Yet, Mr. Alwitry was trying to move Obstetrics and Gynaecology to the Friday without the knowledge of his own Clinical Director in order to suit his family convenience.

98. The Theatre Nurse ultimately declined to assist Mr. Alwitry and instead provided the email to management.

99. Other members of staff took a different course.

100. The Clinic Sister in the Ophthalmology Department sent an email on 1st October in which she expressed her strong displeasure at the proposed timetable describing it as *'clerical chaos'*. The email was addressed to the Clinical Director, Mr. Alwitry and others.

101. At some point, Mr. Alwitry and the Clinic Sister had discussed the 24th September timetable. At least part of the 1st October email was directed towards

Mr. Alwitry personally as it outlined proposals with a view to him having *"the long weekend"* in the United Kingdom which suggests that those discussions had preceded the email. Mr Alwitry strongly denies this and says that the Clinical Sister's reference to the long weekend was a reference to an earlier email that she had seen.

102. At all events, the 1st October email prompted Mr. Alwitry to invite the Clinical Sister to enter into private negotiations. He emailed her *"if you could keep this email discussion just between us for the moment, I'd be grateful".*

103. There followed a series of discussions with the Clinical Sister and another consultant over several days that resulted in the creation of an alternative clinic timetable which, if introduced, would release Mr. Alwitry from being on-call on Mondays. As Mr. Alwitry explained to the nurse by email:

> *"This means I'll be able to fly back to the Island Monday morning F thing which means I get all day [Sunday] with the family. I am over the moon as it will make the period till the end of the school year (when they'll come over to join me) much more bearable".*

104. The issue of the Friday theatre slots remained.

105. Mr. Alwitry sent the Clinical Director an email dated 7th October 2012 which began

> *"Welcome back hope you had a good break. While you've been away [the Consultant, Nurse] and I have been furiously thrashing out the clinic timetable. Hopefully it's sorted and I'll be doing clinics on Monday PM, Wed AM, and Thurs AM. This works out well for everyone so hopefully it's ok by you. If you foresee any problems with it please let me know*

I am a bit confused about the number of sessions proposed for my timetable. The job description says that we do 2 sessions in lieu of on call, 2.5 SPA and 5.5 DCC sessions one of which is an admin session. Thus 7.5 DCC and 2.5 SPA making a ten session contract. That should mean that we do 4.5 clinical sessions per week -2 theatre and 2.5 clinics. I've actually confirmed this in writing with medical staffing but is this right from both your perspectives.

Friday operating — this is the exact same argument you had when you first started. and really the same points you made back then still stand

So I've been trying to work out a solution:

...Is there any way you can wave your magic CD Wand and sort out weekly DSU Thursday list for us? Version 5 of the theatre timetables had eyes scheduled for every Thursday in DSU so it looks like it was almost done and dusted. I have faith in your powers of persuasion. If you could work your wonders I'd appreciate it. Day Case Gynae are apparently fine for waits/capacity so it shouldn't in theory have any significant service implications.

[Mr. Alwitry then proposed a series of alternatives including other doctors covering his patients on Saturdays, giving him an extra PA for the Saturday morning, 'ditching' the Friday list in the short term or limiting the type of operations done on a Friday].

I am over on Monday pm and Tuesday am 22^{1d}/23rd October so am happy to meet up and discuss this face to face with you both.

The breakdown of the relationship with the Clinical Director

106. The Clinical Director was unimpressed by these events. His reply dated 9th October was copied to senior management including the Managing Director. The email was firm:

Dear A mar,

An awful lot of correspondence, in my absence, has arisen consequent upon this email [email of the 24th September with the timetable].

I feel it is important that you fully understand the position concerning your appointment and timetable so would make the following points for clarification.

As a department and organisation, we have made every effort to accommodate your interim requirements from Dec to Feb 12. This has not been the easiest exercise for many reasons not least of which is availability of theatre space.

The timetable below [a reference to the 24th September timetable] will be implemented for you from 11/2/12 — which is the time that you agreed to commence your full time commitments.

As I have made clear, we cannot provide you with what is not available. Further you must understand that your requirements have to fit in with everyone else. I have tried my utmost using what influence I have to get the best possible arrangements for yourself but would remind you that "last man in" must accept that compromise at this juncture is prudent,

I suggest that you follow my advice (below) with regards to your theatre sessions on Thurs/Fri.

Just to clarify my position with regard to theatre allocation on taking up the post in Jersey about which you do not appear to have the full facts.

Your father advised the appointments committee that I would only require a single operating suggestion and suggested that a weekly Friday afternoon session would be adequate. In spite of my protests at the time, sadly not supported by my future colleague, I started with this single session. It took me many months in post before I was able to make inroads in addressing this wholly unsatisfactory situation.

If you have any further queries/questions/concerns in relation to the above please address them to myself [the Managing Director or the Director of Operations] rather than involving a myriad of different individuals which simply serves to confuse.

I would advise/warn that making too many demands at this stage of your appointment is unlikely to bode well for your future relationships within the organisation!

I hope to see you when you are next over later in the month.

107. Mr. Alwitry accepts that he was upset that the email had been copied to management and other members of the Ophthalmology Department (first interview, page 76).

108. This is the last email exchange between Mr. Alwitry and the hospital management. On 18th November 2013, I asked Mr. Alwitry why that was:

> *Because I left it. I didn't want to cause any problems with him. I don't want to cause any problems...If I had issues or problems with this I would taken his advice and gone to [Director of Operations] or [Managing Director] face to face ...I could have gone down the personal disciplinary route But I didn't. (page 78).*

Mr. Alwitry and the BMA

109. On 2' December 2013, Mr. Alwitry's advocate provided me with copies of documents from the BMA, Mr. Alwitry's trade union.

110. These records reveal that on 10th October 2012, Mr. Alwitry contacted his trade union by telephone at 09:23. He made that telephone call as a response to the 9th October email he had received from the Clinical Director. Mr. Alwitry did not mention this telephone call during his interview with me on 18th November 2013.

111. The BMA's record of the conversation reads as follows:

> *The member has accepted a post in Jersey and is due to start part time in December and move to full time work in February. He has received his timetable for February and it is for 11.5 PA s. His full time contract is for 10.*
>
> *He contacted medical staff who confirmed that the timetable was correct. He then contacted the clinical director to ask about either adjusting the timetable or getting APAs. The clinical director replied via email that was copied to the medical director and the senior sister.*
>
> *In the email, the cd told the member to stop making demands and that if he continued to make demands so early in his career, he would jeopardize his future. According to the member, the email basically said to accept the fact that he would be working 11.5 PA s while only getting paid for 10 or to leave*
>
> *(my emphasis)*

112. It is perhaps worth putting this complaint in context by setting out the limited extent to which Mr. Alwitry made any attempt to discuss his contractual hours with the hospital.

113. On 24th September 2012 at 13:02, Mr. Alwitry sent an email to medical staffing at Jersey hospital to ask whether his employment contract was for 10 PA s. He did not ask Human Resources as to why he might be required to work 11.5 PA s or provide any context to his email. No concerns were raised.

114. Mr. Alwitry tentatively mentioned the issue to the Clinical Director in his 7th October email which was of course primarily focused on securing a change of the Friday theatre slot rather than a reduction in hours.

115. The Clinical Director's reply on 9th October is set out in full at paragraph 105 above. It does not respond to this particular enquiry but that is not terribly surprising. The Clinical Director's email of 9th October was intended to address more fundamental management issues but expressly left open the prospect of further discussion with management (and not staff) about the timetable. Mr. Alwitry declined that invitation.

116. That is the full extent of Mr. Alwitry's attempts to discuss his (belated) concern about his contractual duties. It appears that the straightforward answer to the query is that doctors at Jersey hospital do more than their contractual hours in order to balance the fact that they can treat their private patients on public lists. Whatever the rights and wrong of the concerns Mr. Alwitry had about his contract, this was a storm in a teacup that could have been resolved through normal conversation with hospital management.

117. The BMA followed up the telephone call on 10th October with an email at 11:07 am the same day to Mr. Alwitry confirming their understanding of the issues adding that *"The email response from the Clinical Director also made*

inappropriate personal comments in regard to having worked with your father". Mr. Alwitry expanded on that particular issue by email to the BMA at 12:26pm

> *"My father was a consultant in Jersey and he worked with [the Clinical Director] They had a very stormy relationship and were hardly speaking by the time my father retired about eight years ago. I was hoping that the relationship with my father would not have any bearing on how I was treated but it seems that that is not correct. The senior colleague he refers to when he mentions the difficulties he had when he first started was my father. It seems that the son is suffering for the sins of the father."* (my emphasis)

118. This is an allegation of bad faith.

119. This particular allegation is also deeply ironic. Mr. Alwitry had used events involving his father to criticise the Clinical Director in his email to the theatre sister on 29th September:

> *In fact [the Clinical Director] argued vociferously against Friday operating when he first started — my dad thinks he still has scanned copies of those letters from [the clinical director] so he's going to try and dig those out for me should make interesting reading considering that now he suddenly thinks it's ok.*

120. Mr. Alwitry then raised the issue again in his email to the Clinical Director on 7th October:

> *Friday operating — this is the exact same argument you had when you first started and really the same points you made back then still stand*

121. The Clinical Director's response on 9th October was no more than an attempt to put straight criticism that had been circulated by Mr. Alwitry to both him and other hospital staff

122. The BMA asked Mr. Alwitry for " *a copy of your email to the Clinical director and a copy of his response to your email".* This was an obvious request for the email from Mr. Alwitry dated 7th October and the Clinical Director's reply dated 9th October.

123. Mr. Alwitry did not provide the BMA with his email dated 7th October which would have revealed that he had negotiated a different timetable with hospital staff whilst the Clinical Director had been on leave and that it was he and not the Clinical Director who had first raised the issue of Mr. Alwitry's father.

124. Instead, Mr. Alwitry provided a very short email he had sent the Clinical Director on 24th September at 9:26 pm that merely said that he had *"some issues with the proposed timetable which I will discuss directly with you..."*[4] together with the Clinical Director's "reply" dated 9th October.

125. At 11:39 on 10th October 2012, Mr. Alwitry spoke to the Clinical Director by telephone. Telephone billing records that the conversation lasted eight minutes which on Mr Alwitry's evidence is a longer conversation than his negotiations with the Managing Director on 10th August.

126. Mr. Alwitry's evidence to me is that he telephoned to confirm his acceptance of the job plan. He said to the Clinical Director *"Sorry about all this stuff I didn't mean anything by it, I just want to move forward...."* Mr. Alwitry says that the discussion then moved onto private practice:

> *He asked me about Little Grove and whether I was moving there and I said "yeah for the moment I am" and he said*

[4] In fact, Mr Alwitry had already emailed the theatre nurse without the Clinical Director's knowledge.

> *something about "fair enough. "You have decided which camp to be in. so be it". But he said I think "Okay, I'll see you later on in the month" or something like that...so it was pleasant...he was nice. (page 82 of transcript)*

127. The Clinical Director says that he has no recollection of this discussion.

128. At the conclusion of this telephone call, Mr. Alwitry emailed the BMA from his iPhone at around 11:46 and declared that he felt *"helpless and quite distraught"*.

129. Mr. Alwitry told me during the second interview that notwithstanding his comments to the Clinical Director that he accepted the timetable, he did indeed feel helpless and distraught about the timetable at this point in time.

130. It is very difficult to know what to make of this telephone call and I have reached no firm conclusions about it.

131. On 23rd October Mr. Alwitry suggested in a further email to the BMA that the Clinical Director's timetable was *"all v strange"* and that the hospital staff were *upset* about it.

132. Mr. Alwitry told me in his second interview that he had not made a formal complaint against the Clinical Director and he denies that he ever contemplated doing so.

133. However, it is hard to escape the conclusion that the description of the Clinical Director, as presented to the BMA on 10th October 2012 by telephone and email, was highly emotive, selective and unfair. There was an allegation of bad faith. Mr. Alwitry painted the picture of a line manager who had issued an ultimatum for personal and improper reasons. Whether or not Mr. Alwitry was laying the

ground for a formal complaint, it is crystal clear that the BMA records provide further confirmation that the relationship had become dysfunctional.

134. I do not accept the explanation that Mr Alwitry's comments to the BMA were made "off the cuff' or "in private" and therefore of little significance. This was not the case of an employee going home to tell his wife about his difficulties in the workplace. Mr Alwitry had taken the trouble to formally record these matters in written correspondence with his trade union. The assertion that the son was suffering for the sins of his father is to be found towards the end of a two page email that must have taken some time to compose.

135. It is fair to say that the BMA took a somewhat different view to Mr. Alwitry after they had seen the Clinical Director's 9th October email. There was a telephone conversation between the BMA and Mr. Alwitry on 1Ith October 2012. BMA did not think their intervention was appropriate and it is telling that they pointed out to Mr. Alwitry that the 9th October email from the Clinical Director suggested that Mr. Alwitry was trying to get a job plan that suited himself. Mr. Alwitry denied this. BMA proposed that Mr. Alwitry speak to a medical director or the Director of Operations and thought that the matter should be resolved very quickly.

136. Despite this advice, the trade union remained involved at Mr Alwitry's request. The BMA suggested, following further discussions with Mr. Alwitry, that they could make "subtle contact" with the Human Resources department at Jersey hospital in order to ascertain why Mr. Alwitry was apparently being made to work 11.5 PA s when his contract said 10. BMA described the Medical Staffing Officer at Jersey Hospital as pragmatic and understanding. Mr. Alwitry agreed to this course on 23rd October 2012 by email.

137. On 22 and 23$^{'d}$ October, Mr. Alwitry visited Jersey as planned and attended the hospital. Mr. Alwitry made no attempt to speak to the Clinical Director or anyone

else in senior management as had been suggested in the Clinical Director's 9th October email. An email from the Clinical Director on 24th October records that he had learnt from other members of hospital staff that Mr Awlitry had *"General concerns that the timetable does not suit him and his needs. Not happy/prepared to operate on a Friday, Feels PA's are in excess of his contract..."*

138. During the first interview of Mr. Alwitry on 18th November 2013, I had asked Mr. Alwitry why he had not seen the Clinical Director during his October visit. Mr. Alwitry told me that he felt such a meeting would have been 'counterproductive' (first interview page 84).

139. The answer is to be found in the BMA records. I conclude that Mr. Alwitry had decided to cease all contact with hospital management until after the BMA had first contacted the hospital. Mr. Alwitry was waiting to see what the BMA might achieve. That is why there were no further communications between him and the hospital management from 10th October onwards. Mr. Alwitry denied this during the second interview but no other credible explanation presents itself to me.

140. The BMA advice given on 11th October — that there was no justification for their intervention - appears to have had a calming influence on Mr. Alwitry who thereafter repeatedly expressed a desire to the BMA to avoid causing trouble and welcomed a subtle approach to the issue. However, the anger beneath the surface remained: see Mr. Alwitry's emails dated 31st October describing the Clinical Director as *"a well acknowledged control freak"* and 12th November "my *contract says that my duties and timings of those duties are mutually agreed and not forcibly imposed for no reason at all"*.

141. Mr. Alwitry told me in the first interview that he may have had contact with the BMA prior to 30th October 2012 but had said nothing to me about the fact that he had contacted the BMA on 10th October as a direct reaction to the Clinical Director's 9th October email. I asked Mr. Alwitry during the second interview

why he had not mentioned his extensive communications with the BMA from 10th October onwards during our first meeting. He told me that he had not remembered these events. Given the vivid nature of those exchanges with the BMA on 10th October, I conclude that Mr. Alwitry has an extremely poor recollection in respect of some of the most important aspects of this case.

142. Progress was slow and the BMA did not contact the Medical Staffing Officer at Jersey hospital with Mr. Alwitry's consent until 12th November 2012. By this stage, the hospital management were already minded to terminate the contract.

The termination of the contract

143. On 23rd October 2012, Mr. Alwitry visited the hospital and emailed the BMA a summary of his discussion with staff in the ophthalmology department. The email was again critical of the Clinical Director. A Medical Director sent the following email the same day:

> *[the Director of Operations] tells me that the newly appointed Eye consultant is getting even more demanding. This appointment will be a disaster and we should withdraw his offer of a job before he gets here. Mark my words, he will make [former consultant] seem like a walk in the park*[5]

144. This email triggered a siring of further emails between management. There was a collective expression of concern that is perhaps best summarised by the Managing Director's email on 23rd October 2012 @ 6:09pm:

> *...he [Mr. Alwitry] will not accept anything he does not like without an argument and when he doesn't get the answer he*

[5] This comparison was in effect a suggestion that Mr Alwitry would be unmanageable.

wants he tries someone else for a different result and so on. Whenever we do call his bluff he appears to back down but then starts the debate all over again....

145. These exchanges culminated in the hospital's HR Director seeking legal advice from the Law Officers' Department on 23rd October as to the consequences of terminating an employment contract in order to understand what damages might in principle be payable if the contract was terminated at this stage. The emails from the FIR Director hint that there may have been some concern about the hospital budget if a decision was taken to terminate the contract.

146. On 30th October 2012, the HR Director disseminated the legal advice to the hospital management and asked *"do we have the appetite for this difficult decision?"* having regard to the fact that any decision to terminate would attract considerable media and political attention. The Managing Director replied saying that this was *"the real issue which we really need to discuss as a team"*. The Managing Director told me that he knew that a decision to terminate would be *"bloody"* because of these external pressures.

147. It is clear from the tone of the emails that the hospital management team were on the verge of terminating the contract on 30th October.

148. By this stage, the Clinical Director had become aware, possibly as a result of events on 23rd October, that Mr. Alwitry had taken his decisions very personally. Even so, the Clinical Director was prepared to give Mr. Alwitry another chance.

149. On 30th October 2012, the Clinical Director telephoned a consultant in Derby who knew both the Clinical Director and Mr. Alwitry. The Clinical Director asked whether Mr. Alwitry still wanted to move to Jersey. He expressed concern that the dispute about timetable may reflect the fact that Mr. Alwitry no longer

wanted to come. This was the offering of an olive branch at a time when it seems that both men felt unable to communicate directly with each other.

150. The Derby Consultant immediately informed Mr. Alwitry of the telephone call but Mr. Alwitry made no attempt to contact the Jersey hospital. Again, I received no helpful explanation from Mr. Alwitry as to why this was so during the first interview and I infer that Mr. Alwitry decided to maintain radio silence until the BMA had spoken to the Medical Staffing Director.

151. There was a meeting between the Clinical Director and the Managing Director on 31st October 2012. It appears that the rest of management could not attend. It was agreed that the Managing Director would write to Mr. Alwitry giving him a five day period in which to consider his position and confirm his acceptance of the job and the proposed timetable[6]. The Clinical Director noted that *"if he remains unhappy he should be afforded every opportunity to rethink his position......If he remains unsure we would reluctantly (sic!) accept his resignation...."* It was proposed that any resignation was to have no financial penalty for either side which again suggests that the hospital was worried about financial risk. The Clinical Director then went to the United States of America.

152. However, the letter was never sent. The Managing Director cannot now be certain but told me that he may have had a change of heart about offering any further chances to Mr. Alwitry. I am minded to accept that explanation. With the Clinical Director now absent for two weeks, no further meeting was held and the case was now drifting.

153. In the event, the BMA sparked the management into decisive action.

154. On 12th November 2012, a BMA representative sent the Medical Staffing Manager at the Human Resources department at Jersey hospital an email at 16:42 inviting a telephone discussion about:

[6] Of course, Mr Alwitry was already arranging for the BMA to challenge these arrangements.

> *"a delicate issue surrounding Mr. Alwitry ...Dr. Alwitry has run into a few problems with the consultant lead and I would like to appraise you of the situation for the purposes of avoiding any future problem".*

155. The Medical Staffing Officer quickly sent the HR Director an email at 16:55 *"Where are we with Mr. Alwitry"* to which the reply came at 16:58 *"I think everyone is agreed that we formally withdraw the job offer".*

156. There was no attempt to speak to BMA to ascertain the precise details of what the nature of the problem was. Rather it was assumed that there had been a complaint made about the Clinical Director. The hospital did not know if they were facing a complaint and, if so, its merits.

157. On 13th November 2012 at 10:07, the Medical Staffing Officer sent an email to management:

> *Mr Alwitry has referred an unspecified matter to the BMA (see below) in relation to [the Clinical Director]. I have not spoken to the BMA yet regarding this but this possibly strengthens our resolve to terminate the contract accepted by Mr. Alwitry giving three months notice.*
>
> *Before I do this, I need to make sure we are all in agreement and fully understand that there may be subsequent litigation...*
>
> *Please respond asap*

158. A management meeting was held on the afternoon of the same day. The meeting was attended by the Managing Director, the two Medical Directors and

the HR Director. The Clinical Director was notably absent from the meeting. He was still in the United States of America.

159. The decision was taken to terminate the contract. The reasons given for the decision as recorded in the note of the meeting were *"Mr. Alwitry's communication attitude and behaviour since his offer of employment was accepted...along with his reporting of [the Clinical Director] to the BM_A."*

160. The Managing Director informed a consultant on 28th November 2012 that the involvement of the BMA was the *"final tipping point".* The Managing Director told Mr. Beal on 20th March 2013 that the BMA was the *"last straw".*

161. Although some members of the hospital management have sought to persuade me otherwise, I am clear that the BMA 'issue' was a reason for the decision to terminate on 13th November. I entirely accept that it was not the only or even the most significant reason — the principal reasons for the dismissal relate to Mr. Alwitry's behaviour since the job offer was made and the fact that the relationship had become dysfunctional by no later than 10th October.

162. On 15th November 2012, the Medical Staffing Officer spoke to the BMA Representative. The hospital has no note of the conversation. The BMA note records that the conversation lasted three minutes. The BMA Representative provided *"background to Dr A appt and job plan".* The focus of the discussion was the 11.5 PA s timetable and the contract for 10 PA s. The Medical Staffing Officer declined to discuss the matter indicating that it was being considered by senior management. I have interviewed the Medical Staffing Officer who had a very poor recollection of this telephone conversation.

163. On 19th November 2012, the SEB received a letter from the hospital's HR Director that began:

"his 1-Mr. Alwitry's] behaviour and attitude since receiving the offer has been consistently adversarial aggressive inappropriate duplicitous uncooperative and frankly unacceptable. This behaviour has been directed at senior management, senior doctors, HR staff and other clinical professionals in other services. He has now engaged the BMA to support a formal complaint about the Clinical Direction [CD] — even before he has started in post!! The CD, not altogether unreasonably, has indicated that he would feel obliged to resign as CD if the offer is not withdrawn.

We are content that this behaviour constitutes a loss of trust and confidence so fundamental as to undermine the contract of employment"

[my emphasis]

164. On 22nd November 2012, the HR Director wrote to Mr. Alwitry on behalf of the SEB:

I write to inform you that after careful consideration we have decided to withdraw the offer of the post of Consultant in Ophthalmology made on 21'` August 2012 and to formally notify you that any contractual relationship between us (to the extent it may exist) is to be treated as terminated.

The decision has not been reached lightly. It has been informed by

- *The attitude and behaviour displayed in relation to multiple aspects of the role.*

- *Demonstrable evidence of a dysfunctional relationship with the Clinical Director and other senior medical and management staff*
- *Loss of trust and confidence between the respective parties resulting in any employment relationship being irreparably damaged.*

165. Mr. Alwitry emailed the Clinical Director on 26th November 2012:

"What's happened? I am completely confused as to what's gone on. They've put in the letter that 1 have a dysfunctional relationship with the clinical director but that's you.

166. The Clinical Director replied:

Regrettably I am in agreement with the executive decision.

I suggest you reflect carefully on all the previous correspondence with regards to the many aspects, virtually all, of the post and timetable that you found unacceptable and questioned from the outset and <u>in particular your decision to report your manager i.e. me to the BMA</u> (both surprising and extremely disappointing, bearing in mind all the time and effort I put into trying to organise the best possible timetable under the circumstances of major organisation constraints) in order to find the answers to your email. <u>(my emphasis)</u>

167. Mr. Alwitry emailed the Clinical Director on 28th November to say *"1 hate the damn BMA people for sticking their beaks in"* and also wrote to a Medical Director on 30th November to indicate that *"I had sought the advice*

from the BMA but had certainly not instructed them to contact any of the management or human resources teams in Jersey and cause problems I am annoyed about it too and I'm trying to get the BMA to send some formal correspondence apologising for their unauthorised and unhelpful intervention". The BMA file clearly shows that the trade union first obtained Mr. Alwitry's consent before contacting the hospital.

168. On 3rd December 2012, Mr. Alwitry provided hospital management with an email from the BMA confirming that their 12th November email was intended to initiate an informal chat and that there was no formal complaint to be progressed. There was no mention in this email of the events on 10th October or the allegation that *"the son was suffering for the sins of the father".*

169. Mr. Alwitry attempted reconciliation in vain. As part of that process, he told the Medical director that *"I've tried to put myself in your shoes and can see that the volume of communication may have been excessive"* and the Clinical Director was informed that *"I think I was over enthusiastic and in retrospect a bit of prat with the timetable stuff'.* Mr. Alwitry invited me to attribute no weight to these apparent admissions because he says that they were written at a time of great stress and in an attempt to find a way to rebuild bridges. If so, then it appears that Mr. Alwitry does not accept that his behaviour should have caused management any serious concerns.

Procedural Error

170. The BMA email of 12th November 2012 should not have been taken into account on 13th November 2012 by the hospital management. The hospital did not know what the BMA wanted to say or discuss. If there had been a complaint, it might have been justified. The proper course was for the hospital

to speak to the BMA, understand the precise details of the issue, and then take a view as to whether that additional information should be considered relevant to the decision to terminate the contract. For obvious reasons, the fact that an employee has made a complaint is not a ground for their dismissal. Great care should have been taken.

171. No care was taken. The management assumed that Mr. Alwitry had reported the Clinical Manager to the BMA without further consideration. This assumption was a factor in the decision to terminate. This was a serious error.

172. The Medical Staffing Officer did not speak to a BMA Representative until 15th November and only then in a telephone conversation that lasted three minutes. It is extraordinary that the meeting that took place on 13th November was not delayed a day or so to enable a discussion with the BMA to take place first.

173. The hospital informed the States Employment Board on 19th November that there had been a *'formal complaint'* made to the BMA against the Clinical Director which is not a fair reflection of the hospital's somewhat limited understanding of events at that stage.

174. There was a meeting of the States Employment Board on 18th December 2012 to discuss the decision. The hospital management attended. The hospital provided a chronology of events for the meeting that omits any reference to the BMA 'complaint' and the minute of the meeting itself suggests that the BMA `complaint' was not discussed.

175. I am also unimpressed by the fact that Mr. Alwitry was not afforded an opportunity to respond to the criticism of him. I accept that he had no legal right to such an opportunity because he had not yet started his employment period. However, the hospital is an organisation that wants to act and be seen

to act as a good employer that will continue to attract talented doctors. Such an employer should have provided the opportunity to respond regardless of the legal position. The relationship between employer and employee had moved well beyond the job offer stage by November 2012.

176. It is a pity that the hospital management did not recognise the need to move away from correspondence when it became clear that there were serious problems. There should have been a face to face discussion even if it transpired that Mr. Alwitry had no answer to the criticism.

177. Instead, a letter dated 22nd November 2012 was sent out by mail terminating an employment contact in circumstances in which the employee was due to move from the United Kingdom to Jersey to start work just a week later. The posting of such a letter and its timing does not reflect well on the hospital.

178. The hospital should be aware that the procedure adopted in this case has the potential to damage its reputation as an employer. In employment law cases, procedure can be as important as the merits of the decision. If the procedure is non-existent, those failings will cause reasonable observers to worry about the merits of the decision, even if ultimately those worries are proved to be unfounded. The inevitable consequences are investigations that cost money and result in delay.

179. The hospital management might wish to consider further employment law training that is focused on procedural fairness.

Merits of the case

180. This unfortunate procedural muddle does not change the merits of the decision in this particular case.

181. There had clearly been a breakdown in the relationship between employer and employee. There was no communication at all from 10th October 2012 onwards. Mr. Alwitry had been openly critical of management in August and September 2012 and had shopped around in order to find decisions that best suited his family. Mr. Alwitry's email to the theatre nurse on 29th September 2012 is a good example of the dysfunctional relationship that already existed with an employee who had yet to start work.

182. A proper and open investigation of the BMA issue would have revealed Mr. Alwitry's allegation that the Clinical Director was punishing Mr. Alwitry for the 'sins' of his father. That was a baseless allegation of bad faith that provides further confirmation that there had been a breakdown in the relationship between employer and employee.

183. Mr Alwitry says in response that he would not have agreed to the disclosure of the allegation even if there had been a proper investigation. Leaving aside what that admission says about the poor state of his relationship with the hospital, the BMA would still have had to explain precisely what they meant by the 'problems' that they referred to in their 12th November email. Further evidence of a dysfunctional relationship would have emerged. The hospital management were at one in telling me that this felt like a complaint and they regarded the BMA's approach to the hospital as highly unusual. The prospect of Mr Aiwitry fending off these concerns by material non-disclosure was simply not a viable option if he wanted to restore trust.

184. Mr Alwitry's lawyers have advanced the argument to me in writing that the 31s` October meeting between the Managing Director and the Clinical Director shows that the hospital was still prepared to appoint Mr Aiwitry and that but for the error with the handling of the BMA 'complaint', he would now be in post. I am afraid that ignores the realities of this case. For the reasons set out above, the relationship had become dysfunctional by late October 2012. The management had expressed a collective view by late October that the

employment contract should have been terminated. There were a number of reasons for the decision on 13th November to terminate the contract of which the BMA was just one. The 31^{5t} October meeting between the Managing Director and the Clinical Director (but not the other members of management) proposed a final ultimatum which the Managing Director did not follow through with. The management can certainly be criticised for not taking more decisive action on 31st October and at other times but that is very much a procedural point.

185. I have interviewed Mr. Alwitry. I am satisfied that even if he had been afforded an opportunity to respond to the criticisms of him, the outcome would have been the same. I have found much of his evidence to be difficult to follow and contrary to the contemporaneous records in this case. I was left none the wiser by his explanations for his behaviour from 10th October onwards and it is only the BMA records that have shed light on that period of the case. Mr. Alwitry does not appear to accept that his behaviour is a real cause for concern.

186. This case was not about patient safety as has been claimed. Mr Alwitry did not seek a single meeting with the Clinical Director or any of the management at the hospital to discuss any safety concerns. Indeed, he did not raise those concerns with hospital management at all until his email to the Clinical Director dated 7th October 2012 — the last email he ever sent the hospital management. Mr Alwitry's Tiade Union the BMA did not advise him to raise safety concerns as an issue and instead suggested that the dispute should be capable of resolution without their involvement.

187. This case was all about Mr. Alwitry's overwhelming desire to obtain the timetable that suited his family. Ultimately, Mr. Alwitry's family needs were incompatible with the job he applied for.

Other issues

188. There are five further matters I should mention.

189. Firstly, the issue of private practice.

190. Mr. Alwitry's Jersey lawyers wrote a letter to the Law Officers Department dated 24th June 2013 in which it was asserted that there was a *reasonable suspicion* that discussions between Mr. Alwitry and the Clinical Director about private practice had influenced the decision to terminate the employment contract (page 8 of the letter).

191. I remind myself that the Clinical Director took no part in the decision on 13th November because he was in the United States of America. I also note that on 30th October 2012, the Clinical Director had been trying to offer an olive branch to Mr. Alwitry when the rest of the management team had seemingly had enough. On the face of it, this allegation is without any foundation

192. I asked Mr. Alwitry why private practice was relevant. He told me that *"I have no evidence to support anything. What I do know is that people have been telling me that that was a key factor in this"*. These *'people'* are former hospital employees whom Mr. Alwitry has met socially. In other words, this allegation is based on gossip.

1.93. The only relevance of this allegation is that it confirms that the relationship has broken down and that reinstatement is not appropriate.

194. I have been able to ascertain the following facts about private practice.

195. Mr. Alwitry was invited to join the Clinical Director's private practice —the Jersey Eye Clinic. Mr. Alwitry told me that it had *"real wow and impact factor"* and that it *"was the place I wanted to be"* (first interview, page 115). He was shown around the premises on 25th August 2012. That meeting went well. On 10th September 2012, Mr. Alwitry registered a web address for the Jersey Eye Clinic. On 20th October 2012, Mr. Alwitry received an invoice from a website designer for the design of a front page of a new Jersey Eye Clinic website. I have seen a print out of that page dated 7th November 2012.

196. Mr. Alwitry's evidence to me about the telephone call on 10th October—that he informed the Clinical Director that he was joining another consultant at Little Grove instead - is the only piece of evidence that there was any friction with the Clinical Director on the issue of private practice. If Mr. Alwitry did tell the Clinical Director on 10th October that he was not joining him in private practice, it is odd that Mr. Alwitry then received an invoice on 20th October relating to the Clinical Director's Jersey Eye Clinic.

197. Even if Mr. Alwitry is right about the 10th October conversation then, any friction came only after Mr. Alwitry had made contact with the BMA on 10th October 2012. The relationship had already broken down by that point.

198. Again I note that none of this stopped the Clinical Director from seeking to offer last chances to Mr. Alwitry on 30/31 October before leaving for the United States of America.

199. As an aside, I note that Mr. Alwitry emailed a consultant on 5th September 2012 to say *"I would definitely like to join you"* at the Little Grove Clinic and asked *"do you want me to write something now about converting that suite into our dedicated eye area"*. On 28th October 2012, Mr. Alwitry sent an email to Little Grove which was copied to the same consultant indicating that *"I had thought I was all sorted at Little Grove"* and *"I am hoping to commit to Little Grove for the next 25 years". It* appears that Mr.

Alwitry had been giving both the Clinical Director and a consultant in the Ophthalmology Department the same message over the same period of time.

200. Mr. Alwitry told me that his master plan was to start at Little Grove in order to build up his private practice and then join the Clinical Director at a time when he could negotiate more favourable financial terms. I continue to struggle to reconcile that plan with the payment of fees in October 2012 for a new website for the Jersey Eye Clinic but as I have already indicated, private practice is not relevant to the issues in this case.

201. Secondly, I am aware that one consultant wrote to the Chief Minister to express his displeasure in respect of the decision to terminate Mr. Alwitry's contract. I interviewed this consultant on 11th November 2013. I am not minded to attribute much weight to his evidence. For example, he told me that that there was no real problem with waiting times and that the desire to recruit a third consultant was primarily to build expertise in the Ophthalmology Department (pages 9/10 of transcript). That assertion is inconsistent with all the other evidence in the case. The consultant also told me he had resigned this year in protest of the decision to terminate Mr. Alwitry's contract. In fact, it was well known by hospital staff in early September 2012 that the consultant was planning to retire and he has since given nine months notice. The consultant has complained that he was not consulted about the decision to terminate Mr. Alwitry's contract. This consultant is not part of the management team. The management took the view that, given his close liaison with Mr. Alwitry during August to November 2012, it was not appropriate to consult with him. That was a reasonable view to take.

202. Thirdly, I have received anecdotal evidence from witnesses that Mr. Alwitry has had difficult relationships with hospitals in the United Kingdom. I have not, investigated these matters and I have had no regard to them in reaching my conclusions.

203. Fourthly, I provided Mr Alwitry with a draft of this report on 15th January 2014 and invited his comment. On 5th February 2014, I received a 33 pages letter from his advocate in reply that is said to merely highlight *"the most objectionable and unsupportable"* aspects of my conclusions. The letter invites me to change the findings in my report otherwise Mr Alwitry will refer the matter to the General Medical Council on the basis that this case was about the hospital's (unlawful/inappropriate) reaction to his legitimate attempts to raise genuine safety concerns. I have studied this letter with care and taken it in into account when writing this final report. I have already noted that Mr Alwitry made little or no attempt to inform management of his safety concerns and his trade union did not regard this as a safety case.

204. Fifthly, this report does not expressly refer to every event, piece of evidence and information that I have considered. I have produced a report which features my central conclusions. I have taken great care to consider all the information provided to me. If I have not expressly mentioned a particular matter in this report, that does not mean that I did not take it into account in reaching my conclusions.

17th February 2014.

Howard Sharp QC

Solicitor General

Mr Alwitry's timetable negotiation and Patient Safety implications

Mr Alwitry was initially to work a 3 day week from 3rd December 2012 to the 11th February 2013. The timetable negotiations were in relation to the full time post from 11th February 2013.

Mr Alwitry is presently suggesting that his 'excessive communication' (his words) in relation to his timetable was purely to ensure his timetable would enable him to provide safe patient care to his particular sub-specialty patients. Some facts that he is relying upon are:

1. That he is a glaucoma specialist and therefore has a sub-set of patients that are more complex than the average ophthalmology patient. He specifically (and only) references his 'trabeculectomy' patients and his glaucoma cataract patients.
2. That his complex surgical patients may require a return to theatre the day following initial surgery if complications arise.
3. That his complex patients require review on day 1 post surgery. He states that they are day case patients therefore they are not in a hospital ward and would therefore come back to a clinic setting for review.

Mr Alwitry was therefore looking for a timetable that:

a) Enabled a 'return to theatre option' for his complex patients
b) Enabled a post-operative, day 1 review clinic, for his complex patients

He also brings into the negotiations his weekday 'on-call' (available from 5pm to 9am) commitment. Each member of the ophthalmology on-call team (#4) would have a set, weekly, on-call day Monday to Thursday, then on a 1:4 basis they cover the Friday, Saturday and Sunday. Mr Alwitry references his weekday on-call in some of his e-mail correspondence.

Mr Alwitry claims that he is being penalized for raising patient safety concerns, he goes on to report Mr Downes to the General Medical Council stating that he was dismissed because he raised patient safety concerns.

Observations:

Raising of Patient Safety Concerns:

- Initially these concerns were only raised with relatively junior nursing staff in theatres and clinic, these are not the staff members with whom to raise this.
- Raised (appropriately) with the Clinical Director and the other Ophthalmology Consultant on the 7 October 2012 via email. This email sets out the reasons for needing to return a complex patient to theatre and to review glaucoma cataract cases the day after surgery. The email also sets out solutions to both issues, by undertaking the trabeculectomies on his Tuesday operating list only on weeks when the other consultant is away, releasing a spare theatre on the Wednesday; and regarding operating on complex cases on a Friday – his final suggestion is that these cases are not undertaken on a Friday and the list is used for non-complex cases only.
- Mr Alwitry does email the joint medical directors on 27/11/12 and raise patient safety issue about a clinic following his 'big list'. He also states that he would have a problem doing intra-occular surgery on a Friday. This was the first communication with the medical directors about this from Mr Alwitry. He states in his email that he was not expecting a response.
- Mr Alwitry does not use patient safety as an issue or argument in:

- Letter to the other Ophthalmology consultant and the hospital managing director on the 26/11/12
- Letter to the Minister for Health on the 28/11/12 – he lays all of the cause for the events on being pressured by his wife to know his timetable as she is required to tell a prospective GP practice what days she would be able to work.
- Letter to the Medical Director on the 30/11/12 – stating that he recognises he allowed family and personal reasons to influence his timetable negotiations that he should have put aside.

- Mr Alwitry is clearly supported by his wife (a doctor) and his father (a doctor) and other colleagues and acquaintances, again the patient safety issue or argument was not evident in any of their supporting correspondence:
  - Letter from Mrs Alwitry to the joint medical directors, hospital managing director, health minister, clinical director and the director of operations.
  - Letter from Mr Alwitry senior to the Chief Executive Officer for Health
  - Supportive letters x 10 sent to the health minister
  - Letter from 2 States members who had been in discussion with the family, made comments that were clearly as a result of this discussion but did not include patient safety.
  - Letter from a previous consultant colleague that did not reference patient safety.
- To claim that this was all about patient safety does not ring true as a major issue when:
  - In the email with the Medical Director on the 27/11/12 he stated, upon learning the clinical director had not altered the timetable, ' fair enough'. He also stated 'I'll agree to whatever timetable/measures/restrictions you guys want'.
  - In an email to the clinical director on 27/11/12 he stated 'I can assure you that I never ever deemed any timetable unacceptable'.

Complex Case and Other Activity:

- Jersey only has a population of 100,000 and this would be well known to Mr Alwitry as he was brought up on the island, had worked here as a locum, and his father was a Jersey Ophthalmologist.
- This small population would not generate the levels of complex cases that Mr Alwitry would have experienced in Derby which serves a population of 600,000.
- According to hospital data sources **the number of trabeculectomies undertaken in Jersey since 2012 has not exceeded eight in any one calendar year**
- With a specialist on island this is likely to rise but clinical estimates does not put this beyond 20 in any one year.
- A trabuleculetomy is a planned , non-emergency procedure that is completed as a day case
- **A data report shows a further average of 65 patients per year with a co-morbidity of 'glucoma'**
- There are approximately 1000 ophthalmology procedures undertaken per year between all the Consultants ie c330 each – making Mr Alwitry's complex cases about 25% of his overall caseload.

Returns to theatre:

- It is believed that none of the previous Jersey trabeculectomies returned to theatre in the 24 hours post-operation period. Indeed, it is extremely rare for any ophthalmology patient to return to theatre in the immediate post-operative period.
- Mr Stephen Vernon, Consultant ophthalmologist confirmed in a letter submitted by Mr Alwitry "serious complications are now very rare…"
- Both 'expert' Consultants submitting reports in support of Mr Alwitry state:
  - Mr Vernon – "it is ideal for them (theatre sessions) to be early in the week with the second list either the next afternoon or the following day.
  - Mr Kiel – "this is highly desirable and certainly the safest approach, however my feeling is that it is not essential and should be guided by organisational capacity."

Post-Operative reviews:

Royal College of Ophthalmologist guidelines state that routine cataract cases (largest Jersey workload by volume) do <u>not</u> require a day 1 post-operative checks. Complex cataracts, including glaucoma patients, should as good practice, be reviewed on the day following surgery. This is supported by Messers Vernon and Kiel.

This would be a small proportion of Mr Alwitry's surgical case mix, but should be accommodated.

Friday Operating

Operating on a Friday is common place here and across the NHS, all of HSSD theatre sessions are utilised on a Friday across a variety of specialties. Post-operative care varies by specialty with day-case patients being told whom to contact should they experience problems and in-patients being reviewed by the surgical teams (at Consultant and/or junior level).

Friday operating would be considered a safety risk by most Consultants, in most specialties, if this were the only day they had access to theatres.

Patient Safety – specific to surgery

All surgery carries some risk. The risks associated with glaucoma surgery and most ophthalmology surgery are low and comparatively rare. There are no dedicated in-patient ophthalmology beds as the vast majority of surgery is carried out as day case procedures, this is common practice.

Despite the above HSSD have a 24/7 Ophthalmologist on call. Should a trauma case present to the emergency department or a patient present with any post-operative complications there is an on call ophthalmologist available to assess the patient. There are 4 ophthalmologists that work on a rota and would see each other's patients if that was required.

Did the Timetables proposed meet Mr Alwitry's patient safety requirements?

Mr Alwitry was expected to provide both clinics and operating sessions as part of his public job timetable. The job description proposed 4 clinics and two theatres sessions per week.

On 24/09/12 the Clinical Director outlined a revised (from the job description) proposed timetable for Mr Alwitry. This consisted of:

Day	AM	PM
Monday	Clinic	Off in lieu of on call
Tuesday	Theatre	Clinic
Wednesday	Admin/Prof development session	Admin/Prof development session
Thursday	Clinic	Clinic/Theatre (alternate wks)
Friday	Theatre/Clinic (alternate wks)	Off in lieu of on call

Plus a 1 weekend in 4 on call commitment where presence on island and rapid availability is required.

Workable options for post-operative follow-up:

Do complex work on the Tuesday theatre list and make himself available on the Wednesday to check post-operative patients (1-2 per week) – not ideal as interrupts admin/professional development session.

Could do some complex cases on the Friday list when he is due to be on call on the following Saturday to follow them up – not ideal but workable

Do complex cases on Tuesday theatre list but only when another consultant is away and it releases a clinic space for the post-operative reviews – workable

Continue to work with colleagues to re-look at the collective timetable once in post – especially as it was known that one of the Consultants intended to retire within the year - workable

And/Or

Do only routine cases on Tuesday theatre list and do complex cases on alternate Thursday theatre lists and review them in the Friday morning clinic – workable.

There was not a single iteration of this timetable that suggested that Mr Alwitry would only have access to theatres on Fridays. Therefore he **always** had the opportunity to schedule his complex glaucoma patients on a day other than Friday.

Workable options for returns to theatre:

Jersey has a staffed emergency theatre available 24/7 so any emergency return could be accommodated, accepting that this would not involve the specialist ophthalmology theatre team. The specialised ophthalmology team run theatres on a daily basis so in urgent situations it is likely that staff could be released and utilised. For such rare occasions this would be an acceptable solution.

Alternatively a Trabeculectomy undertaken on a Tuesday could return to theatre if required on the Thursday, something deemed acceptable by Messers Vernon and Kiel.

More Concerning Patient Safety Issue:

On-call, weekday

A weekday on call is from 8am to 8am, a 24 hour period. On call Consultants must be available to take phone calls, give advice and attend hospital to assess and treat urgent and emergency cases.

Mr Alwitry makes reference to his on-call day in some of his emails. He was allocated Thursday but did not want this as he would have to undertake a post on call ward round/review on the Friday morning and he was hoping to have left the island on Thursday evening to spend the long weekend with his family especially as he was the children's carer on Fridays.

He suggests that Monday would be better if he could persuade his colleagues to swap their on calls around. However he also suggests in an email that he would like to start any Monday morning clinic later than normal to facilitate a return to the island on the Monday morning rather than on the Sunday. It is pointed out to him that it would be inappropriate to be on call when not available to take telephone calls or respond in person to urgent and emergency cases due to him travelling. The fact that Mr Alwitry suggested this is extremely concerning as this **would definitely** have introduced a highly significant patient safety risk.

Conclusion:

Mr Alwitry had valid views about the follow up of his complex glaucoma patients and about operating on complex patients on a Friday – however these issues were addressed by the proposed timetable and by Mr Alwitry himself. Therefore there was no outstanding patient safety issue for any of the senior staff involved to resolve or to escalate.

There is no compelling evidence to support Mr Alwitry's claim that he has been penalised due to raising patient safety concerns and that his only motivation was to ensure a safe service. He did not raise his ongoing concerns with the appropriate people (medical directors, hospital managing director) during the negotiations or use patient safety in the post contract withdrawal period, neither did his supporters who were both close to him and clinically knowledgeable.

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

January 2010

Verita
53 Frith St
London W1D 4SN
Telephone **020 7494 5670**
Fax **020 7734 9325**
Email enquiries@verita.net
Website www.verita.net 3

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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***

- 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.

- 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.

- 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.

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.

- 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***

- 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.

- 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 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***

- 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***

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***

- The senior management team should implement the outcomes of the staffing review so as to ensure safe levels. ***Urgent***

- 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***

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.

- 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.

- The clinical lead should use the Royal College of Obstetricians and Gynaecologists (RCOG) dashboard annually to monitor the „health" of the department.

- 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***

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. 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. 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***

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.

- 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***

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

- 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.

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.

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.

- 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.

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

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***

- 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.

APPENDIX 8 to P.137/2016 Com.

A TYPICAL YEAR'S ACTIVITIES FOR THE STATES EMPLOYMENT BOARD (2015)

1. Number of meetings

1.1. In 2015, there were 23 meetings of the Board, of which three were conducted by electronic e-mail.

2. A summary of key matters considered by the Board in 2015

2.1. Public Sector Reform and Workforce Modernisation

.

The Board gave continued attention to the employment considerations arising from the Reform of the Public Sector and the Workforce Modernisation programme.

i. The Board recognised the significant contribution made by the Trades Unions and Staff Associations in engaging with the Workforce Modernisation programme, which had seen their representatives working constructively with the Employer. The Board recognised the positive foundations for partnership working that had been laid by the Collective Bargaining Framework, and the Joint Council for Public Sector Unions and Associations.

ii. The Board considered regular update reports regarding Workforce Modernisation including proposals for the Reward Strategy for States employees and progress on Job Evaluation and the Terms and Conditions/ Policy work stream. The Board remained committed to the principles of fairness and equity that were being applied in the new Reward Framework.

2.2 The Board considered a number of issues regarding pay.

i. With regard to the 2015, Pay Negotiations the Board remained committed to maintaining dialogue with employee groups. The Board considered matters relating to budgetary arrangements for pay awards given the constraints of the financial challenges facing the States.

ii. The Board received reports and considered matters relating to the pay of doctors.

2.3 Pensions

i The Board received reports on and considered a number of matters in relation to Pensions, Public Employees Contributory Retirement Scheme (PECRS) and the Jersey Teachers Superannuation Fund (JTSF).

- General Pension provisions
- Admitted Body Status Applications
- Amendments to regulations
- Care Scheme proposals

ii In considering future pension proposals the Board received regular updates from the Treasurer of the States, the Pensions Project Director and the Negotiator for pensions provisions on behalf of the Joint Negotiating Group. The Board noted the package of measures proposed by each side in the negotiations regarding the CARE scheme.

iii The Board approved nominations to the Committee of Management for JTSF.

Iv the Board considered a number of proposals for new pensions legislation and amendments to existing regulations. These included:

- The Draft Public Employees (Pensions) (Jersey) Law 201-.

2.4 Pay & Remuneration over £100,000 (P59/2011)

ii Following presentation and endorsement by the States Assembly of P59/2011 entitled, the Board received a number of applications for appointments to be made where the remuneration for the post attracted a salary of over £100,000. (The report on P59 applications is appended to this document).

1.5 Public Sector Salaries

1.5.1 The Board endorsed a report for presentation to the States Assembly entitled 'Remuneration of States Employees: 2015', which was incorporated into the States of Jersey Financial Report and Accounts 2015.

1.6 Jersey Appointments Commission

1.6.1 The Board endorsed the terms of office for membership of the Commission in accordance with Article 18(2) of the Employment of States of Jersey Employees (Jersey) Law 2005 enabling the appointment of a new Commission Chair Dame Janet Paraskeva.

1.6.2 The Board received the Annual Report of the Commission and agreed that the Chief Minister should present the finalised report to the States Assembly.

1.7 Health and Safety

1.7.1 The Board received a Corporate H&S Performance and Activity Report that showed an overall improvement in health and safety management performance across the States.

1.7.2 The Board received a report regarding the management of Legionella in the Health and Social Services Department and noted the actions that had been taken.

1.8 Voluntary Release Schemes

1.8.1 The Board received approved and received regular updates on the 2015 Voluntary Release Scheme being cognisant of the need for savings.

1.8.2 The Board approved the opening of a further voluntary release scheme for 2016

1.9 Suspensions and the Memorandum of Understanding

1.9.1 The Board received reports from the Suspension Review Panel.

1.9.2 With regard to the Memorandum of Understanding (an agreement to review persons excluded or suspended from duty as a result of potentially concurrent internal disciplinary and criminal investigatory procedures), the Board noted continued use of this forum as an effective and appropriate means of reviewing and managing such cases.

1.10 Codes and Policies

The Board noted the review of a number of policy matters these included:

i. Good Practice Guide: transfer of Public Service Employees
ii. Serious Concerns
iii. Special Leave
iv. Safe recruitment

3. Miscellaneous Matters

3.1. The Board considered a number of miscellaneous matters, including the following:

i. Graduate Training programme
ii. Succession Planning
iii. Staff retirements
iv. Remuneration for the post of Attorney General
v. Various employment matters

4. Key Manpower Statistics

Headcount (the number of people actually in post as at 31st December 2015)

Changes to internal HR Reporting parameters will now include staff covering periods of absence, as well as the following departments:

- Jersey Car Parks
- Jersey Fleet Management
- Non Min SFB-Overseas Aid
- States Assembly

Department	Headcount
Chief Minister's Department	233
Department of the Environment	115
Economic Development	30
Education, Sport & Culture	2,133
Health & Social Services	2,625
Home Affairs	662
Non Min SFB-Overseas Aid	2
Non Ministerial States Funded	235
Social Security	252
Transport and Technical Services	439
Treasury and Resources	240
Sub Total (1)	**6,966**
Less employees with a role in more than 1 department	**-25**
Sub Total (2)	**6,941**

Trading Bodies	Headcount
Jersey Car Parks	16
Jersey Fleet Management	26
Sub Total (3)	**42**

Grand Total	6,983

Assumptions:

All figures have come from the central HRIS (Human Resources Information System), the above figures do not include the following departments:

- Jersey Ports
- Housing

The above departments are not included as they have now incorporated into private companies.

"Licensed" category employees (the number of employees, as at 31st December 2014, with a 'licensed' category housing license (previously 'JJ')):

Staff Grouping	Headcount
Civil Servants	136
Energy From Waste Operations	1
Health & Social Services	311
Education	88
Uniformed Services	7
Others	14
Grand Total	**557**

Non-locally qualified employees (the number of employees as at 31st December 2015, non-locally qualified under the Regulation of Undertakings and Development (Jersey) Law 1973):

68 or 1.0% of the reported Headcount above.

Sickness Absence 2015

Percentage of total possible days lost to sickness absence	3.8%
Average number of days lost to sickness per employee	8.4
Ratio of certified to uncertified absence	70.8% / 29.3%

Attrition (Turnover) 2015
(The movement out of established posts)

Internal Movements (between States departments)	1.1%
External movements (leaving States employment)	10.9%
Total Attrition during 2015	12.0%