Executive Summary

This report presents the outcome of an independent review into the handling by the Health and Social Services Department, Guernsey (HSSD) of issues relating to the clinical practice of Dr Rory Lyons, a medical practitioner based in Alderney, between February and April 2015.

The review, jointly commissioned by the Policy Council of the States of Guernsey and the Policy and Finance Committee of the States of Alderney, and undertaken by the Good Governance Institute (GGI), consists of an assessment of the sequence of events, an analysis of the processes, procedures, governance arrangements relevant to those events, and an assessment of conclusions and recommendations for action.

The report refers to "the events" as a shorthand term covering the escalation from receipt of the initiating complaint about acute deterioration of a patient at end-of-life in the Mignot Memorial Hospital (MMH) on 24 and 25 February 2015, to the high-profile arrival of the police and HSSD on Alderney on 2 April 2015 to execute a warrant in relation to Dr Lyons relating to the death of four patients. The review is limited to this period only and does not cover subsequent events relating to the practice of Dr Lyons, the General Medical Council (GMC) and the police. It should be noted that Dr Lyons has not been suspended from practice.

We are mindful that a number of matters referred to remain part of active and on-going formal processes that lie beyond the remit of the report.

Scope, methodology and context (Section 1)

Our approach combined a comprehensive document and desktop review, and structured interviews with key participants in the events, conducted mainly in Guernsey and Alderney between August 2015 and November 2015.

A detailed timeline has been created in order to identify key events, decision-points, processes and procedures. Evidence was sought from as many sources as possible in order for us to assess whether judgements, decisions, and action taken, could reasonably be regarded as proportionate and soundly-based. We have sought to place the review, where appropriate, in the context of wider interests and issues relating to the provision and regulation of health and care services in the Bailiwick.

The review team followed a process of fact checking during the final drafting of this report. Comments on accuracy and further triangulation of evidence have been received and noted, and given due consideration where relevant in the report.

Timeline and sequence of events (Section 2)

The review considered nine main events and processes in detail:

- a **verbal complaint** received from a relation concerning the death of a patient (patient X) in MMH
- a **first formal referral to the General Medical Council**
- a **Serious Incident (SI)** initiated following a review of the medical notes relating to the one death in hospital covered by the patient complaint. This related to concerns over the management of the acute deterioration of a patient at end-of-life by hospital staff and by the medical practitioner
- a **human resources** process relating to the nursing staff involved and subsequent suspension of staff. (Dr Lyons as a private practitioner lay outside HSSD's employment and direct jurisdiction)
- a **second formal referral of professional issues relating to Dr Lyons** to his relevant regulatory body (GMC) with patient safety concerns brought informally to the attention of the police by HSSD
- **service changes** made to suspend the right to practice by Dr Lyons in the MMH and to manage the implications for patients affected
- a **retrospective audit of medical notes** undertaken by HSSD into deaths at MMH in 2014-2015

- a subsequent **due diligence** process in relation to a further three patient-related cases felt to be of concern by HSSD
- a **formal statement to police** made by HSSD's Interim Medical Director on 30 March 2015

Analysis (Section 3)

The review report includes a detailed assessment of the following lines of enquiry:

- whether correct policies and procedures were in place and followed in relation to complaints handling, investigations, and management of serious incidents
- whether leadership roles and responsibilities were clear and fulfilled effectively
- whether robust processes were used to validate data and information on which key decisions and judgements were made
- whether all reasonable risks and options were identified and appropriate choices and alternatives explored
- whether effective internal and external communication was maintained, official notification and reporting protocols were followed, and reasonable expectations for inclusion and involvement by others met
- whether principles of good governance were followed and any relevant legal and statutory obligations met in full by the HSSD Board and its officers

This allowed the review to arrive at an overall set of conclusions, to record areas of positive practice and to identify issues where improvement action was recommended.

Conclusions (Section 4)

Our high-level conclusions are as follows:

HSSD acted swiftly to address a series of complex issues relating to patient safety in Alderney, and to the practice of Dr Rory Lyons, between February 2015 and April 2015.

The review confirms that HSSD made the appropriate judgement in treating the specific concerns about treatment and care as serious matters requiring proper investigation. However, there is clear evidence that HSSD failed to establish an objective, properly-documented and auditable evidence-base about the nature and scale of the professional and public safety concerns it sought to address. Although appropriate initial contact was made with the General Medical Council (6 March 2015), the subsequent formal raising of concerns, and a formal statement made to the enforcement authorities (30 March 2015), were not at that time supported by sufficient weight of evidence to justify them, in the view of the review team.

The review finds that HSSD did not pay sufficient attention to a number of important aspects of context, assurance, due diligence and risk assessment, in the way that it would have reasonably been expected, at key points in the development of events.

The course of events, and especially the increasing pace of response, was directly determined by judgements of senior staff, in several key instances working outside due process.

The conclusion of the review is that, although HSSD officers acted with speed, the handling of events was progressed without sufficient consideration of all relevant factors, and must ultimately be seen as neither sufficiently proportionate nor soundly-based.

We identify seven positive conclusions relating to the handling of events by HSSD on the escalation processes, on human resources issues, and on the reporting of professional concerns. These include, that HSSD senior officers acted swiftly to address what they genuinely regarded as patient safety issues of serious concern; that the formal complaints procedure was followed properly; and that human resources procedures relating to the suspension and reinstatement of HSSD employees were used appropriately.

The report, however, also identifies a number of issues of concern where we believe action is needed. These can be summarised as:

Leadership and culture

- events escalated too quickly in a climate of pressure to act
- over-emphasis on perceived immediate patient safety concerns at the expense of necessary due diligence processes
- lack of clarity and separation of leadership roles and responsibilities
- insufficient consideration given to contextual issues, including the impact in Alderney
- failure to inform and involve the relations of each of the deceased properly
- lack of effective working with other agencies
- shortage of managerial time and resources available for implementing clinical governance

Standards and governance

- standards of evidence-gathering and due diligence below expected standards
- insufficient reporting to the Board
- poor formal record-keeping
- Board unable to exercise governance function over clinical issues

Procedures and protocols

- Serious Incidents not formally recorded or handled in accordance with consistent procedures
- clinical governance procedures incomplete and accountabilities for reporting unclear
- SI processes undermined by formal referral to professional regulatory body and police
- second formal referral to the GMC initiated (30 March 2015) without, in the view of the review team, sufficient supporting information
- statement to police by HSSD informed by flawed due diligence process
- inter-agency engagement poor and hurried

Recommendations and observations (Section 5)

We make nine firm recommendations within three broad categories:

Leadership and culture

1 A clear process of open public engagement and dialogue should be established to focus on the way forward for health services in Alderney – their organisation, quality, cost and sustainability – putting citizens at the heart of the process.

2 An independent audit should be commissioned of the prevailing culture within HSSD to ensure it is fit for purpose.

3 The HSSD structure should be revised with immediate effect to include a distinct Senior Operating Officer role within the senior leadership team, and managerial capacity and skills for clinical governance should be assessed and if needs be supplemented.

Standards and governance

4 The programme for Board development in 2016 should include sessions which increase the ability, confidence, and knowledge of Board members in exercise of proper governance in relation to clinical risk issues.

5 A schedule of standards of evidence, which would be required to be met at each stage of all investigations and audit processes, should be formally adopted by the HSSD Board in 2016, for use across its whole area of responsibility.

6 HSSD should secure a settled route to independent clinical and expert advice and support for investigations, clinical competence reviews and other sensitive issues.

7 A definite date must be set in early 2016 for the implementation of a fully-operational suite of clinical governance policies and procedures covering health and care services across the States of Guernsey and the States of Alderney.

Procedures and protocols

8 Procedures for responding to a Serious Incident relating to patient safety or health-related issues should be strengthened by addition of a multi-agency Incident Task Force as soon as possible in 2016.

9 Protocols and procedures for inter-agency working should be reviewed and strengthened or, if absent, put in place.

In addition, we make related observations about reporting to regulatory bodies and concerns relating to trust that emerged from the review, which we believe should also be addressed.

We would like to thank everyone who helped us arrive with confidence at our clear, independent, and collective view. We have respected the confidentiality of those who expressly asked us to do so.