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Deputy Fergus O'Dowd
Dáil Eireann
Leinster House
Kildare Street
Dublin 2.

PQ 31717/23 - To ask the Minister for Health with respect to the "Emily" case and the NIRP independent review which was carried out and completed in November 2022, if the community health organisation which the CNU was located in, carried out any separate reviews or reports into the grievous incidents that took place at the home; if so, if he will undertake to make any review/report public in order for the appropriate bodies to learn from this horrendous series of events; and if he will make a statement on the matter.

PQ 31718/23 - To ask the Minister for Health with respect to the "Emily" case and the NIRP independent review which was carried out into an unnamed HSE community nursing unit following a grievous sexual assault which took place in the CNU in April 2020, if he plans to publish the report which was completed in November 2022 in order for stakeholders and service providers to learn from the very serious incidents which took place, including the recruitment processes of the facility, the safeguarding processes which failed in this home, and the wider governance issues; and if he will make a statement on the matter.

PQ 31724/23 - To ask the Minister for Health with respect to the "Emily" case and the NIRP independent review which was carried out and completed in November 2022, if he can confirm whether the HSE has accepted the recommendations contained within the report in full; if not, if he can detail the reasons for same; and if he will make a statement on the matter.

PQ 31838/23 - To ask the Minister for Health regarding the HSE nursing home in which an employee was convicted of raping a resident, to clarify the number of referrals made by the HSE to An Garda Síochána following the public statement by the CEO of the HSE on a radio programme (details supplied) in relation to this; and if he will make a statement on the matter.

- **Fergus O'Dowd**

Dear Deputy O'Dowd,

The Health Service Executive (HSE) has been requested to reply directly to you in the context of the above Parliamentary Questions, which you submitted to the Minister for response.

The HSE undertook two separate investigations following a serious sexual assault on a resident (pseudonym Emily) at a HSE community nursing unit in April 2020. These investigations were undertaken respectively by the National Independent Review Panel (NIRP) and the relevant local Community Healthcare Office (CHO) Safeguarding Team. Both had a different purpose.

1. The National Independent Review Panel (NIRP) reviewed the circumstances surrounding this incident including the response and follow-up action of staff at the unit at that time. NIRP also looked at the governance arrangements in the unit to identify any learning or opportunities for improvement that could lead to improved safety of all residents at this unit and residential facilities across the country.

2. The safeguarding review, which is a case management approach was undertaken to identify if any further reportable incidents may have occurred, and to ensure that any such incidents were dealt with in line with the HSE Safeguarding Vulnerable Persons at Risk of Abuse policy. 21 files in addition to Emily met the safeguarding threshold for referral to the Gardai.

The HSE is mindful of our legal and ethical duty to protect the confidentiality of those we provide care to and also to respect families. Arising from the trial there is an order prohibiting the identification of Emily and of the nursing home concerned. These orders are important. The HSE CEO has communicated publically that we will publish the summary report of the NIRP and the recommendations of our own safeguarding team in a way that balances this confidentiality with the need to openly demonstrate how this devastating crime took place and to learn from this so as to help us better protect those in our care in the future.

The HSE continues to publicly state our most sincere apologies to Emily's family as it is important to recognise that we also failed them, as well as the other families whose loved ones were resident in this unit and whose files were examined. The HSE want to assure these families and indeed all families that the HSE is fully committed to safeguarding all people in our care and it is clear we have much to do in fulfilling this undertaking. The HSE continues to work through each of the reports recommendations and has a plan in place to implement them.

The Deputy will likely be aware that the HSE CEO, in order to ensure that we fully understand all of the issues relating to this case has appointed an external safeguarding expert to review both of these reports, conduct their own enquiries and advise if a further examination of individual records is required to identify past harm. Also, in order to get a better understanding of the wider issues relating to safeguarding and possible options for its future development, this external reviewer has also been asked to undertake a high-level review of the HSE safeguarding policy and procedures and structures. This work will recognise that the HSE has roles in safeguarding in both the community and alternative care settings for adults. Both pieces of work are intended to be published.

I trust this information is of assistance to you.

Yours sincerely,

Yvonne O'Neill
National Director
Community Operations