Seirbhís Míchumais
FSS Bhalle Átha Cliath Theas agus Cill Mhantáin

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06th June 2025

John Brady TD,
Dáil Éireann
Leinster House
Kildare Street
Dublin 2

Re: PQ Ref 26821.25: " To ask the Minister for Health when an external investigation is commissioned by a service provider or state agency into the care and safety of vulnerable persons; the standard process for disseminating the investigation's outcome; whether this process is explicitly defined in the terms of reference; specifically the body that must receive the final report; whether the terms of reference should clearly state the expected recipients of the report to ensure transparency and accountability; the mechanisms in place to ensure the findings are acted upon"

Details Supplied: Received on 23/05/2025:
DOH officials have clarified with the Deputy's office that the focus of this question relates to standard processes relating to investigations relating to HSE & HSE-funded adult disability services so HSE response is appropriate. For information, while the question relates to standard processes, it is asked against the context of a (presumably recent) specific investigation relating to adult disability services provided by Sunbeam House Services, Bray.

Dear Deputy Brady,

Thank you for your recent correspondence. The Health Service Executive has been requested to reply to you in the context of the above Parliamentary Question. I have examined the matter and the following outlines the current position.

For HSE-funded agencies, as set out in the service agreement for section 38 agency 2025, part I & II, under the Health Act 2025, it clearly states that these agencies should comply with the HSE Incident Management Framework (IMF) (2020) and have systems and processes for monitoring the quality and safety of their services.
As per clause 24.3 the Provider will work to enhance Service User safety through systems in order to identify and learn from all Service User safety and other reportable incidents. They will make improvements in practice based on information derived from the analysis of incidents both locally and from national experience.

As per clause 24.12 the Provider shall comply with the HSE Enterprise Risk Management Policy and Procedures (2023) and the HSE IMF (2020).

Where a service provider or state agency commissions an external investigation into the care and safety of vulnerable persons and the investigation forms part of a patient safety incident review, the Terms of Reference should specify that the review is being conducted under the HSE IMF 2020.

In accordance with the IMF 2020 and its supporting policy documents, the Terms of Reference should include the appointment of a Service User Designated Support Person and a Staff Liaison Person. These roles are in place to ensure clear, compassionate, and appropriate communication throughout the course of the review with both the service user/relevant person and the staff involved.

While the Framework does not mandate that the Terms of Reference list all recipients of the final report, it does state within the Systems Analysis Methodology guidance that the draft report should be shared with staff and service user(s) involved in the incident for factual accuracy checking in compliance with fair procedures and natural justice as outlined in the IMF 2020. The provision of the final report is done in a supportive manner with the staff and service user(s) and/or their family, where appropriate, as per the IMF and the HSE Open Disclosure Policy.

If a specific investigation review was undertaken by National Independent Review Panel (NIRP). NIRP guidance is underpinned by the IMF 2020, and the same approach of fair procedures and natural justice applies.
NIRP complete reviews when commissioned by the HSE's National Clinical Director, Quality Patient Safety Directorate and a level of independence is required.
This is usually 'Category 1 incidents', where a very high level of independence is required.

Some examples of the work they do:

- Conduct independent reviews across community health and social care
- Review cases where it is suspected that there are failings that have led to harm or compromised quality of life
- Determine what the relevant services and individuals involved in the case might have done differently
- Report on the findings, conclusions and key recommendations on each review to the Chairperson of the HSE's Safety and Quality Committee and the HSE Board Committee.
- NIRP request that report are treated as confidential. NIRP do not publish reports nor communicate them publicly. To ensure learning is disseminated nationally they produce an annual report and analysis of the cases investigated

The IMF states that it is the responsibility of the Senior Accountable Officer to ensure that an action plan to support the implementation of recommendations made as a consequence of the review is developed. From a governance and oversight role, the HSE as funder of services to SHS, recommendations and associated actions arising from external reviews are monitored through local governance systems such as Integrated Management Review meetings.

I trust this information is of assistance to you.

Kind Regards,

Patricia McEvoy
Head of Services
Disability Services