August 2023

ADULT SAFEGUARDING REVIEW

PROFESSIONAL ADVICE TO THE CEO THE HEALTH SERVICE EXECUTIVE

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1.0 Background

1.1 In 2020, a female resident pseudonymised as ‘Emily’ who lived in a community nursing home, reported to staff that she had been raped by a male member of staff. This allegation was reported to An Garda Síochána (AGS) who arrested the alleged perpetrator. A male health care assistant, pseudonymised as Mr Z was subsequently convicted and received an 11-year prison sentence on 30th July 2020. The Trial Judge imposed a restriction so that ‘Emily’ and the Nursing Home cannot be named publicly, nor could any information be published which could lead to the identification of ‘Emily’ or the nursing home.

1.2 The HSE commissioned the National Independent Review Panel (NIRP) to complete an independent review of the governance arrangements within the nursing home and a safeguarding review to identify whether there had been further incidents or victims of abuse as a direct result of the actions of Mr Z.

1.3 On 3rd July 2023, an independent external reviewer was commissioned by the Health Service Executive to provide professional advice in respect of two elements of work. The term of reference for the work are as follows:

1. **To review the relevant reports ‘Emily’ (specifically NIRP, CHO Safeguarding, NIRP Summary) and conduct any engagements necessary to advise the HSE CEO on the specific question as follows;**

- **Based on the material available and considering best practice is a further examination of individual records warranted such as would likely identify past harm and if so is that examination limited to particular scope and time or full lookback. Report 6 weeks from start.**

2. Against the backdrop of the examination but not limited to that, to conduct a high level review of the HSE safeguarding policy, procedures, structures and advise the CEO on possible options for the future of safeguarding recognising that the HSE has roles in safeguarding in both the community and alternative care settings for adults. Report 16 weeks from start.

This report relates to Part 1 of the Terms of Reference.

2.0 Methodology

- Background reading on adult safeguarding in Ireland to understand the local context.

- Review of Adult Safeguarding Review Report (the “CHO Safeguarding” report referred to in the Terms of Reference) and the NIRP Report.

- Review of relevant research particularly learning from serious case reviews in adult safeguarding.

- Visits over two days to the nursing home in which ‘Emily’ resided, to talk to management, staff and residents and observe interactions within the home.

- Discussions with authors of the NIRP report and the Adult Safeguarding Review Report to understand their findings and learn from their experience.

- Discussions with HSE senior management.

- Invitations were sent to current and former staff from the nursing home and individual meetings were held.

- An invitation was also extended to families known to have been affected. A meeting was organised with family representatives, written submissions were received and the reviewer was also provided with information that families who are currently attending meetings with the HSE management requested to be brought to my attention.

- Meetings were held with a range of stakeholders to understand the structures and processes in place for adult safeguarding.

3.0 The Nursing Home

3.1 Adult safeguarding is not a separate entity, it sits within the context of culture, leadership, environment and quality of care. During a visit over two days, the interim Director of Nursing presented as open and transparent, both in discussions and in the freedom that I was afforded within the unit.

3.2 The environment of the Home appeared warm and friendly and visitors of residents and professional staff from outside the unit seemed to come and go readily. There is a waiting list for admission to the Home. I heard that there is an emphasis on opening the unit to the community both through its day care arrangements and introducing art and music activities from external providers for the residents. Safeguarding is a regular item on the team meeting agenda and I heard that preliminary screenings submitted to the local safeguarding team remain relatively high. This is a positive indicator that staff are more aware and vigilant of forms of abuse and higher levels of reporting at this time is a normal response in the aftermath of Mr Z's conviction.

3.3 The NIRP report states that the NIRP Review Team "*were particularly struck by the trauma experienced by many of the staff and managers in the Nursing Home as a result of the actions of Mr Z. Firstly everyone was shocked and appalled at what happened to Emily whom they loved as a valued resident of the Nursing Home. Secondly many of them appeared to experience secondary trauma expressing feelings of guilt and shame at what happened*".[1] It was clear from the time spent in the Nursing Home and from discussions with former and current staff that the events of 2020 continue to have a lasting impact.

3.4 In recent meetings with management of older people services, it was reported that there have been ongoing service improvements since 2020, including new developments to the record management system, training, environmental changes to the building and enhanced staffing at night.

[1] National Independent Review Panel, Independent review of the governance arrangement in an HSE Nursing Home, February 2023, Executive Summary

4.0 Review of previous reports

NIRP Report

4.1 When Emily's disclosure came to light, the HSE acted quickly to commission a review of governance arrangements so that the system could learn from the tragic events that occurred and improve the systems that would identify and minimise the risk of such abuse occurring again.

4.2 The NIRP examined the culture, practice and governance of the Nursing Home to try to understand how this could have happened in a home which is reported as being well thought of within the community. The NIRP have concluded that:

- *Mr Z had established an 'innocent' profile of himself*
- *He had knowledge of the physical environment, the residents' profiles and the monitoring systems*
- *He had knowledge of the practice of interpreting allegations within a medical/clinical framework*
- *There is a prevailing culture of disbelief that sexual abuse could occur in a care setting for older people.*

They highlight the fact that sexual predators are often able "*to manipulate and groom staff and management into believing that they are not a threat to anyone".*[2]

4.3 The NIRP made nine recommendations for improvement including review of the model of care within community nursing homes, record keeping, training and staff awareness, rotation of staff, crisis response plan, interface with AGS and resourcing of Adult Safeguarding Teams.

4.4 Although the report was specific to the community nursing home in which 'Emily' resided, implementation of the recommendations will be applicable to nursing

[2] National Independent Review Panel, Independent review of the governance arrangement in an HSE Nursing Home, February 2023, Executive Summary

homes across the HSE. Although good clinical care is important, first and foremost such facilities are the person's home. Care should be provided in a holistic way that supports companionship, mental stimulation and a sense of safety in addition to health and care needs. This is relevant as the NIRP found that incidents or allegations made by residents were often viewed through a clinical lens which explained their causation within the context of the person's dementia and health, rather than wider considerations such as the possibility of abuse.

4.5 There is also learning for all services who work with older people because at its core, the NIRP report highlights a societal failure to see older people as sexual beings to whom sexual abuse may occur. *"This issue runs much deeper than just training and speaks to a general societal disbelief that sexual abuse does not happen to older people."*[3]

Safeguarding Review

4.6 The HSE Chief Officer of the area also commissioned a safeguarding review.

The Terms of Reference state that "*This safeguarding review will seek to identify if any further reportable incidents of a safeguarding nature have occurred and to ensure that any such incidents if they occurred have been dealt with appropriately in line with the HSE's Safeguarding Vulnerable Persons at Risk of Abuse, National Policy 2014."*[4]

4.7 The initial terms of reference for the review were approved by members of the Serious Incident Management Team (SIMT) in September 2020. They were subsequently revised in July 2021. However the review methodology remained substantially unchanged.

4.8 The Safeguarding Review was conducted in a phased approach (cohort 1 - 4), the first cohort related to 79 residents. It was agreed that the outcome of the review of the 79 files would determine whether it was necessary to review

[3] National Independent Review Panel, Independent review of the governance arrangement in an HSE Nursing Home, February 2023, Executive Summary

[4] Terms of Reference, Safeguarding Review of a HSE Community Nursing Home, July 2021

further cohorts of residents who had been in receipt of services. Decisions about moving onto the next cohort would be based on the rationale of thoroughness and proportionality.

. 4.9 The Safeguarding Review Team consisted of experienced social workers in adult safeguarding and an external expert in assessing sexual offending and risk analysis was commissioned to advise and support the work of the team. The Safeguarding Review team commenced its work in October 2020 and completed in November 2021.

4.10 Social workers examined 32 resident files during the timespan of the safeguarding review and found that 21 were required to be submitted to AGS in line with Criminal Justice (Withholding of Information on Offences Against Children and Vulnerable Persons) Act 2012. This is in addition to 'Emily' who had previously been submitted by the Nursing Home lead nurse.

5.0 Reflections

5.1 During the last six weeks, I received both oral and written submissions from families and staff who had been affected by the actions of Mr Z. Differing views were expressed, some wondering about the purpose of reopening records given that it is unlikely that the outcome will result in further prosecutions, others calling for a full, open and transparent investigation.

5.2 In determining whether a further examination of records is warranted I was cognisant of the findings of the Safeguarding Review. In particular,

- That 21 of the 32 records reviewed were submitted to AGS.
- That the indicators of potential abuse that the Safeguarding Review Team noted from their review of individual records were in line with those described within the HSE Safeguarding Vulnerable Adults at Risk of Abuse Policy.[5] That does not mean that abuse has been proven but that there were "grounds

[5] HSE Safeguarding Vulnerable Adults at Risk of Abuse Policy , National Policy and Procedures 2014

for reasonable concern" which require further investigation and were submitted to AGS.

5.3 Given these findings it is highly probable that if a further examination of residents' records were conducted, further indicators of possible harm will be found.

5.4 The safeguarding review ended before all the files identified in cohort 1 could be reviewed and it is my opinion that this was a missed opportunity as the file review could have provided timely information on the nature and extent of possible harm caused to residents and whilst pertinent information relevant to the findings was still fresh in the minds of staff, residents and families.

5.5 This view has been shared with HSE senior management who agree that opportunities to gain timely information were missed. Senior management advise that in September 2021, 17 months after the incident, and 14 months after the review commenced, the SIMT informed the Safeguarding Review Team that Cohort 1 (79) was a priority for completion by November 2021, to inform learning and next steps, and that work on other cohorts be paused until a report on Cohort 1 was completed. They report that the Safeguarding Review Team advised that in order to complete the report by November they could only review the files of residents where concerns were identified by staff or families and this was agreed. The report was finalised in April 2023.

5.6 Some families have indicated that although their relative experienced a loss of cognitive functioning, they believe that if they had been asked and given the right support, their relative may have provided relevant information that could have been helpful to the investigation. The 2014 Adult Safeguarding Policy highlights that "*as far as possible, people should be supported to communicate their concerns to relevant agencies*."[6]. Although this is good practice it is however doubtful that it would have changed the outcome in respect of further prosecutions as due to their cognitive decline, their statements would have been unlikely to meet the rigorous thresholds for criminal evidence.

[6] HSE Safeguarding Vulnerable Adults at Risk of Abuse Policy , National Policy and Procedures 2014, page 21

6.0 Professional opinion

6.1 It is my opinion that a further examination of individual records is warranted and this should cover the period of Mr Z's employment. However, over three years have passed since 'Emily' disclosed her abuse and the residents with whom Mr Z worked are for the most part either mentally incapacitated or sadly deceased. I therefore propose a proportionate response that supports openness and transparency.

6.2 It is recommended that a decision to examine resident notes should be made in collaboration with residents and where appropriate with the nearest relative, or whoever has the necessary legal authority.

6.3 The findings from any further examination of records, although likely to be inconclusive, has the potential to have a significant impact on families and their wellbeing. Decisions which are likely to cause distress to residents and their families should not be taken lightly, nevertheless it is my view that they should be given the choice as to whether records should be examined, and supported to make a decision that is informed and suits their own family's circumstances.

6.4 "A Review of Safeguarding at Muckamore Abbey Hospital – A Way to Go" suggests that learning from people's families is invaluable and they should be treated as equal partners in the care and treatment of their relatives.[7]

7.0 Recommended Process

7.1 It is suggested that a letter is issued to residents (or where appropriate the nearest relative or whoever has the necessary legal authority) who were living in the Home during Mr Z's employment and whose records have not yet been reviewed advising them of Mr Z's prosecution and inviting them to indicate whether they would wish an examination of the resident's files to be

[7] A Review of Safeguarding at Muckamore Abbey Hospital – A Way to Go", Dr M Flynn 2019

undertaken. As Mr Z worked in the home for 16 years, a phased approach is likely to be required commencing with more recent residents. I understand that the HSE has begun a process of informing families and it would be my intention that the HSE build on that work.

7.2 Also those families whose relative's file has been examined and were referred to AGS may have further questions given the passage of time.

7.3 I appreciate that what appears to be a simple decision is in fact a complex matter.

The logistics of contacting families of former residents who were there during the time Mr Z worked in the nursing home, some of whom will have moved house, may be deceased etc will be difficult and requires a co-ordinated administrative response. The HSE must also be mindful of the court order that neither 'Emily' nor the Nursing Home can be identified.

7.4 The HSE will need to establish a social work team to examine the files and put in place support services for any families who come forward. I suggest that a dedicated team that can provide consistency, build trust and relationships and ensure good ongoing communication is required. It is important that families are supported within a compassionate, supportive environment that is trauma informed.

"*Trauma informed practice is an approach to care provision that considers the impact of trauma exposure on an individual's biological, psychological and social development".*[8]

8.0 **Conclusion**

8.1 We cannot change the dreadful events that happened within this community nursing home nor will we ever have residential facilities that are totally without risk. However, we can use the learning to minimise the risks for other residents in residential facilities throughout Ireland. We can also help those

[8] Right Decisions for Health and Care, mega-app, NHS Scotland

affected to find resolution and recovery through compassionate care, effective communication and openness and transparency.

8.2 To conclude with the words of a family who reminded me that it is the women who were personally affected by the actions of Mr Z who should be first and foremost in our thoughts and decision making,

"Women who contributed so much in their lives, left without a voice in their golden years and now again denied a voice when they need to be most heard".

Appendix 1

Bio for Jackie McIlroy

Jackie has worked in social care services in Northern Ireland for over 38 years. A professionally qualified social worker since 1990, she is registered with the Northern Ireland Social Care Council. For most of her career she has worked in adult services within the statutory sector in the Belfast area. In 2003, she won the NI Healthcare awards for leading on the development of a cinema and television health education campaign aimed at promoting young men's mental wellbeing. From 2004 to 2013, Jackie held various managerial roles within the Belfast Trust and was the Adult Safeguarding Lead for mental health services obtaining considerable experience of adult safeguarding practice both as a practitioner and as a manager.

In 2013, Jackie joined the Department of Health NI as a social work professional officer and contributed to the development of current policy and practice in adult safeguarding. In 2016 she was appointed as the Deputy Chief Social Worker for Northern Ireland and her directorate had responsibility for providing professional advice and assistance in the formulation of policy, preparation of legislation and leading on professional practice matters, including advising on safeguarding concerns.

Jackie also led on the Reform of Adult Social Care within the Department of Health. She retired in March 2023.