Príomhoifigeach Cliniciúil
Oifig an Phríomhoifigigh Cliniciúil
Ospidéal Dr Steevens, Lána Steevens
Baile Átha Cliath 8 , D08 W2A8

Chief Clinical Officer
Office of the Chief Clinical Officer
Dr Steevens Hospital, Steevens Lane
Dublin 8, D08 W2A8

www.hse.ie
@hselive
t 01 635 2000
e cco@hse.ie

TERMS OF REFERENCE FOR AN INDEPENDENT INVESTIGATION BY RETIRED CHIEF JUSTICE, MR JUSTICE FRANK CLARKE, INTO THE CARE OF PATIENT A IN UNIVERSITY HOSPITAL LIMERICK

BACKGROUND:-

1. This investigation is commissioned by the Chief Executive Officer of the Health Service Executive (HSE) (the "Commissioner"), following his receipt of a report, prepared under the National Incident Management System (NIMS) reference 22759675 ("the SAR Report") dated 30 November 2023 and marked *"Quality assurance completion and resubmission: 30th November 2023*".

2. The SAR Report was the outcome of a Systems Analysis Review (SAR), commissioned by the Chief Clinical Director of UHL into the care of Patient A.

3. The stated purpose of the SAR, which produced the SAR Report was to:

    - *Establish the factual circumstances leading up to and surrounding the incident.*
    - *Identify any findings that may have occurred.*
    - *Identify any contributory factor(s) that may have occurred.*
    - *Recommend actions that will address the contributory factors so that the risk of harm arising from these factors is eliminated or if this not possible is reduced as far as is reasonably practicable.* [1]

4. The "*review method/objectives*" of the SAR was stated as follows:-

    "The review will follow a system analysis methodology as per the HSE Incident Management Framework (2020) and the Incident Management Framework Guidance (2020). It will be cognisant of the rights of all involved to privacy and confidentiality and will follow fair procedures.

[1] Section 4.2 of The SAR Report,

This ensures that all those who participate in the review process are afforded due process and the right of reply."[2]

5. The SAR Report made the following findings:

- *"Crowding, also known as overcrowding, is endemic in Hospital 1's Emergency Department (ED).*
- *The 'boarding' of admitted patients in the ED is a planned part of patient flow in this hospital and includes specific funded jobs for staff to care for these patients, which are yet to be appointed.*
- *There is little apparent understanding of the risks and inefficiencies caused to patient care by a crowded environment by the Hospital System, in terms of the impact on the Emergency medicine doctors assessing, and managing patients and the nursing staff's ability to provide safe care.*
- *The use/misuse of the resuscitation area for all monitored interventions leads to crowding and an overemphasis on activity in this area. A monitored procedure room in Zones A and B/C with adequate staffing would ensure access to an EM Registrar in these areas and decompress resuscitation.*
- *There are insufficient ED nursing staff to provide adequate monitoring and care to the patients in the ED.*
- *There are insufficient Emergency Medicine doctors to care for the numbers and acuity of patients presenting in the timescale expected by the Triage system, the hospital and the community.*

[2] Section 4.8 of The SAR Report

- *There is a high turnover of staff both Nursing and EM Non Consultant Hospital Doctors (NCHDs) which leads to low experience levels and low situational awareness.*
- *There was only 1 Clinical Nurse Facilitator to support nurse integration and education at this time.*
- *There is only 1 EM Consultant who is on-call for the whole weekend and, as they cannot be present all the time, this leads to them providing specific supports only. This has led to an expectation gap.*
- *The National Guideline No. 26: Sepsis management in Adults and Maternity was not followed on the 17th December 2022 leading to a delay in sepsis care of 12 hours.*
- *The escalation protocol was not adhered to on Sat 17th day or night despite numbers of patients awaiting an inpatient bed varying between 42 and 55."*

6. The SAR Report also made the following incidental findings:

"Staff Support

An essential element of any review process is meeting with staff both directly and indirectly involved in the incident. This informs the reviewers understanding of the chronology and wider contextual issues. During the course of this process the Review Team met with thirty staff across nursing, administration and medicine and received written reports from two, who were unable to make themselves available for interview. Subsequently we meet with the executive management team and one of the staff who was previously unable to attend.

A number of staff, not just those directly involved in Patient A's care spoke of the gravity of the impact on hearing of the death of Patient A.

While some staff report being offered informal and formal supports in the immediate aftermath there was no evidence of hospital management identifying staff who may have benefited from a support process and then ensuring a structured assistance program being put in place in timely manner. During this review process such was the evident trauma of the staff, the Chair of the Review Team wrote to the Commissioner in April 2023 and recommended that staff be offered additional supports, which occurred."

7. The SAR Report may be furnished on a confidential basis by the Independent Investigator to any person with whom he seeks to engage in the course of his investigation.

THE INVESTIGATOR:-

8. The Commissioner has appointed retired Chief Justice, Mr. Justice Frank Clarke (the "Independent Investigator") to conduct this independent investigation (the "Independent Investigation").

SCOPE:-

9. The scope of the Independent Investigation is to provide an evidence-based report on the circumstances surrounding the death of Patient A and the clinical and corporate governance of University Hospital Limerick which led to the conclusions set out in the SAR Report and for the Independent Investigator to make any recommendations as he sees fit. The Independent Investigation will also report on any other factors and/or causes which can be identified for the purposes of improving current and future service delivery.

10. The Independent Investigator may make such recommendations as he sees fit.

11. The Independent Investigator is requested to conduct the investigation process within a period of eight weeks or as soon thereafter as practicable.

12. The Independent Investigator is requested to produce a written report.

    The Independent Investigator shall provide a copy of his report to the Chief Executive Officer of the HSE as Commissioner of this process.

13. The Commissioner acknowledges that this is an Independent Investigation.

14. Accordingly, the Independent Investigator will determine the methodology for the approach to be taken in order to achieve the objectives set out above.

15. The Independent Investigator may meet with any person or persons (virtually or in person as deemed appropriate by the Independent Investigator) who can assist with the investigation as the Independent Investigator deems appropriate. The purpose of such meetings is to provide an evidence-based analysis and report into the matters identified above. The Independent Investigator is free to seek any information and to raise any issue, which they consider relevant to the investigation. The Independent Investigator may also determine that any particular issue is outside of the scope of the investigation, but will note same in the final report.

16. All meetings will be recorded by Gwen Malone Stenography services.

17. The Independent Investigator shall make such enquiries, conduct such interviews, examine such documents, and engage in such correspondence as considered appropriate for the purpose of the investigation.

18. Refusal or failure to co-operate by any individual will not prevent the Independent Investigator producing a written report at the conclusion of the investigation based on the information available to them at the time.

19. The evidence considered and/or gathered during this Independent Investigation as well as the report of the Independent Investigator may be used to support, and relied upon in, further processes, e.g. a complaint, an investigation under a HR procedure, or for the establishment, exercise or defence of a legal claim.

20. In the event that the Independent Investigator considers it necessary to seek an extension, variation, amendment or clarification to the Terms of Reference he may make such recommendations to the Commissioner as appropriate.

21. The Independent Investigator will be provided with administrative support for the purpose of the Independent Investigation.

22. In addition, the Independent Investigator may, with the approval of the Commissioner, engage the services of experts with specialist expertise ("Specialists Experts") for the purposes of the Independent Investigation. Where Specialist Experts are engaged, their expert opinion (where it is relied upon) will be clearly identified in the draft report of the Independent Investigation for the purposes of fair procedures. For the avoidance of doubt, any Specialist Experts may attend any meetings conducted in the course of the Independent Investigation at the discretion of the Independent Investigator.