Independent Review of the Governance Arrangements in a HSE Nursing Home

'Emily'

National Independent Review Panel

February 2023

Introduction

On the 26th August 2020 the HSE commissioned the National Independent Review Panel (NIRP) to complete a governance review following a serious reportable event (SRE) on 3rd April 2020 in a HSE community nursing home for older people (hereafter known as 'The Nursing Home').

A female resident pseudonymised in this report as 'Emily' who lived in The Nursing Home, reported to staff that in the early hours of 3rd April 2020 a male care assistant entered her room at 4.00 a.m. and raped her. This allegation was reported to An Garda Síochána (AGS) who arrested the alleged perpetrator. A male health care assistant (HCA) pseudonymised in this report as 'Mr Z' was subsequently convicted and received an 11-year prison sentence on 30th July 2020.

The HSE commissioned the NIRP to complete an independent review of the governance arrangements within The Nursing Home. The focus of the review was to examine the circumstances of the incident in line with the governance arrangements and to identify any learning opportunities/improvements that could lead to improved safety of all residents at The Nursing Home and other residential facilities across the country.

1.3 The review panel

1.3.1 Ms Bernie Mc Nally (Chair)
Ms Clare Quigley (Reviewer)
Ms Joanne Haffey (Service Manager until February 2022)

Terms of reference

The purpose of this review is to examine and review the governance arrangements in place at the HSE's Nursing Home.

The work of the review panel was to:

- Review the response to the serious reportable incident including follow-up actions when it first came to the attention of the Nursing Home staff.
- Review pathways and documentation processes relating to safeguarding reports, complaints and serious reportable events, to ascertain if they are fit for purpose.
- Review application of the national safeguarding policy including safeguarding training, safeguarding practices, role of designated officer and role of social work in the Nursing Home.

- Review the management and leadership arrangements within the Nursing Home including external oversight by the local HSE Community Health Organisation (CHO).

- Review recruitment processes for the Nursing Home including those procedure surrounding the recruitment and vetting of new staff including agency staff to ascertain if they are fit for purpose.

- Review the findings of the most recent Health Information Quality Authority (HIQA) inspection (April 2019) and the follow-up actions taken by the Nursing Home.

Methodology

The National Independent Review Panel:

- Engaged with management in the Nursing Home, senior management within the Community Healthcare Organisation and the HSE's National Community Operations Division to agree a review plan

- Engaged with management in the Nursing Home and senior management in the CHO to establish collaboration with the process and gain access to relevant documentation
- Engaged with Emily's family on ten occasions throughout the review process in order to work collaboratively with them and keep them updated on the review's progress

- On 16th December 2020 held an information meeting with staff members of the Nursing Home to provide them with information about the review process

- Reviewed all relevant records relating to the governance arrangements in the Nursing Home

- Reviewed all records held by the Nursing Home on Emily

- Reviewed other residents' files for the purposes of assessing record keeping in the Nursing Home

- Liaised with the safeguarding and protection team (SPT) through regular meetings for the purpose of sharing information

- Reviewed the personnel file of the male health care assistant (Mr Z) who was convicted of the rape of a female resident

- Completed factual accuracy and due process on every person or organisation referred to in the final report enabling everyone to consider and respond to what has been written about them, making amendments as appropriate.

- Interviewed staff members of the Nursing Home and CHO including some who have moved post or retired

- Anonymised and pseudonymised the report to protect the identity of the victims

The Nursing Home

Staff interviewed during this review described the Nursing Home as being 'friendly' 'relaxed' 'warm' and 'a good place to work'. Others interviewed by the review team described it as a caring environment and one member of the MDT said, 'I would happily place my parents there'. Emily and her family chose this home for its good reputation in the local community and by the welcoming warm reception they experienced.

Management and leadership

Throughout the course of the NIRP review into the SRE of the 3rd April 2020 the staff and management of the Nursing Home cooperated fully with the review team, providing documents and presenting themselves for interview in an open and transparent manner. Some of these staff members had moved post or retired but still made themselves available to the NIRP review team.

Following the allegation that Emily had been raped, the HSE took all the appropriate actions required to ensure a timely response to the incident. The CHO management immediately set up a serious incident management team and mapped out a series of actions required. These actions included commissioning a review of the governance arrangements in the unit (NIRP report) and instigating a thorough safeguarding review to determine if there was evidence of any other criminal behaviour by Mr Z.

Communication

Following a serious incident, such as the one that occurred on 3rd April 2020 in the Nursing Home, the importance of a robust communication plan cannot be underestimated. Effective communication in the wake of a crisis is critical to an organisation's ability to maintain trust and positive working relationship with its employees, residents and their families. When a serious incident occurs, it is imperative that an organisation communicates effectively as the dissemination of information about a serious incident often quells the sense of chaos that comes with a crisis. Importantly, the sharing of correct information will prevent the spread of misinformation. Unfortunately, the HSE management did not develop a clear communication plan until months after the incident was reported. In fact, the need for such a plan was only accepted following contact by a local newspaper on stating that

they wished to run a story. This left staff and families without clear and factually accurate information with rumour and misinformation filling the vacuum.

Managers in the HSE and staff in the Nursing Home appeared to take their direction from An Garda Síochána who asked that no-one be given any information while they were conducting their enquiries. Such a blanket ban on information sharing is not helpful when the Nursing Home was trying to manage a crisis and endeavouring to help a severely traumatised victim and family. The NIRP review team were particularly concerned that when Emily returned to the nursing unit following the visit to the SATU on the evening of the 3rd April that the staff nurse (staff nurse 1) who was asked to care for her during the night and observe her every 15 minutes was given very limited information about her ordeal or why she was being observed. The HSE informed the NIRP that staff were not advised of the full nature of the allegation on the advice of the Gardaí pending their inquiry. Staff members, including staff nurse 1, were advised that an allegation of abuse had been made by Emily against a member of staff, but no details were provided.

The NIRP review team could not find any joint policy guidance/protocols between An Garda Síochána and the HSE around this issue which would provide a framework for HSE and An Garda Síochána to work together. Such a protocol/guidance would be helpful for both parties to understand each other's roles and responsibilities and ensure that the HSE managers are not left with an impression that they are not to communicate with their staff.

Trauma of staff and managers
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. Many staff openly wept in public settings and private interviews as they struggled to come to terms with what had happened. The NIRP review team believe that the limited communication in the weeks and months following the SRE on the 3rd April contributed significantly to the trauma the staff experienced.

The NIRP acknowledge the important and helpful role the psychological support provided had in delivering care and support to staff in the aftermath of the SRE. However, the NIRP also acknowledge that this intervention alone was a wholly inadequate response to a staff team in crisis, who were expected to continue to work on a day to day basis caring for very vulnerable residents with little or no day to day support. In this regard it is the view of the NIRP that the psychology intervention should have been embedded in a more comprehensive / broader suite of supports and interventions that was commensurate to the circumstances that the staff team were experiencing.

Record management
Records management is an area which the NIRP review team believe requires a complete overhaul as part of a service improvement plan.

There are two key issues that the management team in the Nursing Home need to improve. The first relates to the practice of contemporaneous notes and the second pertains to file management.

There were no contemporaneous notes made by any of the staff or management relating to the SRE of 3rd April 2020 and ultimately the absence of contemporaneous records led to differences in staff recollection of the timing of certain actions on the day. Although these differences in recall made no material difference to the overall outcome in this case, it does serve to emphasise the importance of proper record keeping and the taking of contemporaneous notes particularly relating to serious safeguarding incidents. It is also notable that had contemporaneous notes been required as part of the Garda investigation or court proceedings, this could have been problematic for the service.

The NIRP liaised regularly with the Safeguarding Protection Review Team (SPRT) throughout the course of this review. The NIRP have been made aware that this team have reviewed the files of 32 residents. Over all they found the files to have gaps in information for example if an NIMS report was made on a resident there were no corresponding contemporaneous notes on the particular incident, making it difficult for staff to be aware of incidents or allegations. They found the files difficult to navigate as they were not organised chronologically. The SPRT also observed that there is a practice in the Nursing Home whereby healthcare assistants are not permitted to make entries into the daily notes of residents; they give updates to the nursing staff and rely on them to write this into the resident's daily notes. This means second hand information is being recorded in resident's notes which could lead to inaccurate information or misinterpretation of information. In the interests of safe care for residents it is imperative that their files are organised, easy to navigate and that important information about a resident is kept at the front of the file in the form of a profile or synopsis. This is particularly important for new staff, including agency staff coming on duty to be able to pick up what is going on in the home and respond appropriately.

Safeguarding training
Safeguarding training is an essential tool in an organisation's strategy both to prevent abuse and respond to events where abuse is suspected. A key component of safeguarding training is to make staff more aware of the signs and symptoms of all types of abuse and give them clear guidance on how to report concerns of abuse.

The NIRP review team believe that a key issue in this case was that staff could not believe that sexual abuse would occur in their place of work. This is despite the fact that the NIRP have information from a number of sources that a number of residents on occasions displayed signs and symptoms of possible sexual abuse.

This issue runs much deeper than just training and speaks to a general societal disbelief that sexual abuse does not happen to older people. This attitude is reminiscent of the early 1980s in Ireland when concerns around the sexual abuse of children were emerging in relation to Industrial Schools and the Catholic church. At that time there were strongly held societal beliefs that this simply did not happen. However, forty years later society accepts that sexual abuse does happen to children, and we have become much more knowledgeable and protective of children in this regard. Sadly, the HSE appears to have some way to go in relation to believing older people when they claim to have been sexually abused.

How could the sexual predator (Mr Z) operate in a place of safety

Sexual offenders like Mr Z can be difficult to identify as each will develop their own individual pattern of offending which makes it difficult for staff or management to detect a sexual predator within their work environment. They often present as pleasant, helpful individuals on one level while opportunistically targeting and abusing victims.

Mr Z was convicted of a single offence of rape of Emily perpetrated on 3rd April 2020, but it is likely that this was not the only occasion that Mr Z sexually assaulted a female resident in the Nursing Home. On 5th April 2020 Emily disclosed to An Garda Síochána in interview that this man had sexually assaulted her before the 3rd April 2020. She disclosed the same information to her psychiatrist Dr A stating that Mr Z had sexually assaulted her previously, although she was unable to give precise dates.

The NIRP review team had access to a document which outlined allegations of sexual abuse by Mr Z of six other female residents. This document was completed retrospectively after Mr Z's conviction by a member of staff who reflected on incidents reported by residents. These allegations against Mr Z did not appear to be taken seriously or followed up to the same extent as the allegation made by Emily on the 3rd April 2020. Only one of these allegations was reported to the Safeguarding and Protection Team (SPT) accompanied a medical rationale (dementia) for the complaint. The Safeguarding and Protection Team (SPRT) followed up all of these allegations and others with a file review of each resident identified as a possible victim. The SPRT found reports in files that nine other residents in the Nursing Home had alleged reportable incidents of sexual assault by Mr Z, none of which were followed up in accordance with the HSE safeguarding policy. The SPRT also found reports in files of two other residents who had reported physical abuse by Mr Z. All eleven of these incidents have now been reported to An Garda Síochána in line with the HSE's safeguarding policy and the residents' families have been informed. An Garda Síochána however, have indicated that it is

highly unlikely that any further prosecutions will follow due to the fact that most of the alleged offences were committed against residents now deceased or residents who no longer have the capacity to make a formal complaint.

So, while it is not proven 'beyond reasonable doubt' that Mr Z committed offences in the Nursing Home other than the one he was convicted of, the NIRP review team believe that on the balance of probabilities it is highly likely that Mr Z has assaulted other residents entrusted to his care. The key issue for this NIRP review, is to understand why the concerns raised did not trigger a safeguarding response at that time in line with the HSE's safeguarding and protection policy, in a nursing home which is meant to be a place of safety for residents.

Nature of sexual offending

To answer this question one must understand the nature of sexual abuse and in particular sexual abuse by trusted professional Carers. Research suggests that such abusers are usually able to exploit the power imbalance that exists between themselves and the resident. They use secrecy, implicit or explicit threats, rewards and knowledge of the victim to exploit their position of power (Halter, Brown, and Stone 2007).

Sexual predators are often able to groom the staff and the management into believing that they are not a threat to anyone and that they are, as in Mr Z's case 'a good Christian, hardworking man'. The NIRP review team spoke to many members of the Nursing Home staff none of whom believed (before his conviction) that Mr Z was capable of such a heinous crime and have only been convinced by the forensic evidence and his guilty plea.

Because of the nature of sexual abuse there are rarely any witnesses, and the victim is often not believed, or their allegations are explained as confusion or delusion. Having worked in the Nursing Home since 2004, Mr Z was aware that most of the women in his care had dementia, memory loss or an existing mental health condition and that, previous allegations of rape had either been dismissed or explained within a medical model as a symptom of an underlying medical/psychiatric condition. He was therefore quite confident in the way he operated. On the night of the 3rd April Mr Z was able to easily elicit information from his colleague about her planned timetable and work plan and knew when he could carry out his assault. He was also aware that the 'floating' HCA staff member was out on sick leave that evening and a replacement had not been found. He was not concerned that there were CCTV cameras on the corridors, nor that Emily might call out or ring the bell, as he was confident that due to the lay out of the building that no one else would hear her. He was also confident that if Emily did tell someone she would not be believed. After the rape he was able to continue working as normal with no signs of anything unusual which adds to the impression that this was not a one-off incident and that he had confidence that he could perpetrate rape without fear of being caught.

Physical layout of the building

Mr Z was able to fully exploit the physical environment of the Nursing Home to ensure he was not caught in the act of sexual assault. The layout of the building meant that there were private areas where staff members had limited sight of what others were doing particularly at night. There was no viewing window from the nursing station on Unit 1. In early 2021, a viewing window was put in place on the recommendation of the NIRP review team.

Cameras visible to the porter are in fixed locations at fire exits, kitchens, entrances and exits to the unit, and do not cover bedroom entrance areas. The only CCTV which has a view of the bedroom corridor areas is located in the office of the assistant director of nursing and is not accessible to nursing staff on night duty. Mr Z regularly worked at night and would have known about the limited physical monitoring systems within the Nursing Home. It is probable therefore that the shift patterns, temporary staff due to Covid and the physical layout of the building all contributed to enabling Mr Z to operate confidently without fear of detection.

Victims were not believed

The NIRP review team is aware that when female residents made allegations against Mr Z in the past they were not believed, reported or followed up on. It is recorded on the file of one resident, (now deceased) that she had informed a carer that she was 'raped' and that 'no one believes me'. A number of other residents also alleged to staff that they were 'raped' or 'assaulted' but these complaints appear to have been ascribed to clinical causes such as delusions, hallucinations, delirium, confusion or urinary tract infections.

Knowing that victims' allegations were not taken seriously was likely to have increased Mr Z's sense of invincibility and encouraged him to continue to sexually assault residents.

Nine female residents who made allegations that Mr Z had raped or sexually assaulted them and subsequently met the threshold for reporting to An Garda Síochána had a diagnosis of dementia often presenting with confusion and hallucinations. When these female residents made allegations, these were treated as a symptom of their overall level of confusion. A member of the multidisciplinary team, Dr D, informed the review team that 'when working with people who have dementia and are very confused it can be very difficult as a professional to disentangle deluded thoughts from reality'. Dr D went onto say that some residents in the Nursing Home with dementia have said outrageous things that clearly are not true and some of these same individuals have made allegations of sexual assault leaving it very difficult for professionals to determine fact from fiction.

Many of the allegations of rape and sexual assault made by the nine female residents were written in the file notes however, with one exception, it does not appear that any of them were followed up at the time with a safeguarding report or investigation. From interviews with staff it was evident that there was a prevailing culture of disbelief that such sexual assaults could happen in their workplace. Most staff believed that these allegations had

clinical/medical explanations related to the residents' conditions. Victims would also have been aware of the fact their comments, physical signs and behaviours were not believed by staff and did not prevent Mr Z from repeating his abuse. This has most likely have led to a sense of learned helplessness as the victims realised they had no power or control of the situation.

Race
On occasions when residents attempted to identify Mr Z by referring to his skin colour, colleagues and management were keen to support Mr Z so that he would not feel racially abused. This afforded him the opportunity to explain and dismiss allegations made by his victims as being racist and biased.

Lack of awareness of sexual abuse
The staff and management team did not appear to be aware of the potential for rape or sexual abuse within the Nursing Home and did not appear to consider the possibility that abuse could be taking place. In interviews several members of staff expressed shock, disbelief and one person believed (when the allegation was first made) that Emily must have been dreaming. They said that they did not believe it until conclusive forensic evidence emerged and Mr Z pleaded guilty in court.

Conclusion

The undisputed rape of Emily, the subsequent disclosure by Emily that this had happened before and the fact that there were previous, unreported, notifiable incidents suggest that the rape of Emily on the 3 April 2020 was not a one-off incident.

The NIRP review team have examined the culture, practice and governance of the Nursing Home to try to understand how this could have happened in a home which had so many positive qualities. 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

Mr Z's criminal behaviour only came to light as a result of the cognitive clarity, emotional strength and bravery of Emily. On the 3rd of April 2020 Emily's clear statements and consistency in repeating her allegation of rape to three different care staff and eventually to the DON and the GP led to a report to An Garda Síochána. Her consent to submit to a forensic

medical examination proved beyond reasonable doubt that Mr Z, a trusted member of staff, was in fact a rapist who had attacked her in her own bedroom. Emily's actions and sacrifice undoubtedly helped convict her rapist and saved other vulnerable women from his predatory behaviour. His behaviour as a sexual offender was thwarted by Emily and the staff members who heard and believed her and who acted appropriately in securing his conviction. May she rest in peace.

Recommendations:

1. The HSE should establish a working group to examine and reform the management of and model of care in residential facilities for older people in line with international best practice models. Movement towards a more social model of care would emphasise the fact that this is the resident's home rather than a 'nursing' facility. This would reduce the likelihood of allegations and incidents of sexual abuse being viewed through the lens of a medical condition. Such a working group should have wide professional representation and include a user representative and a family representative.

2. HSE should implement a staff awareness campaign (including senior staff in the Community Health Organisations) to ensure older people who are victims of sexual abuse are believed and that safeguarding allegations are taken seriously. This should include awareness raising on the traumatic impact of sexual abuse, compassionate care for victims, and how to support residents, staff and families.

3. All staff working in HSE community facilities caring for vulnerable people should receive face to face/group training on the signs and symptoms of elder abuse and should include direction on how to respond appropriately to allegations that are brought to their attention.

4. The HSE should review the policy of moving much of their safeguarding training to an on- line platform. Group learning and sharing provides a valuable way of ensuring untrue myths around the sexual abuse of older people are debunked in a supported environment and inappropriate cultures and inaccurate staff beliefs are challenged.

5. The HSE should develop a crisis response plan to ensure that in future there is an appropriate management response to staff, residents and families when a serious traumatic event occurs within a facility. This should include a communication plan and an appropriate support programme for residents, staff and families to help them deal with the trauma associated with such an event.

6. The HSE should review the resources that are available to the local safeguarding and protection team to ensure staff are equipped with the time and energy to deal with allegations of sexual abuse in residential facilities. This review should examine the availability of senior experienced social work staff in the HSE to provide strategic advice on the management of safeguarding allegations to ensure each and every

allegation is reported to the appropriate authorities and immediate actions are taken to prevent reoccurrence.

7. There should be a memorandum of understanding/ joint protocol agreed between the HSE and An Garda Síochána on the roles and responsibilities of both organisations (including a communication plan) when allegations of sexual abuse of a vulnerable adult are being investigated.

8. The HSE should review the record keeping /file policy in residential facilities to ensure files are fit for purpose. This should include responding to the difficulties identified in this review, particularly in relation to contemporaneous note taking in the event of an untoward incident.

9. The HSE should review the policy of rotating HCA staff to other units to ensure vulnerable residents such as Emily get the personal, intimate care they require from a trusted individual following a trauma.